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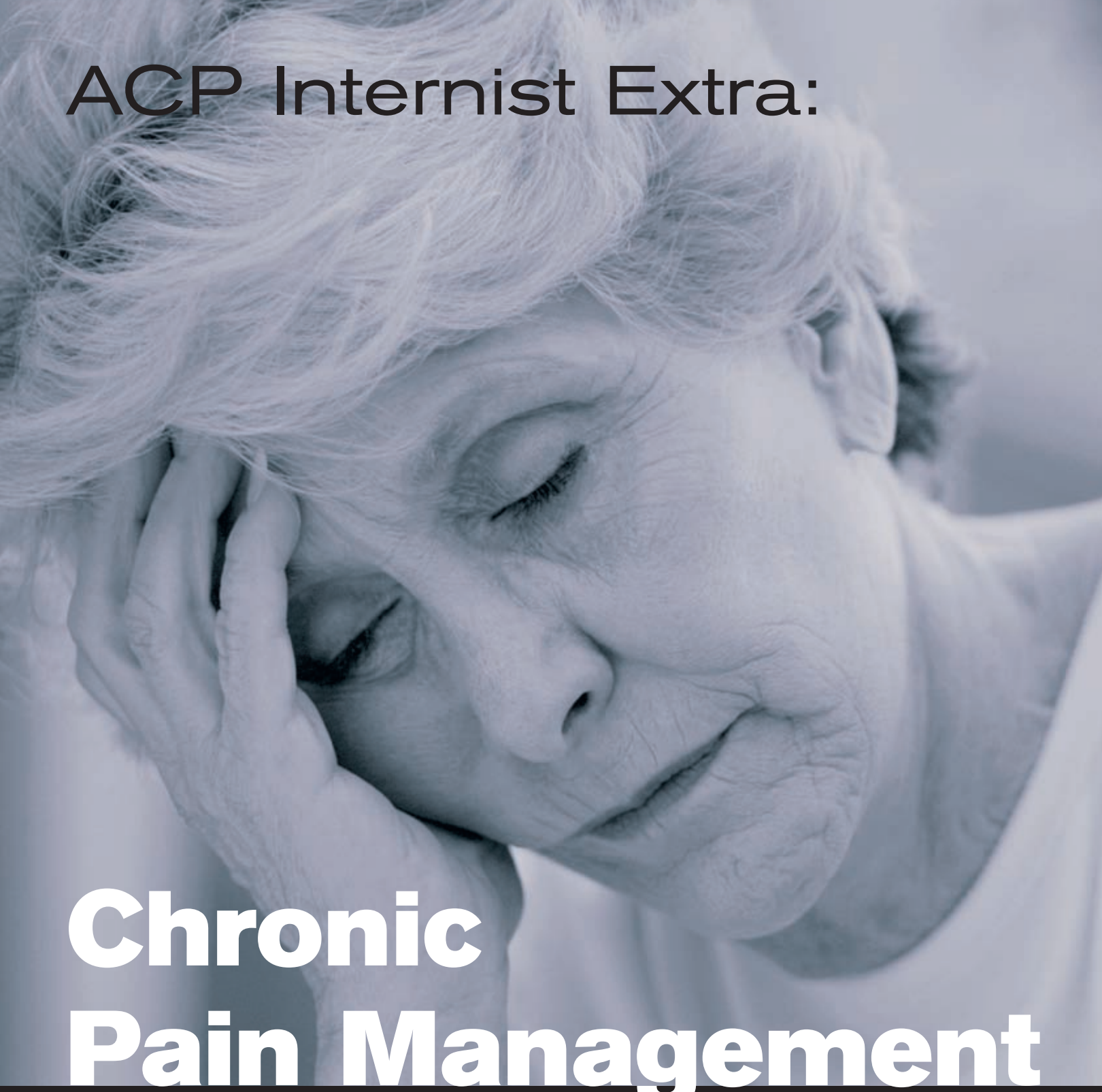

Chronic Pain Management

An Appropriate Use of Opioid Analgesics

Introduction

An accepted definition of pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." Pain is classified as nociceptive (somatic and visceral), resulting from the stimulation of specialized receptors, or neuropathic, based on a primary dysfunction of the peripheral or central nervous system. Acute pain originates from the specialized nociceptive nerve endings, and is protective by warning of potential or actual injury. Chronic pain is defined as pain that persists for one month beyond the normal time of healing.

Chronic pain can be categorized as malignant, nonmalignant or neuropathic (either malignant or nonmalignant). Drug treatment is largely dependent on type of chronic pain syndrome. Even among patients with nonmalignant (degenerative arthritis, sickle cell pain) or idiopathic pain syndromes (low back pain, irritable bowel or chronic headache), syndrome-specific treatments are available for which there is supporting randomized trial evidence. Every attempt should be made to identify pain mechanisms and recognize common pain syndromes in order to help select appropriate, targeted therapy. Treatment strategies targeted specifically to underlying pain mechanism and clinical syndrome are most likely to provide long-term relief of pain.

The focus of diagnosis and evaluation of chronic pain should be on reversible causes of the pain. Initiation of pain treatment should not be delayed while a diagnostic work-up is completed, as uncontrolled pain has significant adverse effects on quality of life, functioning, and mood.

Assessing Pain

Because pain is subjective, physicians need to listen to and believe patients' reports of pain. When assessing chronic pain, remember that autonomic responses, present with acute pain (e.g., tachycardia, hypertension and diaphoresis), are not reliable indicators of chronic pain. They may be entirely absent despite the presence of chronic pain.

Determine the site of pain, its onset, temporal pattern, exacerbating and relieving factors, and associated symptoms. Learn how much the pain is interfering with daily activities or affecting the patient's psychological state. To help patients quantify their pain, use a number of pain-intensity assessment tools—including the universal pain assessment tool (www.anes.ucla.edu/pain/FacesScale.jpg) or quantify on a scale such as the Edmonton Symptom Assessment Scale (www.palliative.org/pdf/esasi.pdf). Note when the worst and least pain occur and the average daily pain. Identify comorbid medical or psychosocial conditions (e.g., depression, substance abuse, alcoholism) that may affect the pain or its management. Particularly, evaluate the potential for substance abuse in patients with chronic, nonmalignant pain by documenting behaviors suggestive of drug-seeking.

The physical examination must focus close attention on the painful and related areas. Laboratory, X-ray, CT and other imaging studies and consultation with others may be necessary for proper evaluation. Ongoing reassessment of the patient's response to therapy helps determine if the therapeutic regimen has been a success.

Drug Treatment Overview

The World Health Organization (WHO) has published a simple and validated three-step approach to pain management that has been shown to be effective in relieving pain in 90% of patients with cancer (See figure, page 4). The basic principles behind the three steps of the ladder include selecting the appropriate analgesic for the pain intensity and individualizing the dose by titration of opioid analgesics.

Treating mild pain

On the 0-10 pain intensity scale, 1-3 equals mild pain. Mild pain can usually be adequately treated with aspirin, acetaminophen, and nonsteroidal anti-inflammatory drugs (NSAIDs). These drugs differ from opioids in two important ways: there is a ceiling effect to the analgesia (more drug is not associated with greater pain control), and they do not produce tolerance or physical dependence. Unless contraindicated, management of all levels of pain includes a drug from this category. Acetaminophen may be preferable in patients at risk for NSAID side effects such as renal failure, bleeding, gastric ulceration or hepatic dysfunction. NSAIDs or aspirin may be appropriate for other patients, particularly if there is an inflammatory component of the pain. Because NSAIDs and acetaminophen have a ceiling analgesic effect, be aware of the maximum recommended doses:

- Acetaminophen, 4 g/d
- Ibuprofen, 2400 mg/d
- Naproxen, 1250 mg/d
- Aspirin, 4000 mg/d

Treating moderate pain

On the 0-10 pain intensity scale, 4-6 equals moderate pain. In the initial treatment of moderate pain, low-dose opioid drugs are added to aspirin, acetaminophen, or NSAIDs. For patient convenience, many opioids are marketed as combination products containing one of these agents. It is the daily cumulative acetaminophen dose that limits the dosing of the opioid in combination medications. For this reason separate dosing of the opioid and acetaminophen is preferred.

Treating severe pain

On the 0-10 pain intensity scale, 7-10 equals severe pain. The treatment of severe pain requires stronger opioid agonist drugs and continuation of aspirin, acetaminophen, or NSAIDs if possible.

Adjuvant therapy

There are a number of drug and nondrug therapies that can enhance the effects of nonopioid and opioid analgesics especially when treating neuropathic pain. Combination therapy with multiple modalities and drugs from different classes may offer synergistic efficacy while minimizing dosing and side effects of opioids. At the top of the list are tricyclic antidepressants, although they are not FDA-approved for pain treatment. Studies have confirmed their effectiveness in diabetic neuropathy and postherpetic neuralgia, and they frequently are used for neuropathic pain from other sources.

Anticonvulsants are used to relieve the shooting, electrical pains of peripheral nerve dysfunction. Clinical trials have demonstrated their effectiveness in diabetic neuropathy, postherpetic neuralgia and trigeminal neuralgia. Glucocorticoids can reduce edema and lyse certain tumors and thereby enhance the analgesic effect of nonopioid and opioid drugs. They are effective in the management of malignant infiltration of the brachial and lumbar plexus and spinal cord compression, bowel obstruction, and headache pain due to brain tumors.

Somnolence due to opioids may last for 3-7 days especially with initiation of therapy or with increase in dose. "Starting low, going slow" is a wise adage. Consider psychostimulants such as methylphenidate, modafinil, or dextroamphetamine to counteract opioid-induced sedation and for additive analgesic effect, particularly in patients with cancer on large doses of opioids. These drugs are underutilized in cancer pain syndromes at the end of life when fatigue due to illness is also present. However, stimulants must be used cautiously in chronic nonmalignant pain since they are associated with tolerance and side effects of their own. There are numerous contraindications to their use.

Randomized clinical trials have demonstrated a benefit of decreased pain over time in patients with osteolytic lesions with breast cancer and multiple myeloma treated with bisphosphonates. Radiopharmaceuticals, such as strontium, are also useful for metastatic bone pain from osteoblastic lesions, but timing and degree of response cannot always be predicted and neutropenia and thrombocytopenia interfering with chemotherapy can limit their use.

Nonpharmacological interventions such as cutaneous stimulation techniques (e.g., heat, cold, vibration) have benefits including making pain more tolerable, as well as actual reduction of pain. The mechanism of action is not well understood. These interventions warrant consid-

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eration despite the limited controlled data supporting their efficacy, given the low cost, minimal morbidity and side effects, and potential benefits.

Recommend psychotherapy, in combination with physical therapy, and one or several nonpharmacological interventions for difficult-to-manage chronic pain

When should opioid therapy begin?

Once it is established that nonopioid therapy has not adequately controlled pain, consider adding a low-dose or low-potency opioid. Use a standardized approach when treating chronic nonmalignant pain with opioids involving only one prescriber and pharmacy, a well-defined plan and goals, and appropriate documentation.

Before initiating opioid therapy for nonmalignant pain:

- Evaluate completely all therapies directed at the cause of the pain.
- Ensure that opioid therapy's benefits will exceed its risks. This will depend on the extent to which pain interferes with a patient's life and well-being.
- Explain the potential risks and benefits of long-term opioid therapy to the patient.
- Establish agreed-upon goals for treatment.
- Ensure comprehensive follow-up.
- Monitor carefully for signs of opioid abuse.
- Consider weaning and discontinuing opioid therapy if treatment goals are not met or if there is evidence of addiction or noncompliance.
- Document your assessment and plans.

Treatment is considered successful if one or more of the following are met:

- Pain relief that improves well-being
- Progress toward goals
- Improved function
- Improved quality of life.

How should I choose an opioid?

Opioids are the major class of analgesics used in the management of moderate to severe pain because of their effectiveness, ease of titration, and favorable risk-to-benefit ratio. Opioids do not have an analgesic efficacy ceiling (higher doses are associated with greater pain relief) and can be titrated upward as needed until limiting side effects appear. The initial opioid should be chosen based on pain severity and the patient's previous experience with specific medications.

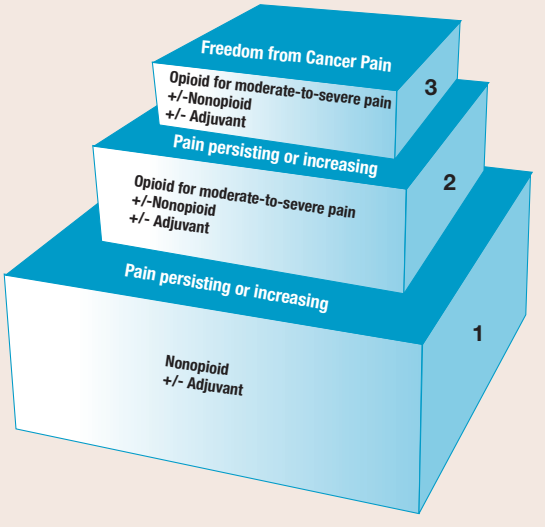
Most patients with chronic, moderate to severe pain that requires opioid therapy will be successfully managed with long-acting agents or a combination of long- and short-acting agents. Several agents are available. Because all are equally efficacious, the choice of agent should be based on cost, although a trial of these drugs may be necessary to determine which achieves the most acceptable balance of benefits and side effects. The less-expensive, long-acting narcotics are morphine sulfate and methadone, whereas the more expensive agents include oxycodone and fentanyl patches, the latter of which offers the benefit of dosing once every 72 hours. Methadone does have a potential role in chronic and cancer pain management, but its complex and highly individual pharmacokinetics require that experienced clinicians initiate, titrate and monitor its use.

Meperidine and mixed agonist-antagonist drugs are not generally recommended. After repeated doses of meperidine, the toxic metabolite normeperidine accumulates and can produce anxiety, tremors, myoclonus, and seizures. Since the metabolite is excreted by the kidneys, patients with renal insufficiency and the elderly are at particularly high risk for this complication. Meperidine is not indicated in the management of chronic pain. Mixed agonist-antagonist drugs offer no advantages over morphine-like drugs in the treatment of pain and have more psychomimetic side effects, and are capable of precipitating opioid withdrawal symptoms when given to patients taking chronic morphine-like opioids. These mixed agonist-antagonist preparations include nalbuphine (brand name Nubain), butorphanol (Buprinex) and pentazocine (Talwin), among others.

WHO Pain Relief Ladder

If pain occurs, there should be prompt oral administration of drugs in the following order: nonopioids (aspirin and paracetamol); then, as necessary, mild opioids (codeine); then strong opioids such as morphine, until the patient is free of pain. To calm fears and anxiety, additional drugs – "adjuvants" – should be used. To maintain freedom from pain, drugs should be given "by the clock," that is every 3-6 hours, rather than "on demand." This three-step approach of administering the right drug in the right dose at the right time is inexpensive and 80%-90% effective. Surgical intervention on appropriate nerves may provide further pain relief if drugs are not wholly effective.

Source: World Health Organization, www.who.int/cancer/palliative/painladder/en/



How do I begin opioids?

Treatment should begin with regular administration (q4h for most oral opioids: morphine, codeine, hydrocodone, oxycodone, or hydromorphone) of short-acting opioids until adequate analgesia is reached. If initial doses do not result in adequate relief, they may be safely increased after steady state is reached (4-5 half-lives or 1 day). Safety is assured by daily increasing the dose by 50% for persistent moderate pain and 100% per day for continued severe pain to reach acceptable analgesia. Consider lowering the initial rate of opioid escalation for opioid-naïve and elderly patients. It is OK to stop increasing doses if satisfactory analgesia is not achieved or if adverse effects intervene.

After satisfactory analgesia is achieved with shorter-acting opioids, begin around-the-clock dosing or long-acting analgesics for pain that is continuous or present most of the day. Fast-onset, short-acting preparations should be available for breakthrough pain in most patients on long-acting opioids. As a general rule, the dose of the immediate-release opioid is calculated as 10% (5%-15%) of the total daily opioid dose. The peak serum concentration (and peak effectiveness) for most oral opioids (see list above) is reached by 60-90 minutes. This peak is reached by 15 minutes with parenterally administered opioids. Repeat dosing for breakthrough pain may be as often as every 60-90 minutes for oral and 15 minutes for IV or sub-q routes. Titrate analgesics carefully based on the need and use of medications for breakthrough pain and on the specific drugs used.

When the patient develops tolerance—needing increasing amount of drug to achieve the same analgesic effect—increase the dose of the current opioid (usually 10-20%), switch to a different opioid (see page 6) and/or add a nonopioid to the current opioid regimen.

Which route and scheduling should I use?

While many opioids can be administered orally, rectally, subcutaneously, intravenously, transdermally/transmucosally or sublingually, use the least invasive and least expensive route of administration possible—usually oral. For most immediate-release opioids, peak blood levels are reached in about one hour. Therefore, if pain is not adequately relieved after 60-90 minutes, and side effects are not a limiting factor, a second dose can be safely taken.

If parenteral dosing is required, avoid intramuscular injections, which can be painful and absorption unreliable, by using intravenous or subcutaneous administration. Intravenous administration is associated with the most rapid onset of analgesia but also the shortest duration of action. For initial intravenous dosing in opioid-naïve patients, one-half the recommended dose is advised. The time to peak effect of intravenous opioids varies with the drug and ranges from 5 to 30 minutes. If severe pain persists but side effects are minimal at the time of the peak effect, a repeat dose is given at this time. Repeated intravenous doses are administered in this fashion to titrate to the point of adequate pain relief followed by a constant intravenous infusion of a maintenance dose. Continuous intravenous dosing is associated with steady blood levels of the opioid and provides the best analgesic control with the fewest side effects. Subcutaneous constant infusion is an equally effective alternative to intravenous infusion.

Consider intravenous patient-controlled analgesia (PCA) for hospitalized patients if oral analgesics don't work or aren't possible and to help maintain patient independence and control. PCA can achieve better analgesic effects using less medication than PRN dosing (medicating only when symptoms are present). A continuous infusion of opioid can be given along with the PCA bolus dosing in patients with chronic pain. Also, transdermal opioid patches are available for treating cancer pain. Fentanyl, for example, provides continuous drug infusion using a 72-hour reservoir. Because it takes 17-24 hours between applying the first patch and reaching a steady blood level, control patients' pain during that interval by titrating doses of short-acting opioids.

Fentanyl is also available as transmucosal tablets and sweetened lozenges that can be sucked like a lollipop. These preparations are rapid acting but their duration of action is short and they may not be as useful alone for chronic opioid therapy as patches, although evidence is lacking on this point.

Interventional approaches, such as intraspinal or epidural routes, should be considered when severe pain is not responding to usual opioid therapy (IV or oral) but these interventions require expertise that may not be available in all clinical settings. (see table, Dosing and Conversion Chart for Opioid Analgesics, at www.acponline.org/journals/news/supplements.)

What side effects of opioid use should I look out for?

Constipation is an almost inevitable side effect of chronic opioid therapy and should be anticipated. An example of a constipation prevention regimen includes docusate, bisacodyl or senna concentrate, and a hyperosmotic agent such as milk of magnesia or lactulose.

Opioid-related nausea and vomiting may be temporary (a week) and are treated with a phenothiazine antiemetic

or metoclopramide transdermal. If nausea is unremitting despite antiemetics, rotation to an alternative opioid is recommended. Some patients will experience less nausea if the opioid blood level remains constant throughout the day rather than experiencing period peaks. Changing the dosing interval of an immediate-release preparation from every four hours to a smaller dose every three hours may even out the blood level and reduce nausea and vomiting. Changing to a sustained-release opioid or the transdermal route also produces more constant opioid blood levels and may be helpful.

Opioid-related itching and urticaria are due to the release of histamine. For these patients, an antihistamine is useful. Oxymorphone and fentanyl are two opioids that do not release histamine and switching to these opioids can be considered. (see chart, below)

Patients quickly develop tolerance to the opioid respiratory-depressant effects. Respiratory depression is rare in patients on chronic opioid therapy. Opioid-naïve patients are more susceptible to respiratory depression than are patients receiving long-term opioids. In some circumstances, careful and close observation and physical stimulation to keep the patient awake may be all that is needed until the opiate level declines, generally in three to four hours. When rapid reversal of opiate depression is indicated naloxone can be administered in small increments to improve respiratory function without totally reversing analgesia. Naloxone should be diluted in a 1:10 saline solution and administered slowly rather than by bolus administration. All patients require careful monitoring until the episode of respiratory depression resolves.

When should I change to a new opioid and how do I do it?

If dose escalation fails, or to address side effects or to address tolerance, try opioid rotation. Switch the opioid and start at a lower dose. Consider incomplete cross-tolerance (increased sensitivity to new opioid) when switching between different opioids by decreasing the calculated dose of the new opioid by one-third or one-half in opioid-tolerant patients. When converting between different routes and different opioids, use equianalgesic dosing charts (See charts online at www.acponline.org/journals/news/supplements).

The five steps of changing opioids

1. Add the total dose of each opioid given during 24 hours. If both parenteral and oral doses were given, calculate the 24-hour total for each.
2. Determine the conversion ratio for each type of opioid and each route by using the "Dosing and Conversion Chart for Opioid Analgesics," available online. The conversion ratio is calculated as the equianalgesic dose of the current opioid (or route) divided by the equianalgesic dose of the alternative opioid (or route).
3. Divide the 24-hour dose of the current opioid (or route) by the conversion ratio to estimate the 24-hour dose of the alternative opioid (or route).
4. Modify this estimate based upon the clinical situation.
5. Divide the estimated dose by the appropriate dosing interval for the appropriate opioid (or route) based upon the "Dosing and Conversion Chart for Opioid Analgesics."

How concerned should I be about addiction?

Monitor patients carefully for signs of opioid abuse, but note that addiction is rare in patients receiving opioids for pain control. Distinguish among addiction, physical dependence, and tolerance.

Counsel patients—who may fear addiction and thus not take opioids as prescribed—that addiction is rare when the drugs are prescribed for legitimate medical indications. Let them know that increasing doses of opioids more often reflect disease progression and not addiction. Explain that tolerance differs from addiction and may also be a reason to increase dosages. If there is evidence of addiction or noncompliance, or if treatment goals are not met, explain that weaning and discontinuing opioid therapy will follow.

If you haven't already done so, consider using a written plan or "opioid contract" that specifies the physician and patient responsibilities regarding chronic prescribing of opioids.

What's an 'opioid contract'?

This is a written consent that may explain, for example, the expectation that the patient comply with recommended diagnostic evaluations and consultations, that the patient will visit and be re-evaluated by the prescribing physician at least once every month (or as defined by the physician), that the patient must keep a pain diary, that no psychotropic medications or illicit drugs not prescribed by you are taken, that drug testing at any time may be asked, and that there are risks and side effects with taking opioids. Failure to comply with the contract will result in discharge from your care.

While recommended by many experts and frequently used by pain clinics, there is limited empirical evidence for these contracts' efficacy. It is not necessary to consult a lawyer before entering into an opioid contract but the physician may decide to stop providing care, after offering a rapid withdrawal program, if the contract is violated by the patient. An example of a patient-physician contract

Conversion to Transdermal Fentanyl (Duragesic)

Parenteral Morphine: mg/24h (recommended)	Duragesic Equivalent (µg/h)
8-22 (17)	25
23-37 (33)	50
38-52 (50)	75
53-67 (66)	100
68-92 (83)	125
83-97 (95)	150

Adapted from the Texas Cancer Council Guidelines for Treatment of Cancer Pain.

can be found on the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's Web site (www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.57980#58727).

When should I refer?

Although most pain can be controlled with noninvasive measures, consider referring patients for invasive procedures for pain relief when noninvasive measures are inadequate or if the side effects are severe. Certain syndromes, such as head and neck pain, upper-extremity pain, and thoracic pain may respond best to invasive measures. Those measures include peripheral nerve blocks, radiation, epidural/spinal catheters for drug delivery, spinal cord stimulation, ablative techniques and surgical interventions.

In addition, refer patients with hard-to-manage chronic pain syndromes to multidisciplinary pain treatment programs to reassess the role of chronic opioid use and consider alternatives. Psychologists, physical therapists, occupational therapists, case managers, social workers, and stress-management and vocational counselors may help if pain causes disability in vocational, emotional, physical or interpersonal aspects of patients' lives. Some patients with chronic pain may become isolated from family or friends because of constant focus on the pain and may inappropriately use narcotics, alcohol or other drugs for relief of psychological angst.

Useful goals may include improving physical and psychological function, learning to cope with chronic pain, reducing use of the health care system, and returning to work if possible.

It also may be important to consult a psychiatric specialist for patients with significant underlying psychiatric conditions since these issues can contribute to and sustain chronic pain syndromes. In addition, psychiatric disorders may be drug induced, independent or interrelated. It is also critical to consult specialists in pain and addiction management for patients with current, or a history of, substance abuse or addiction. While prescribing opioids is not contraindicated in patients with a history of substance abuse, there are unique management issues in controlling pain in these patients.

Follow-up

Maintaining pain control requires close monitoring since pain changes over time as the underlying disease progresses or remits. Both clinical practice guidelines and Joint Commission standards recommend that physicians follow-up on patients being treated for chronic pain by re-assessing pain at regular intervals after starting the treatment plan, with each new pain complaint and after any change in the treatment plan. The frequency will depend on the severity of pain and the complexity of the therapy.

At those visits, assess patients taking opioids for inappropriate or dangerous drug-use patterns, compliance with prescribed drugs and nondrug therapies, follow-up with clinic visits and recommended consultations. Review a pain diary if appropriate. Assess current or past history of drug abuse—look for abuse of alcohol, cocaine, benzodiazepines, heroin and other drugs—and adverse life events related to medication use, such as loss of job. Re-address key elements of the history and physical, and assess and document quantitative pain levels. Monitor for side effects and screen for complications, especially from NSAIDs.

Strategies for detecting opioid abuse

It is unclear how to define addiction for patients treated with opioids for pain, so the diagnosis of addiction is left to individual clinical judgment. Some strategies can help.

First, know that opioid addiction is a neurobehavioral syndrome characterized by repeated, compulsive seeking or use of an opioid despite adverse social, psychological and/or physical consequences within a 12-month period. It is acknowledged that there is a link between previous drug or alcohol abuse and addiction to opioids prescribed for pain.

Second, look for signs of opioid intoxication and withdrawal, such as miosis, somnolence and respiratory slowing or respiratory depression, which may be associated with abuse or dependence. Signs associated with opioid withdrawal include mydriasis, rhinorrhea, tachycardia and hypertension. Consider other conditions that may mimic opioid intoxication or withdrawal, such as diabetes, liver failure, head trauma and epilepsy. Assess for drug-seeking behaviors, including the following:

- Prescriptions from several physicians
- Filling prescriptions at several pharmacies
- Lost medications or prescriptions
- Visits to other doctors for pain prescriptions
- Multiple emergency department visits for refills of pain medications

Be aware that similar behaviors may be due to undertreatment of chronic pain (termed pseudo-addiction). They will end when the patient's pain is treated with adequate doses of analgesics given at appropriate intervals.

Patient Education

Common misconceptions about pain management prevent some patients from finding maximum pain relief. Physicians can correct these misconceptions, especially fears of addiction, fear that the medicine will stop working, or even fear of being thought of as an addict. Provide specific information about drug management and note that pain can be relieved in most cases. Discuss optimal use of medications to maximize efficacy and safety, and prevention and control of side effects.

Also discuss how to assess pain by using a pain rating scale, how to use a pain diary, how and when to contact a physician about unrelieved pain and pain management, and how to use a preventive approach to pain control. Provide information about available or recommended nondrug interventions as well.

Because patients are often reluctant to report pain, address the issue at each follow-up visit and actively involve the patient's family and caregivers in treatment plan information.

Web Resources

Additional charts, tables and tips are online: (www.acponline.org/journals/news/supplements)

- Opioid dosing and conversion chart
- Suggested protocol for opioid therapy (printed on pocket card)
- Opioid conversion tips

See also:

PIER modules on pain and opioid abuse (pier.acponline.org)
American Academy of Pain Medicine (www.painmed.org)

How do you describe pain?

Is the patient's pain sharp? Squeezing? It's important to distinguish neuropathic pain—which may be less opioid responsive—from nociceptive pain to optimize therapy and minimize morbidity. Here are some guidelines, according to the PIER module on pain:

Neuropathic pain: Often described as burning, lancinating, stabbing, stinging, shooting, and sharp. Occurs in postherpetic or trigeminal neuralgia, diabetic and other peripheral neuro pathies and phantom limb pain.

Somatic pain: Often described as dull, aching or throbbing, such as in myalgias, arthropathies and bone metastases.

Visceral pain: Often more difficult to localize but may be described as deep, squeezing or pressure-like, such as in pancreatitis, peptic ulcer disease and myocardial infarction.

Cut Here ✂

Edmonton Symptom Assessment Scale (ESAS Numerical Scale)

Please circle the number that best describes

No Pain	1	2	3	4	5	6	7	8	9	10 Worst Possible Pain
Not Tired	1	2	3	4	5	6	7	8	9	10 Worst Possible Tiredness
Not Nauseated	1	2	3	4	5	6	7	8	9	10 Worst Possible Nausea
Not Depressed	1	2	3	4	5	6	7	8	9	10 Worst Possible Depression
Not Anxious	1	2	3	4	5	6	7	8	9	10 Worst Possible Anxiety
Not Drowsy	1	2	3	4	5	6	7	8	9	10 Worst Possible Drowsiness
Best Appetite	1	2	3	4	5	6	7	8	9	10 Worst Possible Appetite
Best Feeling of Well-being	1	2	3	4	5	6	7	8	9	10 Worst Possible Feeling of Well-being
No Shortness of Breath	1	2	3	4	5	6	7	8	9	10 Worst Possible Shortness of Breath

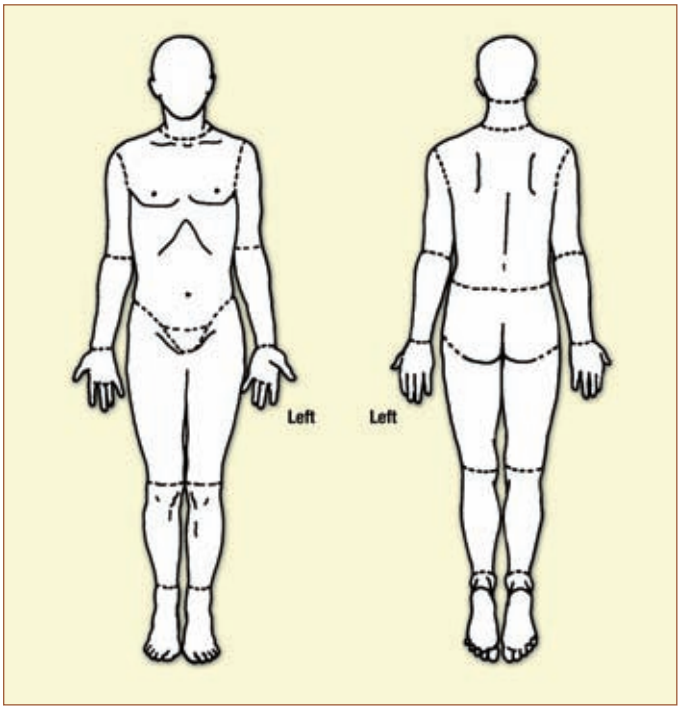
Other Problem _____

Patient's Name: _____

Date: _____

Time: _____

Completed By: ☐ Patient ☐ Caregiver ☐ Caregiver-assisted (check one)



Please mark on these pictures where it is you hurt.

Source: Regional Palliative Care Program