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This website uses cookies. By continuing to use this website, you consent to the use of cookies. For information about cookies and how to disable them, visit our privacy and cookie policy. I got it, thank you! Download... Factors associated with current and severe pain among people living with HIV: sample results across the state. Joseph V, Jones A, Canidate S, Manns, Lou H, Ennis N, Ibanez G, Somboonwit C, Cook R, Joseph V, et al BMC Public Health. 2020 Sep 18;20 (1):1424. doi: 10.1186/s12889-020-09474-y. BMC Public Health. 2020. PMID: 32948167 Free ARTICLE PMC. The publication of the Boli McGill questionnaire (Melzack, 1975) represented an important (r)evolution in pain research. Pain was mostly described and measured in terms of intensity, but thanks to MLA, the qualitative aspect of pain became an important subject in the study of pain. Pain writers were brought together and classified in three dimensions of pain experience: words that described sensory experience qualities in terms of temporal, spatial, pressure, thermal and other properties of words that described affective qualities in terms of tension, fear and vegetative properties, which are part of the pain experience of assessing words that subjectively describe the overall intensity of the overall pain experience In addition, it can also be used to diagnose and control the effects of the disease. The McGill Pain (SF-MP) short questionnaire is a shorter version of the original MP, developed later in 1987. The pain rating index has 2 subscale: Touch subscale with 11 words, and Affective subscale with 4 words from the original MP. These words or elements are rated on the intensity scale as 0 - no, 1 - soft, 2 - moderate and 3 - heavy. There's also one item for the current pain intensity and one item for 10 cm visual analog scale (VAS) for medium pain. In 2009, SF-MP was further revised for use in neuropathic and non-neuropathic pain (SF-MP-2). This new version includes 7 additional symptoms associated with neuropathic pain, a total of 22 points with 0-10 numerical response options. The intended SF-MP population was developed for adults with chronic pain, including pain due to rheumatic conditions, but recent studies have also proven the usefulness of SF-MP-2 in patients with acute lower back pain. The pain score index can be evaluated in several ways: The Pain Rating Index is the value of the rank; Adjectives are ranked according to increasing intensity, so that each descriptor can be given a higher score. 0 - No Pain 1 - Soft 2 - Discomfort 3 - Anxiety 4 - Horrible 5 - Excruciating Pain Rating Index - Scale Value (VAS): Pain Intensity descriptor of pain was in several studies (Melzack and Torgerson in Melzack, 1975). The designated rating can also be accepted as a point for the pain handle. Number of selected words (NWC): Number of words chosen by the patient. The higher the overall score for MPH, the greater the pain for the patient. Evidence of Reliability Test-testing the reliability of the questionnaire has been evaluated in populations with different conditions such as osteoarthritis and musculoskeletal pain. An intra-class correlation factor was used to assess reliability. Since the questionnaire has been translated into 26 languages, reliability varies depending on the language when evaluating the SF-MP reliability test in patients with musculoskeletal pain, the results were adequate (r²:0.70). In the study of the same questionnaire in patients with rheumatic pain, the results were much higher (r²:0.85). Only the sub-scale current pain showed a lower intra-class correlation ratio of 0.75. For the internal reliability of consistency, the Cronbach alpha r²:0.75 was reported by Melzack et al. The percentage of use of 15 pain handles in 2 groups differed significantly for all words except pulsing and punishable-cruel. The average intensity score for each word ranged from 1.69 for a sickening to 2.60 for a tender in a fibromyalgia group and 1.57 for a terrible 2.18 for pain in the RA group. THE SF-MP has been translated into different languages. Some studies have demonstrated the validity of translated versions of SF-MP. The results of the Persian version give the Cronbach alpha 0.906, also showing a high internal consistency. There was also a high correlation between the average VAS and the average overall score (r 0.926) , the results of the Swedish version showed that the 15-point MP descriptor section was internally consistent (Alpha Cronbach: 0.73-0.89), but had no content in the RA sample. The converged reality design has demonstrated significant correlations between SF-MP and other pain measurements This is at this moment, it can be concluded that SF-MP is a very valid tool for assessing pain in patients with and without neuropathic etiology. A revised version of the SF-MP, SF-MP-2, has been tested for use in chronic pain populations. For example, Lovejoy et al demonstrated the excellent reliability and validity of the use of SF-MP-2 in a group of American veterans with chronic neuropathic and non-neuropathic pain. Trudeau et al. concludes that SF-MP-2 is a valid tool for assessing pain quality in patients with acute lower back pain. [4] The purpose of the questionnaire is to obtain descriptive values rather than objectively detect changes over time because pain is a subjective concept. However, it was found that SF-MP had to respond to changes and pointed out a clinically valuable difference in the population with musculoskeletal diseases, but the properties of measurement varied between groups of patients with pain. For the osteoarthritis population, however, a prospective study of the observation cohort showed no significant changes over time. The ratio was calculated as an estimate of the minimum change detected. Another study showed a comparison between the responsiveness of THES and MLAs. Interpretation of the Results clinically important changes (CIC): means an improvement in the overall scores of zgt:5 on a scale of 0-45 Norwegian SF-MP' Minimum detectable change (MDC) for general, Sensory, affective, medium and current pain: 5.2 cm, 4.5 cm, 2.8 cm, 1.4 cm and 1.4 cm, respectively, 3.5 cm , intermittent pain, predominantly neuropathic pain, and effective descriptors. Resources View Melzack 1987 document that includes SF-MP-SF-MP-2 Read 4 Credit Links - Melzack R., Ph.D.: McGill Pain Questionnaire, American Society of Anesthesiologists, 2005: 103:199-202. (Evidence Level No. 5) - 2.0 2.1 Melzack R, Katz J: McGill Pain Questionnaire: Assessment and Current Condition, Pain Measurement Handbook, 2nd edition. Edited by Turk DC, Melzak R. New York, Guilford Press, 2001, page 35-52 (evidence level No. 5) 3.0 3.1 3.2 3.3 3.4 3.5 3.6 3.7 3.8 Gillian A. Hawker: Measures of pain for adults. 63 (11): 20-252 (evidence level - 2C) - 4.0 4.1 4.2 J. Trudeau et al., Check revised short form McGill Pain Questionnaire (SF-MP-2) for self-reported pain quality in patients with acute lower back pain, journal pain, volume 13, issue 4, supplement, April 2012, Pages 54 (evidence level No. 1B) : Rassestment intraclass correlation ratios and consent limits in patients with osteoarthritis. 2005 January-February:21 (1):73-82 (evidence level) 6.0 6.1 Farhad Abelmanes: 'Reliability, reliability and sensitivity measures an extended and revised version of the short form of McGill Pain Questionnaire in Iranian patients with neuropathic and non-neuropathic pain', Pain Medicine,2012 (Evidence Level No. 1B) - K.S. Burkhardt, Swedish version of the questionnaire on short-form pain by McGill, 1994, p. 77-81, Gothenburg, Sweden (evidence level - 1B) - T.I. Lovejoy et al. , of the psychometric properties of the revised short form of the McGill Pain Questionnaire, Pain Journal, Volume 13, No. 12 (December), 2012: page 1250-1257 (evidence level No. 1B) A. Chaufilet et al, Responsibility Of VAS and McGill Pain questionnaire in measuring changes in musculoskeletal pain, J Sport Rehabil. 2011 May;20(2):250-5. (level of evidence) - Strand LI.: A questionnaire about pain in mcGill's short form as a measure of the result: test-recheck Reliability and responsiveness to changes., Eur J Pain. 2008 Oct;12(7):917-25. (level of evidence) - Robert H. Dvorkin, Dennis K. Turk, Dennis A. Rewicki, Gail Harding, Karin S. Coyne, Sarah Pearce-Sandner, Dilep Bhagwat, Dennis Everton, Laurie B. Burke, Penny Cowan, John T. Farrar, Sharon Hertz, Mitchell B. Max, Bob A. Pain, July 2009, 144 (1-2):35-42 Volume 30, Issue 2, August 1987, Pages 191-197McGill Pain QuestionnaireView full text by Ken Nier, in headache, orofacial pain and bruxism. 2009 Shortform McGill Pain Questionnaire (SFMP) was designed to provide a tool that can be completed in less time than an MP, but will still reflect both sensory and affective pain dimensions (Melzack 1987). SFMP consists of 15 descriptors from MP that were selected by more than 33% of patients with nine different pain syndromes including headache, lower back pain, arthritis and toothache. Of the 15 descriptors, 11 are from the sensory section of the MPH and 4 are from the affective section. Each descriptor is ranked on a scale of intensity 0 - no, 1 - soft, 2 - moderate and 3 - heavy. It also includes THE VAS and the numerical rating scale 0-5. Scoring by adding a rating for handles, although sensory and affective handles can be clogged separately (Melzack 1987). VAS points and ranking scales are not usually included in the descriptor scores. It takes about five minutes for SFMP to complete and evaluate. SFMP has been tested against MPH for 40 postoperative, 20 obstetric and 10 musculoskeletal pain patients (Melzack 1987). The procedure was repeated for dental patients. The results showed significant correlations (r 0.65 to 0.93) between sensory, affective and overall scores for results before and after intervention. These results suggest that the SFMP may provide similar data to the IPH on different aspects of pain, but in a more practical and timely manner than the longer version of the questionnaire. Stephen D. Waldman MD, JD, in Pain Review, 2009The McGill Pain Questionnaire (MHS) is a three-part pain assessment tool that measures several aspects of a patient's pain experience (Figure 222-4). The first part consists of an anatomical pattern form on which the patient notes where his or her pain is. The second part of the MLA is VDS, which allows the patient to record the level of intensity of his or her current pain experience. The third part of the MLA is a painful verbal descriptor, consisting of 72 descriptive adjectives. The patient is asked to review this list of painkillers and circle those that serve to best describe his or her current pain experience. Each part or measurement of the MLA is recorded individually, and the cumulative total score is recorded. Although the length of time it takes for a patient to properly complete an MLA is a major limitation to this multidimensional pain assessment tool, the extensive experience of the clinic with MPH has shown that it is a reliable and valid way to quantify the individual patient's conscious pain experience. MLA can also help the doctor in identifying a specific type of pain syndrome, such as neuropathic, that the patient suffers from. Darin J. Correll, in Pain Management, 2007 Short Form McGill Pain Questionnaire (SF-MP) (Figure 18-3) contains three different parts to assess a patient's pain experience.79 There are six words of VDS, as well as VAS that patients use to record their current pain intensity. In addition, there are 15 adjectives that describe the sensory (11 words) and affective (4 words) quality of a patient's pain. The patient evaluates each of the words on a categorical scale, not a single, light, moderate, heavy. SF-MP' has been tested and seems to correlate well with the original long form of MP-.80 As well as the long form, SF-MP may be able to distinguish between different types of pain syndromes.79 In addition, as a long form, has been shown to be sensitive to changes in pain caused by various analgesic treatments in both acute and chronic conditions.81-83Even, although sf-MP can take only about 5 minutes to complete , it is still too cumbersome to reuse in acute pain conditions. Other flaws mentioned earlier for the long form of MLA may also apply to SF-MPAs. Asimina Lazaridou PhD,... Charles B. Byrde MD, Ph.D., in The Basics of Pain Medicine (Fourth Edition), 2018The McGill Pain Questionnaire (MP) and its short counterpart, a short-form MP, are some of the most widely used pain measures. In general, MLA is considered a multidimensional measure of pain quality; however, it also gives numerical indices of several dimensions of pain experience.11 Researchers have offered three dimensions of pain experience: sensory-discriminative, affective-motivational, and cognitive-estimated. The MLA was created to assess these many aspects of pain. It consists of 20 sets of word handles ordered in intensity from the lowest to the highest. These sets of descriptors are divided into those that estimate sensory (10 sets), affective (5 sets), (1 set), and different (4 sets) pain sizes. Patients choose words when describing their pain, and their choice of words is converted into a pain index based on the sum of all words after they are assigned a rank value, as well as the total number of words selected.11.12 In addition, the MP' contains the present value of the intensity of VRS pain (i.e. the current intensity of pain (PPI), ordered from mild to excruciating, that form a sensory (11 elements) and affective (4 items) category of the original MP. Each descriptor is rated on a scale of intensity from 0 (no) to 3 (severe). PPI, along with VAS, is also included (Figure 5.3). The short form strongly correlates with the original scale, can distinguish between different pain conditions, and may be easier than the original scale for geriatric patients to use. Eli Eliab, Richard H Graysley, in Orofacial Pain and Headache, 2008The McGill Pain Questionnaire (MP) (Melzack 1975) is the most commonly used questionnaire for multidimensional pain assessment. THE MLA evaluates three separate components of pain load: sensory intensity, emotional impact and cognitive pain assessment. Patients are presented with 78 adjectives in 20 groups, and are instructed to select one from each group for specific groups that most closely match their own pain experience. The total score for each large measurement is derived from the amount of either weighted points or rows of the chosen word in the group. After the translation of the IPH into many languages, it was shown that people from different ethnic and educational backgrounds use the same adjectives to describe the same pain conditions (Gaston-Johansson et al 1990). In some specific pain disorders characterized by typical adjectives, the questionnaire may also help in diagnosis (Dubuisson and Melzack 1976; Melzak, etc., 1986). In addition, it has been found that MHD is sensitive to pain medication and therefore can assess the effectiveness of treatment (Burchiel et al 1996; Nicolaissen et al. Tesfaye, etc., 1996). In the area of orofacial pain, MPH was confirmed to be trigeminal neuralgia, atypical odontalgia, toothache and burning mouth syndrome (Grushka and Sessle 1984; Melzak et al. 1986). A short form (MPH-SF) consisting of 15 selected adjectives, which patients score on four points, and VAS used to measure pain intensity (Figure 3.2) (Gronblad et al 1990; Harden et al McGuire et Al 1993; Gagliese and Melzack 1997). Other multidimensional questionnaires found common psychological models for pain patients, regardless of etiology, location, treatment or medical or dental diagnosis (Turk and Rudy 1987, 1988, 1990). GABRIELLA IOHOM, in postoperative pain 2006COROFORM (SF-MP) ; Fig. 11-5) was designed to be used in studies when there is limited time to obtain information from patients and when more information is desirable than provided by intensity measures such as VAS or total PPII.23 SF-MP' takes about 2 to 5 minutes to complete, compared to 10 minutes for a longer form. The current pain intensity index is recorded as a number of 1 to 5, in which each number is associated with the following words: 1 mild, 2 discomfort, 3 anxiety, 4 horrible, 5 excruciating. Both VAS and PPII provide data only on pain intensity and no data on pain quality. In the development of SF-MP, the most commonly used set of words was selected from sensory and affective categories of the standard form. The words were divided into two descriptive categories for sensory and affective components of pain. The most common sensory words are throbbing, shooting, stabbing, sharp, cramping, nibbling, hot burning, pain, heavy, gentle, and cleavage. In the affective category, the most commonly used words are tedious, sickening, scary and cruel punishments. Each of the 15 descriptors is evaluated by the patient on the following intensity scale: 0 - no, 1 - soft, 2 - moderate and 3 - heavy. Thus, sensory and affective components can be considered individually or as a general assessment. It has been shown that THE SF-MP' correlates well with the PRI of the longer form of MP-.23 it has also been shown that it is sensitive to clinical changes caused by various interventions, postoperative analgesic drugs and epidural agents used during childbirth.23.24 In addition, consistency has been demonstrated among young, elderly and elderly patients in the ability to effectively complete the questionnaire.25Lucia Gage, Ronald Melzack, in the Pain Management Handbook, 2003The McGill Pain (MP) , affective, appraisal and various components of pain (Melzack 1975). There is much evidence of its reliability, reliability and discriminatory abilities when used with young adults (Melzack and Katz 2001). Recent evidence suggests that the psychometric properties of MPH are not related to age. In particular, the hidden structure, internal sequence and structure of sub-scale correlations of MPH are very similar in young and elderly patients with chronic pain, which were associated with diagnosis of pain, location and duration, as well as for sex (Gagliese et al 1998). Similarly, in a sample of adults with chronic arthritis pain, there were no age-related differences in error on the short form of MPH (SF-MP) (Gagliese and Melzack 1997a). Although older people approved fewer words than younger subjects, the same adjectives were chosen most often to describe arthritis pain, from age (Gagliese and Melzack 1997a). Although further on these results suggest that MLA is suitable for use in older patients. It seems to measure the same designs in the same way throughout adulthood. Obviously, pain assessment in older people should include a verbal descriptor or numerical scale measuring pain intensity and MLA in its original or short form (Gagliese 2001). In addition, pain maps, i.e. the shape of the human body, have been tested for the elderly and provide useful information on the location and spatial distribution of pain (Escalante et al 1995). As with young patients, the assessment of an elderly person with chronic pain should include more than pain relief. Comprehensive assessment should include, but certainly not limited to, measures of physical disability, intervention of pain in the work of daily activities, and psychological stress. The self-reporting and objective performance of many of these designs have been developed and are often used in both scientific and clinical settings (Turk and Melzack 2001). However, only a few of these measures have been confirmed for elderly pain patients (Gagliese 2001). Dale A. Hallaker Ph.D. , Ted L. Wunderlich BA, in Pain Procedures in Clinical Practice (Third Edition), 2011The McGill Pain Questionnaire (MP) is a list of 78 words divided into three areas (sensory, affective, and evaluation) and 6 words for the current pain intensity. While the validity of domains and MLAs has been questioned by some researchers, it is still one of the most widely used pain measures in research and clinical practice. While McGill's quantitative value is open to discussion, quality value is obvious. Melzak identified and organized the lexicon of pain in such a way as to make it accessible to patients and professionals. In three areas a total of 20 subcategories each containing 3 to 6 descriptive words. The first domain (sensory) containing subcategories from 1 to 10 includes 42 handles; The second domain (affective), containing subcategories from 11 to 15, includes 14 descriptors; The third domain (estimated) containing subcategory 16 includes 5 descriptors; and subcategories from 17 to 20 are different elements that contain 17 descriptors. Each subcategory receives a numerical score equal to the rank order of the chosen highest descriptor. For example, subcategory 1 includes the following words with numerical significance: flicker (1), tremor (2), throbbing (3), throbbing (4), beating (5) and knocking (6). Subcategory 2 includes the following words with numerical value in brackets: Jumping (1), blinking (2) and shooting (3). If the patient determines the pulsating and shooting each subcategory will have a numerical value of 3, despite the pulsating is the third six options and shooting is the third of Choice. Subjective order and a diverse number of elements in subcategories reduces the psychometric soundness of the MLA. Similarly, the touch domain has a score range of 0 to 42, the affective domain has a score range of 0 to 14, the appraisal domain has a score range from 0 to 5, and different items can have 0 to 17 points. As a result of the different relative contributions of each area, they cannot be directly quantified. Domains and various elements are summarized to determine the Pain Assessment Index (PRI), and another set of 6 descriptors is provided to determine the current pain index (PPI). Despite the statistical limitations of the Pain Rating Index (PRI) and the current pain index (PPI), it appears to have a high clinical and research utility. They can provide an ipsative comparison for each patient in the retesting format and allow a quick reference point on each patient's contact if ppis is used alone. Descriptors provide an inclusive pain quality lexicon that makes communication between the patient and doctor more accurate and can help with the detection of pain etiology. However, the complexity of terms can be a problem for patients with lower intelligence, and other measures should be used in cases below average intelligence.8ME shortform is a modified version that provides a brief (2 to 5 minute) alternative to mp' (10 to 15 minutes).9 It consists of 15 descriptive words taken from the MP's subcategory with a scale of 0 to 3 words. The 15 descriptors consist of 10 words and 1 set of combined descriptors (Hot-Burning) from the touch domain and 2 words and 2 sets of combined descriptors (ting-debilitating and punishing-cruel) from affective domain. Possible score range from 0 to 45. The short form of MLA also includes the Real Pain Index (PPI) and the Visual Analog Scale (VAS). It has been shown that the short form has a high correlation with the original scale of McGill pain. 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