

Commentary

The article entitled “Validity and Reliability of 11-face Faces Pain Scale in the Iranian Elderly Community with Chronic Pain” raises many important issues regarding measurement and implementation problems associated with various self-report scales designed to assess pain in older people.

A recent systematic review states that the prevalence of any type of pain among older people ranged widely from a low of 0% to a high of 93%.^[1] The world is facing a huge increase in the older population, and the WHO predicts that by 2050, 80% of older people will be living in low- and middle-income countries.^[2] This brings an anticipated increase in the prevalence of chronic pain and with this comes the challenge of assessment of pain in many varied settings.

Different patterns and sites of pain can be seen in men and women; age differences suggest that pain prevalence increases with age up to 85 years and then decreases. The available studies on barriers and attitudes to pain management point toward an adherence to biomedically orientated beliefs about pain, concern among clinicians in relation to activity recommendations, and a negative orientation in general toward patients with chronic painful conditions. Pain assessment is hampered by many communication issues, including cognitive ability and sociocultural factors. Although subjective, patient self-report is the most valid and reliable indicator of pain and it may be necessary to ask questions about pain in different ways to elicit a response.^[3] Pain scales should be utilized alongside the clinical skills of the member of the multidisciplinary team and a clinical assessment should be carried out. The most common self-report assessment tools for pain include Multidimensional Pain Inventory, McGill Pain Questionnaire, pain rating index, Brief Pain Inventory (and in some cases: InterRAI (collaborative network of researchers) long-term care facilities, the standardized evaluation of pain, Oswestry Disability Index, and items from short form 36). Physician recorded diagnosis, structured interviews, body map diagrams, simple checklists, multiple choice questions, and Likert scales designed specifically for the research can also be used to assess pain.^[1] The numerical rating scale or verbal descriptors can be used with people who have mild-to-moderate cognitive impairment. For people with severe cognitive impairment Pain in Advanced Dementia and Doloplus-2 are recommended.

Strong associations have been seen between pain and depressed mood with each being a risk factor for the other. In addition, loneliness and social isolation have been associated with an increased risk of pain. Clinicians should be cognizant of this.

Here, the authors introduce an 11-point FPS which was pretested for reliability and validity in Korean language. This tool enables older people to rate their pain on a continuous scale by adjusting the facial expression (shape of mouth and eyes) to indicate their pain intensity.

The authors’ statements concerning the usability of an 11-point continuous faces scale, namely, reliability and validity in the Iranian population can be agreed upon. However, here the authors have emphasized a presumed direct correspondence between pain intensity and the amount of curvature of the mouth and diameter of the eyes. In doing so, they seem to have ignored a basic rule of psychophysics. They assumed that physically equal changes (intervals) in facial expression are perceptually equal intervals. Subtle changes in one dimension may be highly meaningful whereas large changes in another dimension may not. For example, a 50% change in the physical curvature of the mouth does not necessarily correspond to a 50% change in the perceived amplitude or meaning of that change. The methods needed to select perceptually equal intervals on any physical dimension are psychophysical methods, as outlined by Hicks *et al.*^[4] This approach has been well established since the work of Fechner, published in 1860, who demonstrated that variation in mental events could be measured in relation to variation in physical events.^[5] Moreover, here, eye closure is assumed to reflect greater pain. Although eye closure is a typical feature of the pain face in very young infants, adults are less likely to fully close their eyes during a painful experience. Thus, the assumption that the degree of eye closure, from fully opened to fully closed, corresponds proportionally with pain intensity seems problematic. However, using other valid facial indices of pain, namely, brow furrow, mouth stretch, and increasing nasolabial furrow have enriched the tool.^[6]

Do we need a new, improved, 11-point Faces Pain Scale? In my opinion, yes. It has been discussed and many organizations have recommended^[7] about creating a new faces scale taking advantage of everything that has been learned about this way of measuring pain since the first of these numerous scales^[8] were

published in the 1980s. This article is a step in this direction and hopefully will coordinate the efforts with those of the other groups around the world who are working on this topic.

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Arunangshu Ghoshal

Department of Palliative Medicine, Tata Memorial Hospital, Mumbai, Maharashtra, India


Address for correspondence: Dr. Arunangshu Ghoshal, Department of Palliative Medicine, Tata Memorial Hospital, Mumbai - 400 012, Maharashtra, India.
E-mail: arun.bata@yahoo.com

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