SAWA UNIVERSITY

جامعة ساوة الاهلية
كلية التقنيات الصحية والطبية
قسم التخدير - اللجنة العلمية

# اسم المادة و الكورس

# HISTORY AND CLINICAL EXAMINATION

جامعـــــــة ســـــــــاوة الاهلية — Sawa University

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المرحلـــــــــــــة الرابعة — Fourth Stage

الجانب العملي — Practical

محاضرة رقم 2 — Lecture No. 2……..

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# HISTORY AND PHYSICAL EXAMINATION OF PAIN PATIENT DIAGNOSIS OF PAIN

Pain Medicine – Week 2 Lecture

# OBJECTIVES

- Understand key elements of pain history
- Recognize steps of physical examination
- Identify diagnostic approaches in pain medicine
- Correlate findings with possible pain syndromes

# IMPORTANCE OF HISTORY TAKING

- Pain is subjective and multidimensional
- History provides most diagnostic clues
- Directs investigations and treatment choice
- Essential for distinguishing acute vs chronic pain

# KEY ELEMENTS OF PAIN HISTORY

- Onset: sudden, gradual, traumatic event
- Location: local, referred, radiating
- Character: sharp, dull, burning, throbbing
- Severity: mild, moderate, severe (use scales)
- Duration: continuous, intermittent, episodic
- Aggravating/relieving factors: posture, activity, medications

# PAIN ASSESSMENT SCALES

- Visual Analog Scale (VAS)
- Numeric Rating Scale (0–10)
- Verbal Descriptor Scale
- Wong-Baker Faces Scale (children)
- Pain questionneir McGill (qualitative and quantitative)

The McGill Pain Questionnaire (MPQ) provides both qualitative and quantitative assessments of pain by using word descriptors to capture the sensory and emotional components of pain. Patients select words that best describe their experience, which are then categorized and scored to yield quantitative measures like the Pain Rating Index (PRI), the number of words chosen, and the Present Pain Intensity (PPI). This multidimensional instrument was developed by Ronald Melzack to offer a more complete understanding of pain than simple intensity scales alone

# ASSOCIATED SYMPTOMS

- Neurological: numbness, tingling, weakness
- Systemic: fever, weight loss, fatigue
- Autonomic: sweating, color changes
- Sleep disturbance
- Mood: depression, anxiety

# PAST MEDICAL AND PSYCHOSOCIAL HISTORY

- Chronic illnesses (diabetes, cancer, arthritis)
- Previous surgeries or injuries
- Medication and allergy history
- Substance use (alcohol, smoking, opioids)
- Occupation and daily activities
- Psychological background and stress factors

# PHYSICAL EXAMINATION OVERVIEW

- General observation
- Inspection
- Palpation
- Range of motion testing
- Neurological evaluation
- Special provocative tests

# INSPECTION FINDINGS

- Posture and gait
- Visible deformities
- Muscle wasting or asymmetry
- Skin changes (swelling, scars, discoloration)
- Movement limitations

# PALPATION FINDINGS

- Localized tenderness
- Trigger points
- Muscle spasms
- Temperature asymmetry
- Joint swelling or effusion

# NEUROLOGICAL EXAMINATION

- Motor strength testing
- Sensory testing: touch, pinprick, vibration
- Reflex assessment: tendon reflexes, pathological reflexes
- Coordination and balance
- Cranial nerve exam if indicated

# RED FLAGS IN PAIN DIAGNOSIS

- Unexplained weight loss
- Persistent night/rest pain
- History of cancer or immunosuppression
- Neurological deficits or bladder/bowel involvement
- Fever or systemic illness

# DIAGNOSTIC APPROACH

- 1. Clinical diagnosis from history + exam
- 2. Laboratory tests: CBC, ESR, CRP for systemic conditions
- 3. Imaging: X-ray, MRI, CT depending on site
- 4. Electrophysiological studies: EMG, NCV
- 5. Diagnostic nerve blocks in selected cases

# CASE EXAMPLE

- 45-year-old with chronic low back pain
- Symptoms: radiation to left leg, worsens on bending
- Exam: positive straight leg raise, reduced ankle reflex
- Diagnosis: Lumbar disc herniation with radiculopathy

# SUMMARY

- History is cornerstone of pain assessment
- Systematic physical exam confirms findings
- Use pain scales for objective assessment
- Always look for red flags
- Combine clinical findings with investigations

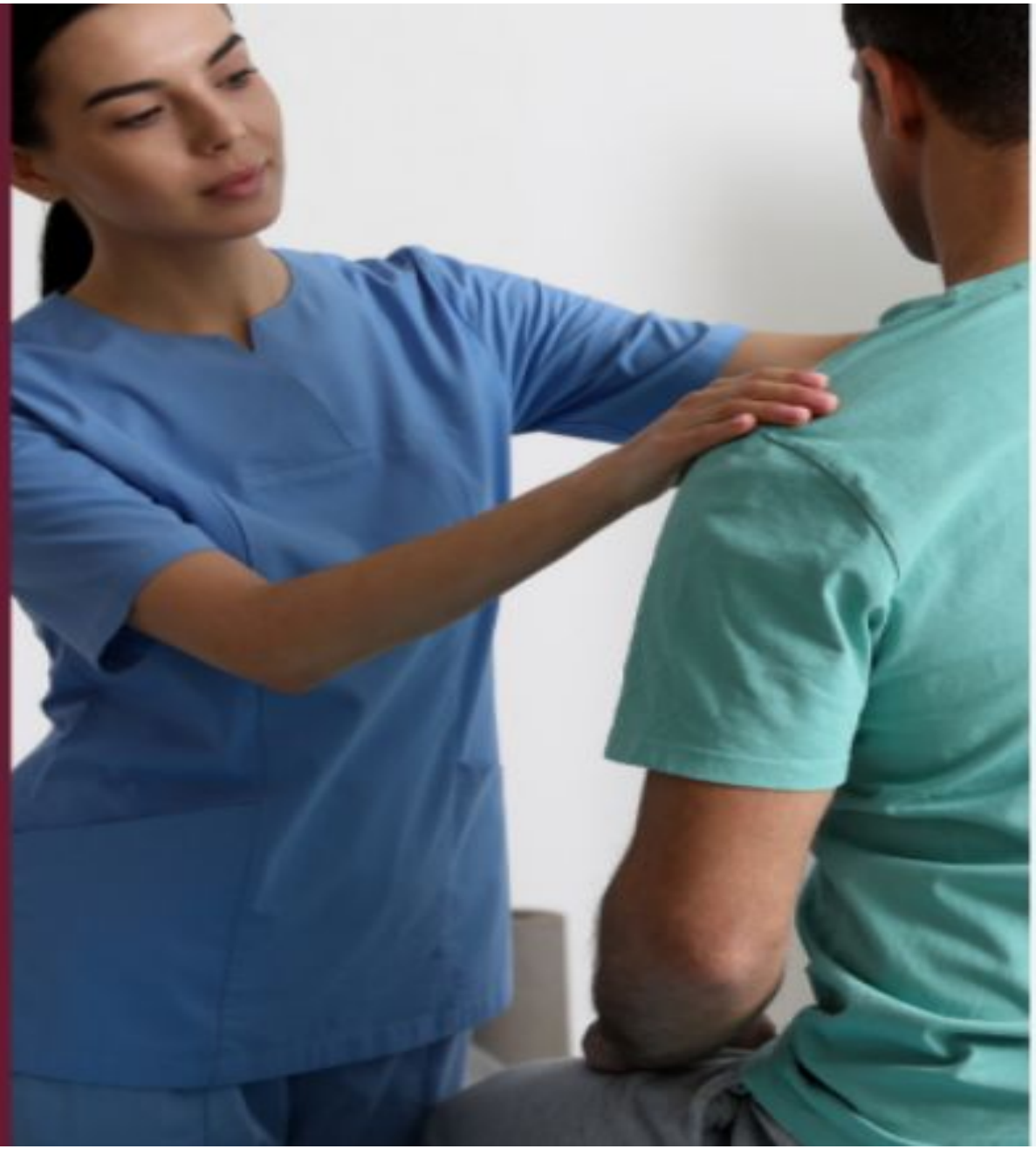
# Low Back Exam

Low back exams include:

- An inspection, noting the spine's contour.
- Palpitation, focusing on the center of the back & para-spinal regions.
- Provocative tests, which determine whether a nerve is being irritated.

For many patients, palpation and provocative tests are enough to confirm a musculoskeletal cause.

Severe or prolonged pain can indicate a neurological exam should be conducted.



# Shoulder Exam

Did you know shoulder pain is one of the most common complaints in the outpatient setting?

Causes can include the following:

- Sports
- Injury
- Arthritis
- Degenerative Joint Disease

Shoulder exams start with a general inspection, looking for musculoskeletal abnormalities and functional deficits. More specialized tests can uncover lesions of the muscular or ligamentous structures of the joint.

# REFERENCES


- Wall & Melzack’s Textbook of Pain
- Bonica’s Management of Pain
- IASP Guidelines on Pain Assessment

Which of the following is considered a red flag in pain history that warrants urgent investigation?

A. Pain worsens with activity
B. Pain improved with rest
C. Night pain associated with weight loss
D. Pain relieved by analgesics

Answer: C
Explanation: Night/rest pain with weight loss suggests systemic pathology such as malignancy or infection, requiring urgent evaluation.

- Q5.
- Which statement about pain history is most accurate?
- A. Physical examination is more important than history in diagnosing pain
- B. History alone is sufficient to exclude red flag conditions
- C. Pain history should include onset, character, severity, and associated factors
- D. Pain questionnaires replace the need for clinical history

- Explanation: A thorough pain history must systematically cover onset, character, severity, aggravating/relieving factors, and associated symptoms. History and examination together guide diagnosis.
- Answer: C

# Any questions?