Thai Short-Form McGill Pain Questionnaire

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Objective: *To validate the Thai Short-Form McGill Pain Questionnaire (Th-SFMPQ).*
Material and Method: *A postal survey to find the most corresponding terms to those used in the original English short-form McGill Pain Questionnaire had been performed. The Thai version was created and validated. Sixty patients who had either musculoskeletal or neuropathic pain were assessed by two interviewers with this Th-SFMPQ.*
Results: *Forty four women and sixteen men participated in this study. Average age was 44.3 $\pm$ 12.8 years and 80% of them had musculoskeletal pain. Means of sensory score was 8.98, affective score was 5.73, total score was 14.71, total count was 7.33, Present Pain Intensity (PPI) was 3.21 and Visual Analog Scale (VAS) was 53.61. Cronbach's α value was 0.7881 and inter-rater validity value of PPI was more than 0.7. The correlation coefficient was quite high ($r > 0.8$) for all scales. Regarding content validity, three pain descriptors (i.e. stabbing, gnawing, and splitting) did not meet 33% in Melzack's criteria.*
Conclusion: *The Th-SFMPQ has good internal consistency and inter-rater validity. Three uncommon descriptors should be substituted by other words or discarded in later version.*

Keywords: *Pain, Questionnaire, Thai short-form McGill Pain Questionnaire, Musculoskeletal pain, Neuropathic pain, Validation test*

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Pain is a common symptom in rehabilitation and in general practice clinics. Pain assessment is important as a method for detecting severity of disease and evaluating benefits from treatment. In general, the assessment contains pain intensity, quality or descriptor, site, duration, and disturbance of daily activity[1]. Various scales fall into three categories, self report, behavioral measures, and physiologic response[1,2]. Self report comprises of uni-dimensional and multi-dimensional scales, and is widely used in clinical settings because of the validity in measuring individual pain experience. Examples of uni-dimensional self report scale are Visual Analog Scale (VAS), verbal rating and numerical rating scales. Examples of multi-dimensional pain scale are McGill Pain Questionnaire, short-form McGill Pain Questionnaire, and brief pain inventory. Behavioral measurement includes facial expression during pain and amount of pain killer used. Physiologic response to pain, such as pulse rate response to pain, is not correlated with pain experience[1,2]. The uni-dimensional self report scale is the most widely used as it is easy, simple and requires little assessment time. However, because this scale is not adequate to collect information on the affective component of pain makes it is less reliable for assessing chronic pain where affective components are involved[3,4]. Based on the International Association for the Study of Pain (IASP) terminology of pain, the affective or emotional aspect of pain should also be recognized[5]. At present, symptom-oriented and mechanism-based pain therapies are more acceptable[6]. The multi-dimensional pain measurements are applicable and compatible with these aspects.

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The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) of the United States of America also recommended the multi-dimensional scale[7]. In 1975, Dr. Ronald Melzack developed the McGill Pain Questionnaire (MPQ) that has become one of the most widely used pain measurement tools that provides sensory, affective, site, pain pattern, and intensity information. It is both useful and valid for acute, chronic, musculoskeletal, postsurgical and neuropathic pain[1,2,8-10]. As the full-version of MPQ usually takes 15-20 minutes to complete, which may be too long for patients in outpatient clinics, Dr. Melzack then developed a Short-Form McGill Pain Questionnaire (SF-MPQ) that required only 2-5 minutes to complete. The validity of this questionnaire was approved[11] and it is currently used in various researches and clinical settings[12-15].

The original version of SF-MPQ is in English and some pain descriptors were too difficult to understand when applied in countries where English is not an official language or not even spoken. Such a problem caused much confusion for interviewers and may decrease the validity of the test; therefore it comes to the reason why the original SF-MPQ should be translated into Thai as it has already been translated into Czech[1], Swedish[16] and Greek[17]. In the present study, the short-form McGill Pain Questionnaire (SF-MPQ) was translated into Thai and validated for clinical use in Thailand.

Material and Method

Study design

Descriptive analytic study.

Subjects

All patients were recruited from the outpatient clinic and inpatient ward of the department of rehabilitation medicine at Maharaj Nakorn Chiang Mai Hospital, Chiang Mai University.

Inclusion criteria:

- Patients having pain from musculoskeletal or neuropathic etiology.

- Patients older than 15 years on the interview day.

Exclusion criteria:

- Patients with any brain diseases or older than 65 years leading to cognitive impairment; the Thai Mental Status Examination (TMSE)[18] was also used for screening cognitive impairment. The subjects who had a total score less than 23 points were excluded.

- Psychiatric patients who have any active psychiatric management

Instrumentation

Two hundred surveys were sent by post to physiatrists and orthopedic surgeons asking for the most appropriate Thai terms corresponding to those used in SF-MPQ. The most proper and compatible Thai words that describe each pain descriptors were collected from the questionnaire and were then incorporated into the newly created Thai Short-Form McGill Pain Questionnaire (Th-SFMPQ). The Th-SFMPQ consists of three parts. The first part has eleven sensory and four affective pain descriptors, the second part has VAS and the third part has Present Pain Intensity (PPI). Pain intensity of each descriptor was scored ranging from 0 to 3 (no pain, mild, moderate, severe, respectively). The sensory and affective scores are derived from summation of intensity score of each item. The total score will be the combination of scores from both sensory and affective domains. The maximal value is 45. The Th-SFMPQ is shown in appendix.

Method

The study protocol had been approved by the Ethics Committee of the Faculty of Medicine, Chiang Mai University and all subjects had given informed consents before interview. Subjects were screened according to the inclusion and exclusion criteria and both new and old patients were included. Demographic data were noted. History taking and physical examination were performed in all subjects and the patient would be asked about their current pain. Each pain descriptor was asked in a random order. The intensity of each descriptor was rated among “no”, “mild”, “moderate”, or “severe pain”. PPI and VAS were consequently assessed. Each patient was assessed by two interviewers (Dr.Wasuwat K. and Dr. Jakkrit K.) in the same period (interval between each assessment was of not more than 15 minutes) in order to minimize possible time-related pain variation and to evaluate validity of the questionnaire

Statistical analysis

The pools of data were analyzed using the SPSS Statistic Program for Window package version 10.0. The demographic data was presented in percentage. Pain of each disease, sensory score, affective score, total score and count, PPI, and VAS of musculoskeletal and neuropathic pain group were presented in mean, standard error, minimum and maximum value.

Appendix. The Thai short-form McGill Pain Questionnaire (Th-SFMPQ)

Short-form McGill Pain Questionnaire (Thai version)

Name.....…...……..... Diagnosis…….....……... Date.....Month.....Year.....…

	No pain	pain	Not bother daily life	Pain bother daily life
	(None)	(Mild)	(Moderate)	(Severe)
Throbbing	0).....	1).....	2).....	3).....
Shooting	0).....	1).....	2).....	3).....
Stabbing	0).....	1).....	2).....	3).....
Sharp	0).....	1).....	2).....	3).....
Cramping	0).....	1).....	2).....	3).....
Gnawing	0).....	1).....	2).....	3).....
Hot-burning	0).....	1).....	2).....	3).....
Aching	0).....	1).....	2).....	3).....
Heavy	0).....	1).....	2).....	3).....
Tender	0).....	1).....	2).....	3).....
Splitting	0).....	1).....	2).....	3).....
Tiring-exhausting	0).....	1).....	2).....	3).....
Sickening	0).....	1).....	2).....	3).....
Fearful	0).....	1).....	2).....	3).....
Punishing-cruel	0).....	1).....	2).....	3).....

No pain ——————————————————————— Worst possible pain

Present pain intensity; PPI

0 No pain	.....
1 Mild	.....
2 Discomforting	.....
3 Distressing	.....
4 Horrible	.....
5 Excruciating	.....

The frequency of each pain descriptors was presented. Cronbach's α was used for analysis of internal consistency of the questionnaire. Inter-rater validity was analyzed using Kappa statistics. Pearson's correlation coefficient was used for determining correlation of each interviewers scoring.

Results

Sixty patients were recruited in the present study. Ninety percent were outpatients and most of them were female. Average age was 44.3 $\pm$ 12.8 years (range 19-69). The demographic data are shown in Table 1. Forty-eight (80%) patients had acute or subacute pain (pain less than 3 months). Means of total score was 14.71, VAS was 53.61 and PPI was 3.21. Means, standard error and range of pain score are shown in Table 2. Most of the patients had pain from musculoskeletal cause. Myofascial pain syndrome was in the top rank. Means of total score, VAS and PPI were also categorized by disease and are shown in Table 3.

The validity of this questionnaire was reflected as an internal consistency (Cronbach's α), content validity (using 33% Melzack criteria) and inter-rater validity (Kappa coefficient). Cronbach's α value was 0.7881. Regarding the content validity, three pain descriptors (i.e. stabbing, gnawing and splitting) did not meet the 33 % Melzack criteria. "Punishing-cruel" was the most frequently complained pain descriptor. Frequency and intensity of each pain descriptor is shown in Table 4. Kappa coefficient of sensory score was 0.0987, affective score was 0.2322, total count was 0.2512, total score was 0.0361, VAS was 0.2428 and PPI was 0.7551. Pearson's correlation coefficient between the two interviewers of sensory score was 0.8985, affective score was 0.8126, total count was 0.8138, total score was 0.9006, VAS was 0.8300 and PPI was 0.8678.

Discussion

The Th-SFMPQ has good internal consistency, which means all items in this questionnaire assess the patients in the same way. Pearson's correlation coefficient between the two interviewers is high in total score and all subscales but Kappa coefficient is high only in PPI, meaning that both interviewers rated each patient in a relative way but the absolute score values were different. The three pain descriptors that did not meet the 33% Melzack criteria should be replaced by other proper words or left blank allowing each patient to fill in with their own pain description.

The result of the present study is comparable with the original and Greek version study where most of the patients also have musculoskeletal pain. Mean

Table 1. Demographic data of the patient (n = 60)

Characteristic	N (%)
Age	
- < 65 years	56 (93.3)
- $\geq$ 65 years	4 (6.7)
Sex	
- male	16 (26.7)
- female	44 (73.3)
Status	
- married	35 (58.3)
- single	17 (28.4)
- widow	5 (8.3)
- divorced	3 (5.0)
Education level	
- elementary school	25 (41.7)
- high school	8 (14.3)
- graduate	22 (36.7)
- postgraduate	5 (8.3)
Career	
- housewife	8 (13.3)
- government official	15 (25.0)
- merchant	6 (10.0)
- employee	16 (26.7)
- farmer	4 (6.7)
- student	4 (6.7)
- monk	1 (1.6)
- none/retired	6 (10.0)

Table 2. Descriptive statistics of subscale, total scale, total count, PPI, and VAS (n = 60)

Scale	Mean $\pm$ SE	Minimum-Maximum
Sensory score (0-33)	8.98 $\pm$ 0.49	1-28
Affective score (0-12)	5.73 $\pm$ 0.33	0-12
Total score (0-45)	14.71 $\pm$ 0.73	1-34
Total count (0-15)	7.33 $\pm$ 0.27	1-14
PPI (0-5)	3.21 $\pm$ 0.17	1-5
VAS (0-100)	53.61 $\pm$ 2.27	1-100

Table 3. Total score, PPI and VAS by disease category

Disease	N (%)	Mean ± SE (min-max)		
		Total score	PPI	VAS
- Lumbar spondylosis, spondylolisthesis, HNP	10 (16.7)	14.75 ± 1.70 (3-33)	3.20 ± 0.33 (1-5)	57.05 ± 3.94 (36-90)
- Cervical spondylosis	4 (6.7)	10.13 ± 2.36 (2-20)	2.50 ± 0.33 (2-4)	50.75 ± 11.26 (21-100)
- Muscle strain	8 (13.3)	12.06 ± 1.91 (1-26)	2.44 ± 0.27 (1-4)	42.44 ± 7.25 (1-93)
- Myofascial pain syndrome	12 (20.0)	13.50 ± 1.57 (4-32)	2.67 ± 0.58 (1-4)	56.88 ± 3.65 (28-80)
- Sprain, tendinitis, fasciitis	9 (15.0)	17.06 ± 1.60 (5-29)	2.89 ± 0.21 (2-5)	56.72 ± 5.00 (27-100)
- Knee osteoarthritis	4 (6.7)	10.63 ± 2.31 (5-25)	2.50 ± 0.19 (2-3)	38.75 ± 6.80 (12-59)
- Nerve entrapment	3 (5.0)	15.33 ± 5.30 (3-33)	2.67 ± 0.58 (1-4)	29.33 ± 7.33 (17-53)
- Neuropathic pain	10 (16.7)	19.40 ± 1.61 (9-34)	3.15 ± 0.22 (1-5)	68.80 ± 6.39 (9-94)

Table 4. Frequency and average intensity of each descriptor

Pain descriptor	Frequency (%)	Intensity (mean ± SE)
Throbbing	53 (44.2)	0.88 ± 0.10
Shooting	58 (48.3)	0.80 ± 0.09
Stabbing	31 (25.8)	0.49 ± 0.09
Sharp	58 (48.3)	0.80 ± 0.09
Cramping	64 (53.3)	1.03 ± 0.10
Gnawing	15 (12.5)	0.24 ± 0.06
Hot-burning	44 (36.7)	0.81 ± 0.11
Aching	64 (53.3)	1.01 ± 0.10
Heavy	63 (52.5)	1.10 ± 0.11
Tender	83 (69.2)	1.41 ± 0.10
Splitting	23 (19.2)	0.42 ± 0.08
Tiring-exhausting	85 (70.8)	1.39 ± 0.10
Sickening	65 (54.2)	1.29 ± 0.12
Fearful	83 (69.2)	1.38 ± 0.10
Punishing-cruel	89 (74.2)	1.63 ± 0.11

total score, VAS and PPI score of the present study are similar to the result of the Melzack's study[11]. The Greek version study showed a higher total score and VAS score but less in PPI[17]. Mean intensity score of each descriptor was about 1, which means most of them had mild pain. It may be drawn from the fact that certain subjects that had been treated as mixed subjects (before and after treatment) were included.

Regarding musculoskeletal pain, the total score of the present study is not different from other studies[11]. Total score and VAS score of low back pain and neck pain are the same as the study in Greece[19]. In the knee osteoarthritis group, total score and VAS are also the same as the studies in Greece[19] and in the U.S.A.[20] Total score and VAS score in patients with neuropathic pain seem higher than those with musculoskeletal pain. This does not differ from other studies[21]. The PPI in other studies[11-17,19-21] is more or less the same as that from the present study. However, comparison of pain scale score of the same diseases may show some difference due to individual pain experience, cultural effect[22,23] and the state of diseases at the time the patients were evaluated.

"Punishing-cruel" is the most common pain complained about by descriptor. This means most patients feel troublesome no matter how high total pain score is. "Tender" is the most common descriptor in the sensory subscale and is in accordance with other studies[11]. This is not surprising because 80% of the patients had a musculoskeletal problem. "Hot-burning" is the most common sensory descriptor in the neuropathic pain patient. Another study found

sharp and tenderness as the most common in postherpetic neuralgia[24]. This could be from the difference in pain etiology where spinal cord central pain is the main cause of neuropathic pain in the present study.

The result of this questionnaire is convincing and reliable because normal cognition was found in all patients screened with TMSE. Besides, all patients were interviewed with no more than 15-minutes rest between the two physicians and there is also high inter-rater correlation in scoring. The short-term memory hardly contributed to this high correlation as each item was asked by the interviewer in a random order and many pain descriptors and intensity levels that were not easy to remember. For these reasons, this questionnaire could be very useful for assessing the effect of treatment.

However, the present study still had some limitations in disease-related pain characteristics. Firstly, the total score, PPI and VAS did not indicate a pain severity at the new onset of diseases; therefore, some patients might be in various stages of diseases or even had already received treatment. Secondly, some patients despite having normal cognition from screening test found some pain descriptors difficult to understand and needed help from interviewers to clarify them. Thirdly, three descriptors were chosen less than 33% of all items. Therefore, in the future it is necessary to improve the validity of this Thai version revision.

In conclusion, the Thai Short-Form McGill Pain Questionnaire (Th-SFMPQ) is simple, easy to use and requires less than five minutes to complete. It has good internal consistency and high correlation between raters. However, the three pain descriptors should be substituted by other appropriate words or discarded in later version because they are uncommon pain characteristics described by Thai patients. The revised version should be subjected to ongoing research.

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แบบประเมินความปวด Short-form McGill ฉบับภาษาไทย

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วัตถุประสงค์*: ทดสอบความเที่ยงตรงของแบบประเมินความปวด short-form McGill ฉบับภาษาไทย*

วัสดุและวิธีการ*: ออกแบบสอบถามเพื่อหาคำแปลภาษาไทยของความปวดแต่ละคำในแบบประเมินฉบับดั้งเดิม รวบรวมความหมายและสร้างแบบประเมินฉบับภาษาไทย ประเมินผู้ป่วย 60 รายที่มีอาการปวดจากโรคระบบกระดูกและกล้ามเนื้อและจากโรคของระบบประสาท เพื่อทดสอบความเที่ยงตรง*

ผลการศึกษา*: ผู้ป่วยหญิง 44 ราย ชาย 16 ราย อายุเฉลี่ย 44.3 $\pm$ 12.8 ปี ร้อยละ 80 มีอาการปวดจากโรคระบบกระดูกและกล้ามเนื้อ ค่าเฉลี่ยของ sensory score, affective score, total score, total count, present pain intensity (PPI) and visual analog scale (VAS) เท่ากับ 8.98, 5.73, 14.71, 7.33, 3.21 และ 53.61 ตามลำดับ ค่า Cronbach's α เท่ากับ 0.7881 ความเที่ยงตรงระหว่างผู้ประเมินมากกว่า 0.7 เฉพาะส่วน PPI ความสัมพันธ์ของแบบประเมินในส่วนย่อยต่าง ๆ ทุกส่วน มีค่ามากกว่า 0.8 ด้าน content validity พบว่ามีความปวด 3 คำถูกผู้ป่วยเลือกน้อยกว่าร้อยละ 33 ได้แก่ ปวดเหมือนถูกแทง ปวดเหมือนถูกแทะ และปวดเหมือนแตกเป็นเสี่ยง*

สรุป*: แบบประเมินความปวด short-form McGill Pain ฉบับภาษาไทยมีความเที่ยงตรงในด้าน internal consistency และ inter-rater แต่มีความปวด 3 คำที่ถูกเลือกน้อยกว่าร้อยละ33 ในการศึกษาต่อไปจึงควรหาคำอื่นที่เหมาะสมทดแทนหรือตัด 3 คำนี้ออก*

Appendix.

แบบประเมินความปวดฉบับภาษาไทย Short-form McGill Pain Questionnaire Thai version

ชื่อ-สกุล……..…… การวินิจฉัย……..…….. วันที่ประเมิน .....…

	ไม่ปวด/รู้สึก	ปวด/รู้สึกน้อย ไม่รบกวนชีวิตประจำวัน	ปวด/รู้สึกปานกลาง รบกวนชีวิตประจำวัน	ปวด/รู้สึกมาก จนทนไม่ได้
ปวดตุ๊บ ๆ	0).....	1).....	2).....	3).....
ปวดจี๊ด	0).....	1).....	2).....	3).....
ปวดเหมือนถูกแทง	0).....	1).....	2).....	3).....
ปวดแปลบ	0).....	1).....	2).....	3).....
ปวดเกร็ง	0).....	1).....	2).....	3).....
ปวดเหมือนถูกแทะ	0).....	1).....	2).....	3).....
ปวดแสบปวดร้อน	0).....	1).....	2).....	3).....
ปวดตื้อ ๆ	0).....	1).....	2).....	3).....
ปวดหนัก ๆ	0).....	1).....	2).....	3).....
กดเจ็บ	0).....	1).....	2).....	3).....
ปวดเหมือนแตกเป็นเสี่ยง	0).....	1).....	2).....	3).....
รู้สึกเหนื่อยล้า	0).....	1).....	2).....	3).....
รู้สึกไม่สบาย	0).....	1).....	2).....	3).....
รู้สึกหวาดกลัวความเจ็บปวด	0).....	1).....	2).....	3).....
รู้สึกทรมาน	0).....	1).....	2).....	3).....

ไม่ปวด ——————————————————————————— ปวดมากที่สุด

ระดับอาการปวดในขณะนี้

0 ไม่ปวด	.....
1 ปวดเล็กน้อย	.....
2 ปวดพอรำคาญ	.....
3 ปวดจนรู้สึกรบกวนการดำเนินชีวิต	.....
4 ปวดจนทุกข์ทรมาน	.....
5 ปวดมากจนทนไม่ได้	.....