SigN-PQ Neuropathic Pain Questionnaire Development and Validation in English and Filipino Languages

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ABSTRACT

Objectives. This study aimed to develop and validate a simple questionnaire for chronic neuropathic pain that can be administered as a screening tool by general practitioners and internists in order to help them identify patients with probable neuropathic pain.

Methods. Following a development phase and a pilot study, the revised version of the screening tool which included eleven descriptors associated with neuropathic pain both in English and Filipino languages was validated on 120 consecutive patients with any type of pain except psychogenic pain, recruited in the out-patient clinics of six hospitals. The questionnaire was validated by assessing the sensitivity, specificity, positive and negative predictive value of each item and the overall questionnaire. The internal consistency of the questionnaire items was assessed using the Kuder-Richardson formula 20.

Results. Overall, the internal consistency of the SigN-PQ using the Kuder-Richardson formula 20 was 0.7837; the sensitivity was 91.89% with specificity of 80.22%, PV (+) was 65.38% and PV(-) was 96.0%. For the English version, the descriptors with the highest scores were burning (Sensitivity: 100%, Specificity: 93%) and electricity-like (Sensitivity: 100%, Specificity: 93%). For the Filipino version, *mainit* (burning) has the highest sensitivity of 88% with specificity of 82.6%, followed by gumagapang (tingling) with sensitivity of 86.96% and specificity of 85.42%. The sensation of *saksak* (stabbing) and *hiwa* (lancinating) have the lowest sensitivity, 60% and 54% respectively, although their specificity scores are high. Since this study is a validation of a screening tool for neuropathic pain, the investigators decided to choose descriptors with higher sensitivity. Thus, in the final version of the SignN-PQ, the descriptors *saksak* and *hiwa* were removed.

Conclusion. The SigN-PQ Neuropathic Pain Questionnaire has a high overall sensitivity of 91.89% and specificity of 80.22%. The pain descriptors in the questionnaire are consistent with the descriptors cited in the literature. It is a valid screening instrument for neuropathic pain that can be easily incorporated in the daily practice of general practitioners and internists.

Key Words: neuropathic pain, screening questionnaire, general practitioners, validation

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Introduction

Chronic pain remains one of the most challenging conditions in clinical medicine. When a physician is confronted with a patient who is in pain, it is the responsibility of the physician to determine whether the pain is nociceptive or neuropathic in origin. This is because successful treatment of chronic pain relies heavily on identifying the underlying mechanism that is generating the pain. Nociceptive pain which is generally well defined in character results from direct activation of pain receptors due to an ongoing injury such as an inflamed joint or viscus. It is effectively managed by analgesics and nonsteroidal anti-inflammatory drugs (NSAIDs), opioids and neural blocks. On the other hand, neuropathic pain (NP) is associated with disease, dysfunction or past injury to the peripheral or central nervous system without any evidence of ongoing tissue injury.[1] It is manifested in a variety of conditions such as diabetic neuropathy, trigeminal neuralgia, spinal cord injury and stroke among others. The symptomatology of NP is more complex than nociceptive pain with patients presenting with positive and negative symptoms that fluctuate in frequency and intensity with time. Experts in the field generally agree that the various signs and symptoms that characterize the disorder can be divided into three major groups: spontaneous pain which include among

others burning, tingling, lancinating, stabbing pain; evoked pain which include hyperpathia, cold, warm or touch allodynia; and negative symptoms such as numbness.[2,3] Unlike nociceptive pain, neuropathic pain responds poorly to conventional analgesics but responds invariably to some antiepileptic drugs, antidepressants, antiarrythmics and to some antipsychotic drugs. It may also respond to opioids. Therefore, it can be concluded that the mechanism of neuropathic pain is different from nociceptive pain and, hence, the symptoms and treatment are different.

The difficulty in defining neuropathic pain is reflected in the different neuropathic pain mechanisms as currently understood. Proposed mechanisms include both peripheral and central processes. Peripheral processes include altered ion channel expression in injured nerves, ephaptic discharges, sensitization of regenerating axonal sprouts and sprouting of sympathetic neurons into the dorsal root ganglia.[4] Central processes include hyperexcitability of central neurons activating the N-methyl-D-aspartate (NMDA) receptors, cortical reorganization and central disinhibition as a result of breakdown in pain modulation involving various neurotransmitters.[5] More recently, glial cells have been shown to contribute to neuropathic pain by releasing cytokines and chemokines which are pro-inflammatory signals with pathological effects such as neuronal hyperexcitability.[6,7] Thus, it is not surprising that the complex pathophysiologic mechanisms cause difficulty in recognizing NP. It has been reported that in clinical practice many clinicians tend to diagnose any clinical pain that is difficult to categorize as neuropathic.[3]

The use of appropriate pain measurement instruments cannot be overemphasized. Having an assessment tool for neuropathic pain is essential for successful management of this condition. Thus, several investigators have devised pain assessment tools specific for NP for use by pain specialists. These assessment tools include the Neuropathic Pain Scale (NPS) by Galer and Jensen,[8] the Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) by Bennett[9] and the Neuropathic Pain Questionnaire (NPQ) by Krause and Backonja.[10] However, the NPS by Galer and Jensen has only been subjected to a preliminary validation, while the NPQ by Krause and Backonja is not currently available for clinical use. More recently, another assessment tool has been developed and validated by French investigators, Bouhassira, Attal, et al, called Neuropathic Pain Symptom Inventory (NPSI).[11] Although quite long and tedious to answer, it provides for a more comprehensive assessment that evaluates both quality and intensity of pain. All four pain assessment tools include items that ask for the presence of the four distinct pain dimensions of neuropathic pain, namely, spontaneous ongoing pain, spontaneous paroxysmal pain, evoked pain and paresthesias/dysesthesia.

In the Philippines, with 107 language groups, there is no existing validated screening questionnaire for neuropathic pain in English and in Filipino, the latter being the national language. Most pain specialists practice in big urban centers; thus, access to specialized pain management is limited for the majority of the 80 Million population. Therefore, the important role that general practitioners and internists play in making the proper diagnosis of NP is recognized. In view of this and cognizant of the fact that the language of pain has linguistic and cultural nuances, it is the objective of this paper to develop and validate a simple questionnaire that can be administered by any physician in order to help them diagnose neuropathic pain.

Methods

Initial development phase of the questionnaire

Nine nationally recognized pain specialists (PSs) generated a list of signs and symptoms of NP in the English language. This was based on the specialists' analysis of current literature and experience. The PSs selected 14 descriptors in English which reflected the three distinct dimensions of NP: spontaneous pain, presence of a negative symptom (numbness) and evoked pain. Seven items were selected for spontaneous pain, three of which were for spontaneous continuous pain (burning, tingling, pins and needles); four for spontaneous paroxysmal pain (electricity-like, stabbing, lancinating and itching); and one item for the negative symptom (numbness). Four items were selected to evaluate evoked pain: pain on light touch, cold allodynia, warm allodynia and hyperpathia. Sensory testing for allodynia and hyperpathia were also included. Furthermore, the temporal pattern of more than three months to indicate chronicity was incorporated. A sensory map was provided at the end of the questionnaire (Appendix C) on which the clinician will shade the location of the pain.

For the Filipino language translation, the PSs selected 21 descriptors since there may be more than one translation of an English descriptor in the Filipino language. In the same manner as the English questionnaire, the Filipino descriptors reflected the four distinct dimensions of NP, sensory testing for allodynia and temporal pattern.

The items of the English questionnaire were approved and translated into the Filipino language by the PSs. The Filipino translation was checked by a separate group from the Institute of Filipino Languages of the University of the Philippines, Manila to determine congruence with the original translation. Back translation was done by a third group. A Working Committee consisting of three PSs was created to make the initial version of the questionnaire. Following an Ethics Review Board approval, the questionnaire was pilot tested.

Pilot testing of the initial version of the NP Screening Questionnaire

The objective of the pilot test was to do a construct validation of the questionnaire and to find out if the

phrasing of the questions were clear and easily understood by patients. The length of time it took to administer the questionnaire was also noted. The questionnaire was pilot-tested by the nine PSs to a total of 70 out-patients with all types of pain except psychogenic pain, pain associated with major mood disorders and/or substance abuse. Subjects were informed that they could use English, Filipino or *Taglish* (i.e. code-switching to English and Tagalog). Based on the results of the pilot test, the questionnaire was revised deleting six items in the Filipino version and one item in the English version.

Validation study

- Pre-test

Each of the nine PSs were paired with nine General Practitioners or General Internists designated GPs who were trained to use the questionnaire. Using the revised NP Screening Questionnaire from the pilot study, an inter-rater reliability test was done on several pain patients prior to the actual validation study. The questionnaire was again revised and items that require sensory testing were removed. This was upon the recommendation of the GP partners who suggested that in their busy practice, GPs prefer a simple questionnaire to help them screen patients with neuropathic pain. The questionnaire was again revised and the version used for the validation study is presented in Appendix A. Each item in the Questionnaire was a yes or no question. The scoring system included any of the symptoms in item N1 which had been going on for more than three months (N2) in the presence of pain without any signs of inflammation (N3). The pain was considered most likely to be neuropathic if the patient tested positive in all three items.

- Participants

One hundred and thirty (130) consecutive patients fulfilling the inclusion criteria seen in the out-patient clinics of six medical centers were recruited for the study. Patients of either sex from 18 years and above who were able to give informed consent, had intact cognitive functions and could understand, read and write in English and/or Filipino participated in the study. Inclusion criteria included those patients with any type of pain except psychogenic pain, migraine, pain associated with major mood disorders and/or substance abuse based on Diagnostic and Statistical Manual (DSM) criteria. In addition, those patients who for any reason might have been unable to accurately understand the questionnaire were excluded.

Validation process

After approval by the Institutional Ethics Review Board, the study was done in six general clinic settings and three pain clinic settings. Patients who fulfilled the inclusion criteria were interviewed by the GP partner using the NP Screening Questionnaire-3 version. The same patients were interviewed by the PS partner using the same questionnaire. The interview was also done in the reverse order, that is, some patients were seen first by the PS followed by the GP. In both scenarios, the PS and the GP were blinded to the responses of the patient. In addition, the patient was not told which doctor was the PS and which the GP. The patient was given the freedom to choose the English, Filipino or *Taglish*.

The answers gathered by the PSs were used as the gold standard against which the answers of the GPs were compared. Descriptive statistics was used to characterize the patients' demographic and clinical data. The internal consistency of the questionnaire was determined using Kuder-Richardson 20 Formula.[12] Sensitivity and specificity were computed for each item. Using the software 2x2 Program (DOS-based), an overall validity estimate and the confidence intervals of the composite questionnaire in English and Filipino were calculated.

Results

Demographic and clinical details

One hundred thirty (130) patients participated in the study; however, only 120 were included in the analysis since some of the data was not complete (e.g. some questionnaires do not have entries for N2 or N3) .Demographic and clinical data are provided in Tables 1 and 2.

Table 1. Demographic features of the patients included in the study

Demographic data	
Age (mean, SD, range)	51.8, 16.4, 18-87
Men	45 (38.0%)
Educational Attainment	
College	92 (76.6%)
High School/Vocational	19 (15.8%)
Elementary	9 (7.5%)
Employment status	
Professionals	32 (26.7%)
Housewife	18 (15.0%)
Unemployed	20 (16.7%)
Informal sector or Self employed	23 (19.2%)
Technicians/laborer	27 (22.5%)

Data are numbers (%) unless otherwise stated.

Fifty nine percent (59%) of the patients chose the Filipino version of the questionnaire while 37% and 4%, respectively chose the English and bilingual versions. Those who chose English were mostly professionals. The mean interview duration including the time it took the GPs and PSs to fill out the questionnaire was less than seven minutes for all three versions. All except ten patients appeared to understand the questionnaires easily and were able to complete them accurately.

Validity estimate of each item

The internal consistency of the questionnaire items was assessed via the Kuder-Richardson formula 20. Items in the

questionnaire that are proposed to measure the same general construct which is neuropathic pain are supposed to produce similar patient responses if the whole set of items exhibit internal consistency. A KR20 of at least 0.80 indicate a high level of internal consistency. Based on the patient responses, the computed value of KR20 was 0.7837.

Table 2. Etiology of pain

Etiology	N
Radiculopathy (Cervical/lumbosacral)	27
Osteoarthritis	18
Musculo-skeletal back pain	12
Malignancy*	18
Fibromyalgia	10
Headache (muscle tension and migraine)	6
Post traumatic arthritis	5
Rheumatoid arthritis	4
Visceral pain	4
Carpal tunnel	3
Polyneuropathy (diabetic)	2
Post herpetic neuralgia	1
Tendinitis	1
Gouty arthritis	1
Central post stroke pain	1
Peripheral vascular disease	1
Acute traumatic injury	1

**Both in situ and metastatic*

The sensitivity and specificity of each item in both English and Filipino versions of the questionnaire are shown in Table 3. The pain descriptor of burning has three common translations in Filipino, all of which were included in the questionnaire. The sensitivity and specificity of each pain descriptor was generally high. For the English version, the descriptors with the highest scores were burning and electricity-like, followed by tingling, itchy and painful to light touch. All pain descriptors in Filipino except for the Filipino translations for lancinating and stabbing had high sensitivity and specificity scores. Overall, the questionnaire had high sensitivity and specificity as shown in Table 4. Although the positive predictive value was relatively low, there was a high negative predictive value. The final validated version of the screening questionnaire which we named SigN-PQ Neuropathic Pain Questionnaire is shown in Appendix B. A similar sensory map (Appendix C) is also provided at the end of the questionnaire.

Table 4. Overall validity estimates and their Confidence Intervals

	Filipino	English	Overall
Sensitivity	92.86% (0.68, 0.98)	92.86% (0.64, 0.99)	91.89% (0.77, 0.97)
Specificity	82.00% (0.68, 0.90)	74.00% (0.55, 0.87)	80.22 % (0.70, 0.87)
PV (+)	67.86% (0.48, 0.83)	62.00% (0.38, 0.81)	65.38% (0.51, 0.77)
PV (-)	95.35% (0.83, 0.99)	95.38% (0.77, 0.99)	96.00% (0.88, 0.99)

PV (+) : Positive Predictive Value; (-) : Negative Predictive Value

Discussion

This study describes the development and validation of the first neuropathic pain screening questionnaire which we called SigN-PQ Neuropathic Pain Questionnaire in English and Filipino designed specifically for use by general practitioners. In an archipelago such as the Philippines with few pain specialists, there exists a need for a screening test for NP that general practitioners can easily incorporate into their busy practice. Several instruments have been developed over the past several years. The Neuropathic Pain Scale by Galer and Jensen[8] were designed to specifically evaluate the various symptoms of neuropathic pain and possibly to evaluate pharmacological trials. On the other hand, the LANSS Pain Scale,[9] the Neuropathic Pain Scale[10] and the Neuropathic Pain Symptom Inventory by Bouhassira[11] were designed to differentiate between neuropathic and nociceptive pain. However, these tests were all developed in a pain clinic setting where the patient population may not reflect those seen by general practitioners. Furthermore, these tests demand more time to perform and to incorporate in the daily practice of the GPs.

One difficulty encountered in pain research is defining a gold standard since the symptoms experienced by patients are subjective. To minimize variation in the assessment, the use of standardized definitions of pain types was utilized.

Table 3. Validity estimates of each item

Pain Domain	Filipino (n=74)		English (n=45)		Overall (n=120)	
N1	Sensitivity B	Specificity A	Sensitivity B	Specificity A	Sensitivity B	Specificity A
Burning/mainit	88.00	78.26	100	93.10	84.21	80.22
Mahapdi	83.33	81.82			84.62	81.58
Nakapapaso	70.59	90.48			66.67	92.41
Tingling/gumagapang	86.96	85.42	92.86	93.55	84.78	89.29
Pins and needles/tinitusok	83.33	88.24	87.50	89.66	86.21	88.73
Numbness/manhid	86.11	80.00	69.23	93.75	77.59	87.50
Electric-like/ kinuryente	72.00	88.89	100	88.24	77.78	89.29
Stabbing/saksak	60.00	94.64	77.78	88.89	65.62	92.86
Lancinating/hiwa	54.55	93.22	66.67	94.59	66.67	94.34
Itchy/Makati	84.62	89.66	100	97.67	86.67	93.91
Painful to touch / Masakit sa hipo o dampi	66.67	98.46	83.33	97.44	78.57	96.55

Furthermore, both the pain specialists and the general practitioners had a training session on how to administer the questionnaire.

The patients recruited in this study were drawn mostly from the general clinic consisting of a heterogenous group of patients with any type of pain excluding psychogenic pain. Unlike previous studies where acute and the mixed type of pain were excluded to magnify the descriptive differences between nociceptive and neuropathic pain,[8,9,11] patients included in this study were those with chronic and acute nociceptive, neuropathic and mixed type of pain. This is to simulate the profile of patients normally seen by general practitioners in their daily clinic practice. The initial version of the questionnaire devised by the nine pain specialists included a section on sensory testing for touch, cold and warm allodynia and for hyperpathia. However, during the training session with the GP partners prior to the actual study, the GPs found all tests for allodynia too tedious to incorporate into their practice and suggested that this may not be acceptable to general practitioners. Thus, the portion on sensory testing for the different forms of allodynia was removed. To eliminate an on-going nociceptive input, a question on whether pain exists in the absence of inflammation or sign of injury which the practitioner needed to observe was included. This item on the absence of an inflammatory process constituted the N3 domain of the questionnaire. Since the objective of this study was to provide a simple and validated screening instrument for use by the general practitioners, we deliberately chose to reduce the number of items to a minimum necessary to differentiate between nociceptive from neuropathic pain. We made sure however, that the four distinct dimensions of neuropathic pain were represented in addition to the item on the presence of a negative symptom (numbness). The items on the symptoms of neuropathic pain constituted the N1 domain. Lastly, the temporal pattern of the pain of more than three months to signify chronic neuropathic pain constituted the N2 domain of the questionnaire. A most likely diagnosis of neuropathic pain was given to patients who scored positive in at least one item for N1 and in both N2 and N3.

The validation studies were mainly oriented toward the analysis of the sensitivity, specificity and predictive values of each item in the questionnaire and its overall rating. This is primarily because the questionnaire is a dichotomous scale of yes or no questions to find out whether the pain is neuropathic or not. Among those who chose English, the pain dimension of spontaneous continuous and spontaneous paroxysmal pain described as burning, electricity-like and itchy, respectively, have the highest sensitivity and high specificity, reflecting the specific pain domains that characterize neuropathic pain. These terminologies are straightforward and are commonly understood by any educated Filipino. On the other hand, the Filipino term for burning has at least three common translations with subtle differences depending on the context. *Mainit* indicates the sensation of "dry heat", *mahapdi* describes burning with stinging sensation while *nakapapaso* is similar to the sensation of scalding. We decided to include all three translations to cover the spectrum of burning sensation. The pain descriptor lancinating and its Filipino equivalent were also removed from the final version of the questionnaire. Although its specificity is high, its sensitivity is low and during the interview, the terms needed some extended explanation to most of the patients which suggests that the terms may be confusing or not clear at all. In fact, the word lancinating is not a common pain descriptor in the Philippines. Similarly, the descriptor "itchy" and its Filipino equivalent were also removed in spite of their high sensitivity and specificity. The Philippines is a tropical country where mosquito and other insect bites are common. In addition, fungal diseases are prevalent in tropical climates. These dermatologic conditions give rise to itchy sensations which may be confused with the itchy pain descriptor. In the Neuropathic Pain Scale (NPS) by Galer and Jensen, "itchy pain" is described as 'like poison oak' and 'like mosquito bite'.[8] If the NPS is used in the Philippines without proper local validation, the Filipino respondent will not know what 'poison oak' is and may unnecessarily increase the prevalence of itchy pain as pain descriptor due to the description of 'like mosquito bite'. In other neuropathic pain questionnaires, itchy pain is not included in the checklist.[9,11] Thus, we decided to remove the item on itch and its Filipino equivalent. Appreciation of the role of language within a cultural context in using pain descriptors is essential as it leads physicians and researchers to a more valid understanding of the meaning of pain. This has important implications when a clinical trial for a new drug for pain is brought to a developing country where English is not the first language. Validation of pain questionnaires as measures of outcome is therefore necessary. With the increasing number of clinical trials being outsourced in the Philippines and in other non-English speaking populations, local technical and ethics review boards now require proof of translation and validation to the local language of questionnaires that are used to measure outcomes with strong cultural context.

This study also showed that the predictive value of a negative test (PV^-) for Sign-P is high (96.0%) which means that the proportion of patients who tested negative does not have neuropathic pain. However, its predictive value of a positive test (PV^+) is relatively low (65.38%). This low PV+ reflects the tendency of the GPs to label as "neuropathic" those unfamiliar or complex pain symptoms which would be recognized by the PSs as being otherwise. This is consistent with what is reported in the literature that many clinicians tend to diagnose as neuropathic any clinical pain presentation that is difficult to categorize.[3,13] Lastly, the use

of the sensory map (Appendix C) is emphasized as this will help the practitioner determine later during follow up of the patient whether the area of sensory affectation has enlarged or has diminished. Enlargement of the affected sensory area may mean ineffective pain management. These findings in this study highlight the need for pain specialists through their pain societies to conduct continuing medical education on neuropathic pain for general practitioners.

In conclusion, the SigN-PQ Neuropathic Pain Questionnaire which has a high overall sensitivity of 91.89% and specificity of 80.22% is a valid screening instrument for neuropathic pain that can be easily incorporated in the daily practice of general practitioners. However, just like any screening instrument, it can be more helpful in making a definitive diagnosis of neuropathic pain when used in conjunction with clinical findings that confirm the existence of the disorder. For this reason, a positive result based on this instrument should be followed by doing a routine physical and neurological examination and pertinent laboratory tests. This emphasizes the need for continuing dialogue between specialists and general practitioners. This validation study is limited only to English and Filipino languages including Taglish. Translation and validation of this questionnaire to other major language groups found in the Philippines such as Cebuano, Ilonggo and Ilocano maybe necessary.

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Appendix A

NP Screening Questionnaire

(Neuropathic Pain Screening Questionnaire - Version :Pilot Test)

MM/DD/Y: _____

Patient's Code: ___

Instruction to the GP: Please ask the ff questions

1. Shade the part/s of the body with pain (see back of this page)
2. Put a check on the appropriate column below

N1 Pain Domain	YES	NO
1. **Do you have burning sensations?** *May nararamdaman ka bang mainit?*		
Mahapdi ba ang sakit?		
Ang sakit ba ay parang nakapapaso?		
2. **Do you have tingling sensations?** *May pakiramdam ka bang parang may gumagapang?*		
3. **Do you feel pins and needles in the affected part?** *Ang sakit ba ay parang tinutusok?*		
4. **Is there decreased sensation in the affected part?** *Manhid ba ang pakiramdam?*		
5. **Is the pain electric-like?** *Para bang kinukuryete ang sakit?*		
6. **Is the pain stabbing in character?** *Para bang sinasaksak ang sakit?*		
7. **Is the pain lancinating?** *Para bang hinihiwa ang sakit?*		
8. **Is it itchy in the painful area?** *Makati ba sa parteng masakit*		
9. **Is it painful to light touch?** *Masakit ba kahit mahipo o madampian* lamang ng damit o magaan na bagay?		
N2 - **Is the pain more than 3 months?** *Mahigit na bang 3 buwan ang sakit?*		
N3 For observation by the MD **Is there pain in the absence of inflammation or injury?** *Nararamdaman ba ang mga simtomas kahit walang nakikitang pamamaga o pinsala sa laman?*		

Diagnosis:Mostlikely Neuropathic Pain = Any of N1 + N2 + N3

Result: ☐ Most likely Neuropathic ☐ Not neuropathic

Etiologic Diagnosis: _____

Time Duration Administered:_____ Name of Consultant:_____

Appendix B

SigN-PQ Neuropathic Pain Questionnaire

(Neuropathic Pain Screening Questionnaire - Final Version)

Patient's Name: _____ MM/DD/Y: _____

Instruction to the GP/IM: Please ask the ff questions

3.Shade the part/s of the body with pain (see back of this page)

4. Put a check on the appropriate column below

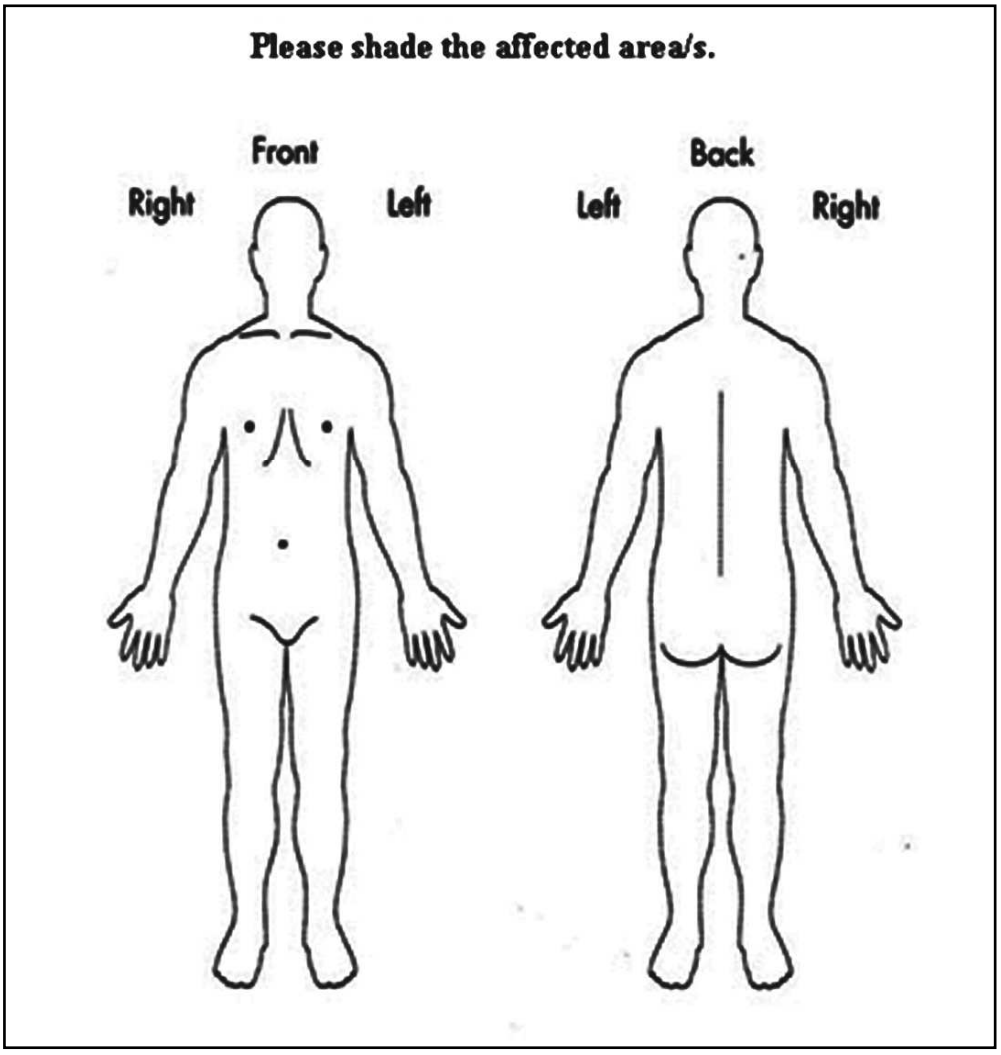
N1 Pain descriptors	YES	NO
1. **Do you have burning sensations?** *May nararamdaman ka bang mainit?*		
Mahapdi ba ang sakit?		
Ang sakit ba ay parang nakapapaso?		
2. **Do you have tingling sensations?** *May pakiramdam ka bang parang may gumagapang?*		
3. **Do you feel pins and needles in the affected part?** *Ang sakit ba ay parang tinutusok?*		
4. Is there decreased sensation in the affected part? *Manhid ba ang pakiramdam?*		
5. **Is the pain electric-like?** *Para bang kinukuryete ang sakit?*		
6. **Is the pain stabbing in character?** *Para bang sinasaksak ang sakit?*		
7. Is it painful to light touch? *Masakit ba kahit mahipo o madampian lamang ng damit o magaan na bagay?*		
N2 - Is the pain more than 3 months? *Mahigit na bang 3 buwan ang sakit?*		
N3 For observation by the MD **Is there pain in the absence of inflammation or injury?** *Nararamdaman ba ang mga simtomas kahit walang nakikitang pamamaga o pinsala sa laman?*		

Mostlikely Neuropathic Pain = Any of N1 +N2 + N3

Diagnosis: ☐ Neuropathic Pain ☐ Not Neuropathic Pain

Etiologic Diagnosis: _____ Consultant: _____

Appendix C


Please shade the affected area/s.
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