APPENDIX FOR CASE REPORT FORM

Ketamine Infusion for Paediatric Cancer Related Mucositis Series 42

RAPID Pharmacovigilance in Paediatric Chronic Pain

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Faces Pain Scale – Revised (FPS-R)

In the following instructions, say "hurt" or "pain", whichever seems right for a particular child.

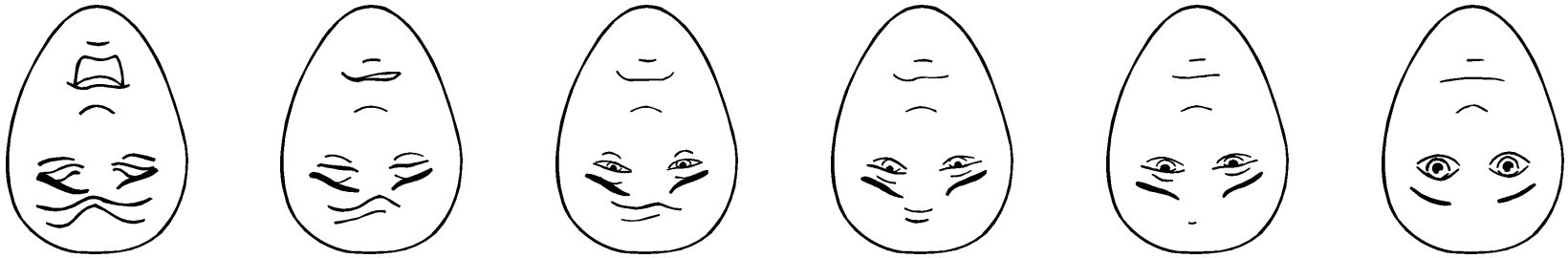
"These faces show how much something can hurt. This face *[point to face on far left]* **shows <u>no pain</u>. The faces show more and more pain** *[point to each from left to right]* **up to this one** *[point to face on far right]* **- it shows <u>very much pain</u>. Point to the face that shows how much you hurt** [right now]."

*Score the chosen face **0**, **2**, **4**, **6**, **8**, or **10**, counting left to right, so "0" = "no pain" and "10" = "very much pain". Do not use words like "happy" or "sad". This scale is intended to measure how children feel inside, not how their face looks.*

Sources. Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. Pain 2001;93:173-183. Bieri D, Reeve R, Champion GD, Addicoat L, Ziegler J. The Faces Pain Scale for the self-assessment of the severity of pain experienced by children: Development, initial validation and preliminary investigation for ratio scale properties. Pain 1990;41:139-150.

(fold along dotted line)

10 **8** **6** **4** **2** **0**



Symptom Severity Score – (Revised FLACC Scale)

Revised FLACC Scale SCORING			
Categories	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, sad, appears worried	Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/panic
Legs	Normal position or relaxed, usual tone and motion to limbs	Uneasy, restless, tense, occasional tremors	Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking
Activity	Lying quietly, normal position moves easily, regular, rhythmic respirations	Squirming, shifting back and forth, tense, tense. guarded movements, mildly agitated, shallow respirations, intermittent sighs	Arched. Rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting
Cry	No cry (awake or asleep)	Moans or whimpers: occasional complaint, occasional verbal outbursts, constant grunting	Crying steadily, screams, sobs, frequent complaints, repeated outbursts, constant grunting
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to: distractible	Difficult to console or comfort, pushing caregiver away, resisting care or comfort measures

Each of the five categories **(F)** Face; **(L)** Legs; **(A)** Activity; **(C)** Cry; **(C)** Consolability is scored from 0-2, which results in a total score between zero and ten.

FLACC pain scale

The following table provides the criteria for the FLACC Behavioural pain scale.

Behaviour	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting, back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams, sobs, frequent complaints
Consolability	Content, relaxed	Reassured by touching, hugging or being talked to, distractible	Difficult to console or comfort

Instructions

Patients who are awake:

- Observe for at least 2-5 minutes.
- Observe legs and body uncovered.
- Reposition patient or observe activity; assess body for tenseness and tone.
- Initiate consoling interventions if needed.

Patients who are asleep:

- Observe for at least 5 minutes or longer.
- Observe body and legs uncovered.
- If possible, reposition the patient.
- Touch the body and assess for tenseness and tone.

Each category is scored on the 0-2 scale which results in a total score of 0-10.

Assessment of Behavioural Score:

0 = Relaxed and comfortable
1-3 = Mild discomfort
4-6 = Moderate pain
7-10 = Severe discomfort/pain

Reference: Merkel S, Voepel-Lewis T, Shayevitz JR, et al:*The FLACC: A behavioural scale for scoring postoperative pain in young children.* Pediatric nursing 1997; 23:293-797.