

# Evaluation of the patient with acute pain

## Avaliação do paciente com dor aguda

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### Abstract

Assessing the intensity of pain and its impact on the individual's quality of life is the starting point for effective analgesia. Segregating groups helps in evaluating the pain component through the use of distinct scales and metrics adapted to each context. Understanding pain expression beyond the lesion, so as not to overvalue and/or undervalue the painful complaint, is the responsibility of the healthcare team, thereby avoiding discrimination of the patient's individual moment of suffering. Acute pain, unlike chronic pain, allows for a faster and more objective assessment, which also makes it a clinical condition that requires urgent therapy in the same proportion, bringing immediate results and leading to comfort and relief of suffering. Its assessment goes beyond the hospital setting, starting from the initial contact with the patient in a painful condition. Understanding the behavior of different groups with varying limitations of expression and communication becomes a challenge in pain assessment in special populations.

**Keywords:** Acute pain; Quality of life; Pain assessment.

### Resumo

Avaliar a intensidade da dor e seu impacto na qualidade de vida do indivíduo é o ponto de partida para uma analgesia eficaz. Segregar grupos nos auxilia na avaliação do componente doloroso com o uso de escalas e métricas distintas para cada realidade. Entender a expressão dolorosa para além da lesão, para não hipervalorizar e/ou subjugar a queixa algica é de responsabilidade da equipe de saúde, evitando assim discriminar o momento de sofrimento individual do paciente. A dor aguda, diferente da crônica, tem a possibilidade de uma avaliação mais rápida e objetiva, o que também a torna uma condição clínica que necessita de uma terapêutica urgente na mesma proporção, que traga um resultado imediato, conduzindo ao conforto e alívio do sofrimento. Sua avaliação vai além do ambiente hospitalar logo no contato inicial com o paciente em quadro algico. Entender o comportamento de grupos distintos nas mais variadas incapacidades de expressão e comunicação se torna um desafio na avaliação da dor em grupos especiais.

**Palavras-chave:** Dor aguda; Qualidade de vida; Avaliação da dor.

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## Introduction

Pain assessment is fundamental for both clinical treatment and research, as it helps determine the type and needs of therapies. Because pain is a complex subjective experience, in which objective assessment is virtually impossible, unidimensional tools are often used in the assessment of acute pain. In recent decades, pain has evolved from a simple symptom to “the 5th vital sign,” which has created a need for more comprehensive screening and reassessment policies. However, the sole emphasis on simple intensity scales has resulted in negative consequences, such as an increase in adverse events related to the use of analgesics. Mere adherence to regular pain assessments does not guarantee improved treatment, unless structured processes are implemented in therapeutic approaches. Therefore, a robust and pragmatic approach to pain measurement is necessary to ensure effective communication among healthcare teams and between professionals and patients, in order to optimize appropriate management and achieve the positive results of “optimal analgesia”. When aiming to assess and measure pain, the first step is to identify the profile of the patient, taking into account their individual characteristics, special needs, difficulties in interpretation and interaction with the healthcare team. The team must then be able to integrate the assessment in an objective and reproducible way. Consequently, separating groups such as children, the elderly, non-communicative patients, or those with impaired cognition is imperative to ensure the most accurate therapeutic choice. For this reason, the development of specific scales adapted to the individual realities of subgroups has provided a gain in pain treatment. It is important to note that a behavioral pain score should not be confused with a simple self-assessment of intensity, as it may only reflect the existence of pain rather than the capture the effectiveness of relief <sup>(1,2)</sup>.

Starting from the first major point of pain assessment, its temporality, acute pain can be reliably measured using unidimensional tools such as numerical or visual scales, while chronic pain and its physical, emotional, and social dysfunctional effects require broader, multidimensional tools that quantify the impact of pain on quality of life. This text will focus on the assessment of acute pain, aiming to promote an effective action plan following clinical evaluation <sup>(2)</sup>.

## Importance of pain quantification

The way we quantify pain levels is mainly based on subjective reports from patients. Even though pain is a subjective experience, it should be considered the fifth vital sign due to its prevalence and influence on clinical conditions<sup>3</sup>. Pain is related to loss of productivity at work, causing a significant economic impact in several countries around the world<sup>4</sup>.

It is important to quantify pain in order to provide the best treatment for patients and monitor their clinical progress. It also allows for individualized treatment, adjusting approaches according to the intensity and underlying pathophysiology. In addition, pain measurement enables effective communication among healthcare professionals, improving the exchange of information and promoting a result-oriented, effective approach (Figure 1).

## Scales and medical history in acute pain

The initial assessment of patients with pain should include a detailed medical history, which is essential for diagnosis and therapeutic planning. This approach must cover somatic aspects and psychosocial variables, such as emotional distress and dysfunctional beliefs. The interview should follow the principles of conventional clinical history-taking, adapting to the complexity of the case, which may require multiple encounters for a complete narrative. Patients with difficult-to-control pain often undergo evaluations by various specialties,

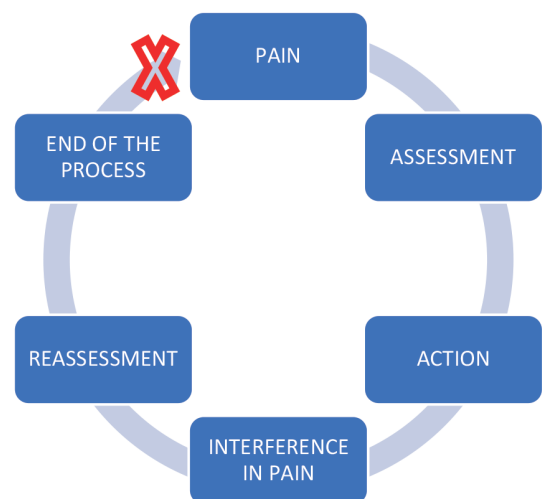


Figure 1. Pain assessment-coping cycle.

resulting in frustration and low expectations for resolution. In this context, it is crucial to establish a doctor-patient relationship based on empathy and active listening to improve treatment adherence and the accuracy of clinical information. The medical history should begin with open-ended questions, allowing the patient to express their experience, and then progress to targeted questions that help formulate diagnostic hypotheses, while avoiding suggestive questions that may compromise the objectivity of the responses<sup>(5)</sup>.

## Clinical Characterization of Pain

The systematic evaluation of pain should include fundamental attributes that help identify the type and probable origin of the symptom. The main domains include: location, quality, intensity, chronology, triggering and relieving factors, as well as associated clinical manifestations<sup>6,7</sup>.

### Location

The precise location of pain guides the etiological assessment. It is important to distinguish between localized (superficial) and diffuse (deep or visceral) pain, as well as to identify its irradiation. Topographic patterns are useful for differentiation<sup>7-9</sup>:

- Localized pain: without radiation – common in osteoarthritis and musculoskeletal pain;
- Projected pain: follows nerve pathways (e.g., trigeminal neuralgia or herpes zoster);
- Referred pain: due to somato-visceral convergence – exemplified by lower back pain secondary to a subphrenic abscess;
- Complex regional pain syndrome: subdivided into type I (without nerve injury) and type II (with nerve injury) – characterized by disproportionate pain, hyperesthesia, vasomotor, trophic, and motor changes;
- Psychogenic pain: lacks a defined neuroanatomical pattern – often associated with primary psychiatric disorders; diagnosis is clinical and institutionalized in a biopsychosocial context.

### Quality of pain

Descriptions such as burning, electric shock, or stabbing sensations provide essential clues. Tools like the *McGill Pain Questionnaire* and its brief forms have been validated to distinguish nociceptive, neuropathic, and nociplastic components<sup>6,10</sup>.

## Pain intensity

Unidimensional scales such as the Visual Analog Scale (VAS) and numeric Rating Scale are widely used, correlating with quality of life, especially in elderly people with chronic pain<sup>7</sup>.

## Pain chronology

The assessment should consider duration, pattern, and progression. It is structured in three phases: onset of symptoms (initial analysis with identification of precipitating factors); evolutionary period (monitoring of patterns); and therapeutic responses<sup>6,7</sup>.

- Current situation: comparison with previous phases to provide updated data on progression, remissions, or relapses;
- Triggering and aggravating factors: These include physical, postural, chemical, emotional, or lifestyle stimuli that directly influence symptoms;
- Relief factors: These include strategies such as positioning, heat/cold applications, medications, and previous interventions—essential for outlining future interventions.

## Associated symptoms

The investigation should include autonomic symptoms (sweating, nausea) or systemic symptoms (fever, weight loss, skin changes), which may indicate severity or specific etiology<sup>8,11,12</sup>.

## Physical examination

### General Physical Examination

A thorough physical evaluation of patients whose main complaint is pain is an indispensable step in clinical reasoning, requiring in-depth knowledge of anatomy and pathophysiology. As a nonspecific and multifactorial symptom, pain requires a detailed examination to guide diagnostic investigation<sup>11</sup>.

Clinical observation should begin at the first contact with the patient: facial expression, gait, posture, and signs suggestive of pain (antalgic posture) offer important clues. The examination should be performed with the patient wearing appropriate clothing or undressed when necessary, respecting privacy and comfort, to allow adequate inspection of the integument<sup>11,12</sup>.

The general examination includes assessment of vital signs, weight and height, cardiac and pulmonary auscultation, abdominal palpation and percussion, as

well as inspection of the skin and mucous membranes — evaluating integrity, color, texture, elasticity, and signs of inflammation (redness, warmth, edema, pain, and loss of function). Evaluation of hair and nails identifies trophic changes that may suggest systemic or autonomic impairment<sup>(11,12)</sup>.

## Neurological Examination

Regardless of the location of the pain, an objective neurological screening must be performed: evaluation of cranial nerves, spinal nerves (sensitivity and motor function), deep tendon reflexes, cerebellar exams, and evaluation of higher cognitive functions (memory, language, and orientation). In addition to being essential for detecting neurological deficits, this examination guides the diagnosis of the causes of pain<sup>(13)</sup>.

## Examination of the Painful Region

A targeted evaluation of the affected region should be performed after the general physical examination. The classical steps of propaedeutics—inspection, palpation, percussion, and auscultation—should be applied according to the nature and location of the complaint<sup>14</sup>.

## Inspection

Observation of the skin in the painful area is essential to identify signs such as cyanosis, hyperemia, edema, localized sweating, and hair rarefaction. The presence of localized piloerection, especially when restricted to a dermatome and associated with pain, may suggest sympathetic involvement or radiculopathy<sup>14</sup>.

## Palpation

Being the stage of greatest diagnostic sensitivity, it should be performed progressively, starting with light palpation and comparing with the contralateral side. Points of hyperalgesia, pain on compression, muscle stiffness, spasms, masses, or joint crepitus should be identified. The response to palpation guides the differentiation between nociceptive, neuropathic, or mixed pain, in addition to guiding the need for complementary tests<sup>(14,15)</sup>.

## Pain Measurement

Pain measurement is an indispensable part of clinical assessment, as it allows objective communication between the professional and the patient besides supporting therapeutic planning. Although pain is a

subjective experience, the use of validated scales—both unidimensional and multidimensional—enables the monitoring of the analgesic response over time. The choice of scale should take into account characteristics such as age, cognitive ability, level of consciousness, and overall clinical condition. Periodic and systematic reassessment is recommended, respecting the dynamic nature of the condition and the instituted interventions.<sup>16</sup>

## Unidimensional Scales

Unidimensional scales measure pain intensity exclusively and are widely used due to their simplicity, low cost, and rapid applicability. They are particularly useful for lucid adult patients with good communication skills<sup>17</sup>.

The main scales in this category include<sup>7,18</sup>:

- **Numeric Rating Scale (NRS):** the patient assigns a value from 0 to 10 to represent their pain, with 0 indicating no pain at all and 10 being the worst imaginable pain. It is one of the most widely used scales in clinical practice (Figure 2).
- **Visual Analog Scale (VAS):** consists of a continuous 10 cm line with no visible markings, where the patient marks the point corresponding to the intensity of the pain. The distance in millimeters is measured (0–100);
- **Verbal Rating Scale (VRS):** uses descriptive categories (“no pain,” “mild pain,” “moderate,” “severe,” “unbearable”). It is useful for patients with low literacy levels or mild cognitive comorbidities (Figure 3);



Figure 2. Numeric Rating Scale.

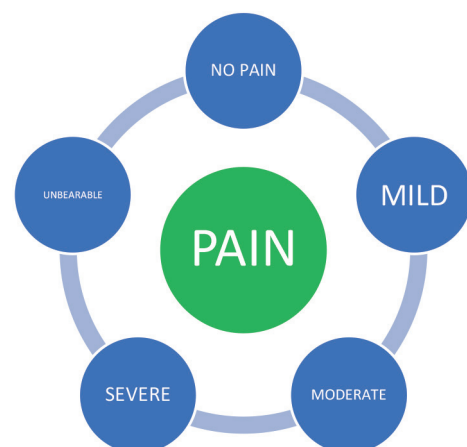


Figure 3. Verbal Rating Scale.

- Faces Pain Scale – Revised (FPS-R): useful for children and adults with difficulty in verbal communication. The patient points to the face that best represents their pain; each face corresponds to a numerical value from 0 to 10.

## Scales for Special Populations

Observational or behavioral scales<sup>19</sup> should be used in patients who are unable to express themselves verbally—such as those admitted to intensive care units (ICUs), in the immediate postoperative period, or with cognitive impairment.

- Behavioral Pain Scale (BPS) and Critical-Care Pain Observation Tool (CPOT) are validated for intubated and sedated patients in the ICU. They assess facial expression, limb movements, muscle tension, and adaptation to the ventilator. Both show good validity and psychometric reliability<sup>19</sup>.
- PAINAD: specific for patients with advanced dementia; assesses vocalization, facial expressions, body posture, breathing, and consolability<sup>20</sup>.
- FLACC: indicated for nonverbal young children; scores five behavioral domains (Face, Legs, Activity, Cry, Consolability)<sup>21</sup>.
- NIPS: appropriate for newborns, assessing crying, facial expression, respiratory pattern, and muscle tone<sup>21</sup>.

## Multidimensional Scales

Pain assessment is not limited to its intensity. Multidimensional instruments allow the analysis of sensory, affective, cognitive, and behavioral components, providing a broader understanding of pain—especially in patients with chronic pain. The *McGill Pain Questionnaire* is among the most widely used multidimensional scales in research settings<sup>22</sup>.

## Other Scales and Specific Applications<sup>23</sup>

- OBAS: used in the postoperative setting, especially in sedated patients or those on mechanical ventilation.
- CAPS: integrates subjective and objective data, useful in multimodal surgical analgesia protocols.
- ESCID: designed for assessing pain in elderly patients with mild to moderate cognitive impairment.

## Considerations in the out-of-hospital setting

Managing acute pain outside the hospital presents some challenges, such as the unavailability of the same resources that are present in the hospital environment. Non-pharmacological and pharmacological treatments can be used in combination, and it is important to train the healthcare team and ensure good communication with the patient for the treatment to be successful. Acute pain is one of the most frequent complaints in pre-hospital and outpatient care, characterized by its sudden onset and frequent association with a specific cause, such as trauma. In cases of acute pain, faster intervention is required to ensure treatment effectiveness and minimize patient suffering. The approach to acute pain in an out-of-hospital setting requires knowledge of specific protocols for the use of therapies with rapid results and depends on the training of healthcare professionals. Thus, when performed outside the hospital setting, analgesia will depend specifically on the intensity of the pain and the patient's clinical condition. Comorbidities must be considered, because some medications can worsen pre-existing clinical conditions. Effective communication with the patient is essential for therapeutic success<sup>(24)</sup>.

The approach to acute pain in prehospital settings (ambulance, rescue units, and home care) requires a rapid and effective approach, considering resource limitations. It has been demonstrated that in prehospital treatment of acute traumatic pain around 70% of patients report pain and more than 40% do not report adequate relief<sup>25</sup>.

Non-pharmacological treatment may include rest and immobilization of the affected limb in cases of fractures, ligament, tendon, and muscle injuries. In traumatic injuries, the application of ice (cryotherapy) may be recommended. The absence of pharmacological treatment is less effective in the treatment of acute traumatic pain when compared to the pharmacological use of morphine, cryotherapy, and emotional support<sup>25</sup>.

Healthcare professionals working outside the hospital environment (clinics, outpatient facilities, offices, health centers, and home care) should be trained to correctly assess acute pain, especially in terms of intensity and cause, as the early management of this pain can prevent it from becoming chronic. In the pharmacological treatment of acute pain, the analgesic ladder can be used as a guide, considering whether the

pain is mild, moderate, or severe. For mild pain, simple analgesics such as dipyron and paracetamol can be used, in addition to nonsteroidal anti-inflammatory drugs. For moderate pain, weak opioids such as tramadol and codeine may be prescribed. In cases of severe pain, strong opioids such as morphine, buprenorphine, methadone, and oxycodone may be necessary<sup>(26)</sup>. When opioids are used, it is important to monitor adverse effects such as nausea, dizziness, constipation, respiratory depression, and the risk of increased chronic use<sup>(27)</sup>.

## Considerations in the hospital setting

Acute pain affects the majority of hospitalized patients at some point during their stay. Despite its high prevalence in hospital care, the management of acute pain has been little addressed in medical curricula and practical training, leaving many health professionals unprepared to manage it effectively<sup>28</sup>. There has also been an increase in hospitalizations of patients with prior opioid tolerance, chronic pain, or opioid use disorder. Combined with the limited availability of trained specialists, these factors create additional challenges for prescribers and overload healthcare resources<sup>(29)</sup>.

Pain assessment in a hospital setting must be adapted to the care sector, as outpatient clinics, wards, intensive care units (ICUs), and surgical rooms have different dynamics. In outpatient clinics, communication with the patient is usually complete, allowing the use of verbal or written scales and a detailed collection of the pain history. In wards, however, assessment tends to be more pragmatic and time-limited, requiring quick and reproducible scales. In ICUs, assessment is often compromised by sedation, intubation, or delirium, requiring the use of validated behavioral scales, such as BPS or CPOT. In the surgical room, assessment is mainly intraoperative or immediate postoperative, based on vital signs, motor responses, and scales adapted to the state of consciousness<sup>(19)</sup>.

Periodic reassessment of pain is a critical component of in-hospital management. It enables verification of treatment effectiveness, early identification of adverse effects or therapeutic failures, dynamic adjustment of interventions, and, most importantly, prevention of pain chronification - a condition associated with worse functional outcomes, prolonged suffering, and increased hospital costs. The frequency of reassessment should

correspond to the severity of the condition, preferably at intervals established by institutional protocol.

## Pain assessment in the hospital setting

The most effective strategy to improve pain control and reduce adverse drug-related events in this context is multimodal analgesia. This “rational polypharmacy” maximizes benefits while minimizing risks by combining lower doses of multiple drugs with complementary mechanisms of action<sup>30</sup>. Consequently, all patients with acute pain should receive non-opioid analgesics of different classes, prescribed appropriately and on a scheduled basis (i.e., given continuously rather than “as needed”), in addition to any opioid therapy. However, this recommendation should not be confused with the indiscriminate or overly standardized prescription of all available non-opioids for every patient.

Multimodal analgesia must be balanced and judicious, using complementary mechanisms to improve pain control while minimizing exposure to high-risk drugs—and without disregarding cumulative risks or individual patient characteristics. Multimodal analgesia should combine non-pharmacological approaches with appropriate medications according to the specific case, within the available institutional protocols, ensuring safe and clinically meaningful use. The prescriber must consider the characteristics of pain, risk factors for adverse events, potential drug interactions, and the patient’s overall clinical status when initiating and adjusting the multimodal analgesic regimen. At the institutional level, the healthcare team should act proactively in creating order sets or “pain management menus” to support decision-making and cohesively operationalize the various multimodal resources available<sup>(31)</sup> (Table 1).

**Table 1.** Therapeutic possibilities in the hospital environment for a multimodal approach.”

- Paracetamol (acetaminophen) and dipyron (metamizole)
- Anti-inflammatory drugs
- Agents for neuropathic pain – gabapentinoids, serotonin reuptake inhibitors, anticonvulsants
- Corticosteroids
- NMDA antagonists
- Central alpha-adrenergic agonists
- Systemic anesthetics (e.g., intravenous lidocaine, inhalational anesthetics)
- Topical agents – lidocaine, anti-inflammatory drugs, capsaicin
- Regional anesthetic modalities supported by a specialized pain management team (e.g., peripheral nerve blocks, neuroaxial blocks)
- Physical therapy, cognitive/behavioral therapies, thermotherapy, and other non-pharmacological interventions



When prescribing opioids for acute pain, clinicians should consider several factors, including the type of pain, its severity and location, the speed required for the analgesic effect to begin, the desired duration of action, ease of administration, resources available at the institution, patient preferences, adherence to treatment, and cost. The professional should assess not only which opioid agent is most appropriate, but also which route of administration is the most suitable, what the ideal dose is for that route, and whether there are specific limitations or contraindications for that patient.<sup>(32)</sup>

In addition to pharmacological measures, several non-pharmacological therapies can complement the use of medications. Three examples with growing evidence and increasing integration into hospital practice include: massage therapy, acupuncture, and music therapy. Massage therapy has been extensively studied in the context of cancer pain, but its principles can be applied to the management of acute pain. Therapeutic massage can increase blood and lymphatic circulation, reduce inflammation and edema, relax muscles, raise dopamine and serotonin levels, and decrease anxiety, depression, anger, and fear<sup>(33)</sup>.

Acupuncture is a popular form of complementary medicine that helps relieve symptoms and stimulates the body's self-regulation and self-healing mechanisms<sup>33</sup>. Finally, music therapy is an emerging discipline that helps eliminate psychological barriers and the restore or improve of physical and mental health. Studies have shown that music therapy reduces anxiety levels, which may lead to a reduced need for analgesia<sup>(34)</sup>.

## Subgroups and painful experience

Individuality has long been recognized, as illustrated by Plato's observation: "No two persons are born exactly alike, but each differs from the other in natural endowments, one being suited for one occupation and the other for another." Individual differences are a relevant aspect of the experience with pain and have been a topic of great interest to scientific research in the field of pain ever since. In this context, the evaluation of demographic data is not merely statistical, but implies and is directly connected to a group of phenotypic and genotypic factors in the pain treatment flowchart<sup>(35)</sup>.

Within the concept of pain, there has been the record of an unpleasant experience characterized by enormous interindividual variability, in which biological and psychosocial variables interrelate, leading to the

manifestation of pain. In the meantime, demographic variables, genetic factors, and psychosocial processes are included. Differences in sex, age, and ethnicity in the prevalence of chronic pain conditions are recorded in the literature. Demographic factors are associated with responses to induced pain, while genetic and psychosocial factors contribute to clinical and experimental responses to pain. It should be noted that these different biopsychosocial influences interact with each other in a complex interconnectivity, shaping the experience with pain. Some genetic associations with pain vary between genders and ethnic groups, and genetic factors interact with psychosocial factors, thus influencing the manifestations of pain. The combined individuality of these biological and psychosocial variables leads to a unique mosaic of aspects that contribute to each individual's unique pain. Understanding the mosaicism within pain is basic and unique condition for optimal and personalized treatment. Evolving towards a practical application of the individual factors in pain, one must consider that:

- an important fact may be that the awareness of individual differences within the clinical environment is fundamental from the initial assessment to the end of treatment;
- knowledge and identification of the multifactorial complexity influencing pain requires an equally sophisticated approach;
- pain treatment should follow the multimodal and preemptive concept, avoiding a single therapeutic modality, which is commonly employed in medical routines, and known to bring suboptimal results.

## Gender

Chronic pain is more prevalent among women than men, and women are at higher risk for most common chronic pain conditions, such as migraine and tension-type headaches, low back pain, fibromyalgia and widespread pain, temporomandibular disorders, irritable bowel syndrome, and osteoarthritis. Females tend to have greater pain sensitivity than men, including lower pain threshold, lower pain tolerance and stronger responses to supraliminal stimulus patterns<sup>(35)</sup>. However, men are more likely to experience neuropathic chronic pain<sup>(36)</sup>.

## Ethnicity

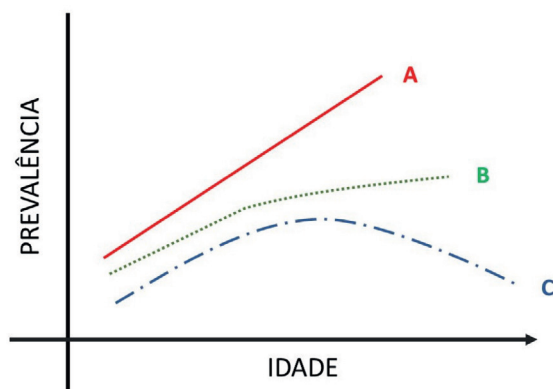
Ethnic and racial interpretations are complex concepts in associative evaluations of pain sensitivity

and pain manifestations patterns, with an intrinsic multifactorial component. Therefore, differences in pain perception among groups may contribute to distinct models of pain severity. Biological factors linked to genetics promote this variability from coping with the painful condition to its clinical manifestation<sup>35</sup>. Ethnic minorities tend to experience higher frequencies and intensities of pain and are more affected by chronic pain conditions, although there is no consensus on whether these differences may be related to sensitivity *per se* or to access and quality of care<sup>36</sup>.

## Age

The patterns of pain prevalence throughout life are complex and vary according to algogenic conditions, with studies showing age-related changes in the intensity and impact of pain (Graph 1)<sup>35</sup>.

Elderly people report lower intensity of acute pain, lower sensitivity to superficial pain, higher sensitivity in deep tissues, and increased total pain duration when compared to younger individuals. Pain modulation consistently decreases with aging due to changes in the modulatory balance of pain, since the elderly experience greater pain facilitation combined with less pain inhibition<sup>35</sup>. However, given the high incidence of cognitive impairment along with peripheral neurological changes that affect pain perception, pain assessment in elderly patients may extend beyond these methods for better therapeutic equalization<sup>37</sup>.



**Graph 1.** Patterns of pain prevalence across the lifespan. A – Arthralgia and neuropathic pain; B – General chronic pain; C – Headache, abdominal pain, back pain, and chest pain. Adapted from *Fillingim*<sup>35</sup>.

Children exhibit variations in their developmental characteristics, from cognitive to affective, posing unique challenges for medical conduct. Quantifying pain does not cause more pain. As with the elderly, the pediatric group has its particularities. Failure to adequately and sufficiently assess pain and to respond promptly to the results of the assessment perpetuates the inadequate management of pediatric pain and compromises the desired treatment.

Nociceptive pathways in early life are not only a version of those in adults. Children have their own characteristics, which determine different sensations and perceptions of pain. It is common to mistakenly believe that children do not feel pain or that they experience less intense pain than adults. It is known that the nociceptive system is already functional from the 20th week of gestation, culminating in its maturation only in adulthood<sup>(38)</sup>.

Due to the importance of pain assessment for its effective management, some steps are crucial:

- assessing pain means recording its history in medical records;
- when quantifying a child's pain, an age- and cognition-appropriate tool should be used;
- constantly reassess the effectiveness of interventions for pain relief.

## Conclusion

Interpreting pain beyond mere intensity promotes effective treatment of painful conditions. Acute pain should be assessed and treated from the first contact with the healthcare team, even outside the hospital setting. Categorizing distinct groups according to demographic variables, educational profile, neurological level, and multifaceted knowledge of pain aids in the pain management process. Our passivity, underestimation, delayed approach, and single-target therapies leave us unable to achieve a consistent standard of care in the management of acute pain, which negatively and relentlessly fosters the development of chronic pain, which is among the most costly health conditions in the modern world and one of the leading causes of disability with lost workdays, dysfunction, and, fatally, loss of quality of life. We must be acute in our approach to acute pain.

**Authors' Contribution:** MF: Conceived and planned the activities that led to the study; wrote the manuscript; participated in the review process; approved the final version. TKM: Interpreted the study results; participated in the review process. RVR: Participated in the review process; approved the final version.

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