Visual Analogue Pain Scale with Convenient Digitizer

To the Editor:—Since the introduction of the visual analogue pain scale by Huskisson, its reliability and reproducibility have been questioned. However, when pain intensity is expressed numerically, it is important to digitize it precisely and quickly. For this purpose, we have combined a visual analogue pain scale with a numerical scale (fig. 1). The analogue scale on one side is for use by the patient. The reverse side contains the simultaneous digitizer.

After providing a standard explanation of the visual analogue scale, we ask the patients to estimate their experience of pain using the cursor, and we then read the corresponding number from the numerical scale on the other side. Some patients understand the concept of a visual analogue pain scale better when they see the present scale than when they are only given an explanation. An additional advantage with our scale is that we avoid the difficulties with understanding the meaning of unfamiliar foreign words stated by patients for whom Japanese is not the native language.

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REFERENCES


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Editor's Comment

A recent publication by Lanier et al.\(^1\) contained an unusually large number of typographical errors, the most important of which are included as errata in this issue of ANESTHESIOLOGY. It has been previously suggested\(^4\) that three quarters of the errors that appear in print fall into the category of authors' errors and that one quarter are printers' errors. Furthermore, it was noted that printers' errors are also the responsibility of the author since they are published as a result of the author failing to meticulously correct the galley proofs.

In the case of the article by Lanier et al., the authors were never offered an opportunity to review the galley, and thus all the errors were translated directly to the Journal. This letter is meant both as a formal apology to the authors for this inexplicable oversight and as notification to our readers that the numerous and embarrassing typographical errors in this manuscript are not the result of author negligence.

LAWRENCE J. SAIDMAN, M.D.
Editor in Chief

REFERENCES

1. Lanier WL, Iaizzo PA, Milde JH: Cerebral function and muscle afferent activity following intravenous succinylcholine in dogs anesthetized with halothane: The effects of pretreatment with a defasciculating dose of pancuronium. ANESTHESIOLOGY 71: 87–95, 1989

Errata

In the May, 1989, issue a Laboratory Investigation (Serrao JM, Stubbbs SC, Goodchild CS, Gent JP: Intrathecal midazolam and fentanyl in the rat: Evidence for different spinal antinociceptive effects. ANESTHESIOLOGY 70:780–786, 1989) contains an error. The dose range used 0.054–1.5 nmol for dose response curve and dose used in analgesic comparison with midazolam was 0.74 nmol and not 3.45 nmol.

In the July, 1989 issue, a Laboratory Investigation (Lanier WL, Iaizzo PA, Milde JH: Cerebral function and muscle afferent activity following intravenous succinylcholine in dogs anesthetized with halothane: The effects of pretreatment with a defasciculating dose of pancuronium. ANESTHESIOLOGY 71:87–95, 1989) contains the following errors.

On page 88, in the legend for figure 1, the second sentence should read: The raw MAA data in this group II dog consisted of a biphasic signal of approximately 16–24 \(\mu\)V amplitude superimposed upon a constant background noise signal of approximately 7 \(\mu\)V amplitude.

On page 90, table 2, under Treatment Groups, Group II, the dose for pancuronium is 0.01 mg/kg pretreatment.

On page 93, column 2, line 24 of the second paragraph should read: The ability of "defasciculating" doses of metocurine to prevent SCh-induced increases in ICP in lightly anesthetized patients . . . etc.

On page 94, in the legend for figure 6, the second to the last sentence should read: We believe these changes are due to cerebral stimulation from MAA increases accompanying endogenous muscle activation.