All Over The Place: Pain in ICD-11.

If it cant be coded, it doesn't exist? right ?

真的吗??

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What are the issues?

- Chronic pain constitutes an immense, invisible crisis at the centre of contemporary life. Morris 1993
- A systematic review and meta-analysis found that:
- Between 1/3rd -1/2 of the UK population are affected by chronic pain.
- The UK prevalence ranged from:
  - 35–50% for chronic pain.
  - 10-15% for moderate to severely disabling pain
  - Over 75 years the prevalence for chronic pain was 62%.
  - Over many decades the figures have not radically changed

Fayaz, 2016 Van der Linden et al 2022.

Challenge

- If we want to ensure that limited healthcare resources are appropriately distributed … we must have a reasonably clear idea
  - what is a disease? *The significance of symptoms*
  - which diseases are most worth the investment of time and money
- Pain perception can be a protective to the environment and constitutional and   and yet can also become disease and disabling

Challenge

- *How do we distinguish properly between real(?) diseases, and human behaviours or characteristics that we (or the person in question) just happen to find disturbing?*

Scully 2004

History of pain as a symptom and a disease

- Tension between the standard definition of a dis-ease (top down) and the pathophysiological approach) and pragmatic clinical view (bottom up).
  - Bottom up: Bonica in 1948 founded the first pain clinic Washington. USA Dame Cicely Saunders , founder of the first hospice in Sydenham UK 1967. 'The Group' in 1967, Intractable Pain Society in 1969-71 (from 1973 the British chapter of the IASP) The Pain Society 1987. The multidisciplinary BPS 2004. These pioneering clinicians wanted to combat under-treatment of pain with more sophisticated techniques of nerve blocks, new generations of analgesic drugs and new forms of behavioural and psychotherapy. Montreal 2010. Pain relief as a human right.
  - Top down: Gate control theory Melzack and Wall 1965 , Neuromatrix of pain Melzack 1995.
    - 1973: 'Invention of pain medicine' IASP Bonica 1973

Baszanger (1998)

History

- The IASP-definition of pain (1976–1979)
  - The founders realised that achieving the goals of more scientific research on and better treatment of pain stood or fell by an adequate definition and classification of pain. Harold Mersky UK Psychiatrist.
  - Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage' (Merskey et al., 1979).
  - Murat Ayede, (a strong supporter) stressed that 'we should not confuse scientific theory construction and its application in clinical settings and with the task of providing a taxonomic definition'

Classification of chronic pain

- In the IASP-classification of 1986, the definitions and descriptions of ‘chronic pain diagnoses’ were clinically descriptive, not etiological. This was in line with the IASP's pragmatic approach from the outset and aimed at combating under-treatment and reducing unnecessary suffering for patients.

Classification of chronic pain by the Subcommittee on Taxonomy (1986)

Relatively generalized syndromes

- Peripheral neuropathy or radiculopathy
- Causalgia and reflex dystrophies
- Central pain
- Stump pain
- Phantom pain
- Pain purely of psychological origin.

Relatively localized syndromes

- Relatively localized syndromes of the head and neck
- Spinal pain (divided into three sections)
- Local syndromes of the upper limbs and relatively generalized syndromes of the upper and lower limbs
- Visceral and other syndromes of the trunk apart from spinal and radicular pain
- Local syndromes of the lower limbs.

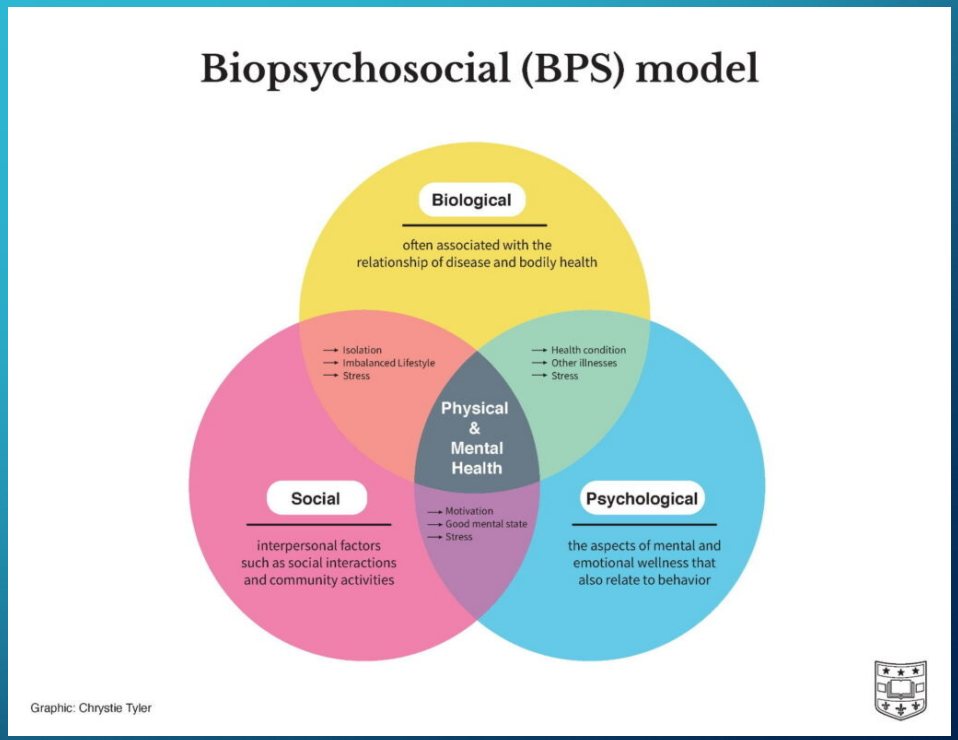
Fig. 1. Classification of chronic pain by the Subcommittee on Taxonomy (1986).

The scientific (reductionist) model in understanding and treating chronic pain

- From the scientists within the IASP in the 1990s new insights emerged
  - Cognitive biasing (1970). Central (de)sensitization (Woolf, 1983) and the Neuromatrix Theory of Pain (Melzack, 1990, 2001), gave rise to new ideas and higher expectations.
  - The theory of chronic pain was constituted by an autonomous, and distinct mechanism. A top down approach.
  - Hope that pain medicine would move beyond trial-and-error to more targeted therapies based on actual mechanisms involved in the pathogenesis of pain to benefit the effectiveness of pain treatments (Woolf 2017).
  - Evidence based medicine movement (MacMaster University David Sackett 1970-1980, Oxford 1995) and the obvious lack of proven effectiveness of pain treatments and therapies in general pain populations has been an increasing concern in the world of pain medicine since the 1990s.
  - Along side this : Biopsychosocial approach (Engel 1977)

The Biopsychosocial model in understanding and treating chronic pain

- An alternative to the biomedical model, suggesting that health and illness result from the interaction of biological, psychological, and social factors.
- Engel (1977) argued that the purely biomedical approach was too limited and failed to account for the person's experience of illness, their psychological state, and broader societal influences like family, work, and culture.
- A framework for understanding health and disease by acknowledging the complex interplay of these three components.
- In practise this means
- pathophysiology ≠ dis-ease



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Pleas for recognition: criticism of the ICD-10 (2000s)

- European chapters of the IASP began to advocate for the recognition of chronic pain as a 'disease in its own right'
- The IASP view was that the ICD-10 (introduced 1990 -1993) didn't help because it lacked a systematic categorization of chronic pain (Rief et al 2010)
- Instead, pain conditions were placed in different categories based on where and how pain symptoms manifested themselves.
  - Local bodily sites v General bodily conditions
  - Fibromyalgia was in unspecified soft tissue disorders, not elsewhere classified' (M79) within the category 'diseases of the musculoskeletal system and connective tissue'
  - Additionally, chronic pain was also be classified as a symptom, 'pain, unspecified' (R52),
  - Chronic pain could also be classified as 'pain disorder related to psychological factors' (F45.4) within somatoform disorders.

Pleas for recognition: criticism of the ICD-10 (2000s)

- The code G89.4 refers to the ICD-10-CM code for Chronic Pain Syndrome,
  - which signifies persistent pain accompanied by substantial psychological and behavioural issues, like depression, anxiety, fatigue, and sleep problems.This is distinct from chronic pain without these associated dysfunctions, for which other codes, like those under the G89.2 category, would be used.
- What G89.4 Represents
  - **Chronic Pain:** The pain has persisted beyond the normal healing time.
  - **Significant Psychosocial Dysfunction:** This pain is linked to significant psychological changes, emotional distress, and social problems.
- Common Symptoms of Chronic Pain Syndrome
  - **Persistent Pain:** May be burning, aching, or sharp.
  - **Emotional Effects:** Including anxiety, depression, and irritability.
  - **Sleep Disturbances:** Due to the pain.
  - **Fatigue:** Exacerbated by poor sleep quality.
  - **Reduced Daily Activities:** Decreased participation in daily activities.
  - Guilt, loss of interest in sex, drug or alcohol abuse, and family problems.
- **Impact on Function:** It indicates that the pain is impacting a person's life significantly.

Pleas for better recognition: criticism of the ICD-10 (2000s)

- Related and similar ICD-10 codes
- G89.0: Central pain syndrome
- G89.1: Acute pain, not elsewhere classified
- G89.2: Chronic pain, not elsewhere classified
- G89.3: Neoplasm related pain (acute) (chronic)

- This was not a pathophysiological classification but an anatomic and or symptom constellation based classification

Criticism of the ICD-10 (2000s)

- The IASP concluded ‘fragmentation’ of chronic pain conditions across different categories
  - hindered the progress, and funding of pain medicine.
  - made chronic pain underappreciated as a medical, health care and research priority.
  - The lack of adequate coding in the ICD 10 makes obtaining accurate epidemiological data related to chronic pain difficult, prevents adequate billing of healthcare costs related to pain management, and hinders the development and implementation of new therapies

The development of ICD-11

- In 2012, the IASP convinced the WHO that chronic pain should be included in the ICD-11 as a separate category.
- However, in the ICD-11, ‘chronic primary pain’ and ‘chronic secondary pain’, are different from the 1986 distinction between general and localized syndromes.

Pain in ICD-11 (2022)

- CHRONIC PRIMARY PAIN a pain in one or more anatomical regions that persists or recurs for longer than 3 months and is associated with significant emotional distress or functional disability (interference with activities of daily life and participation in social roles) and that cannot be better accounted for by another chronic pain condition' (Treede et al., 2019).

- CHRONIC SECONDARY PAIN:, pain initially manifests itself as a symptom of another disease, e.g breast cancer, a work accident, diabetic neuropathy, chronic caries, inflammatory bowel disease, or rheumatoid arthritis' (Treede et al., 2019

The development of ICD-11

- The IASP Task Force made it very clear that their classification was pragmatic in its purposes:
- The category of chronic primary pain was to recognise chronic pain as a disease
- The category of chronic secondary served to make visible chronic pain as a public health priority.
- The Task Force explicitly stated that the most important thing was that 'all patients with chronic pain came into the picture' as pain patients and received adequate treatment for their pain complaints.

Classification of chronic pain in ICD-11

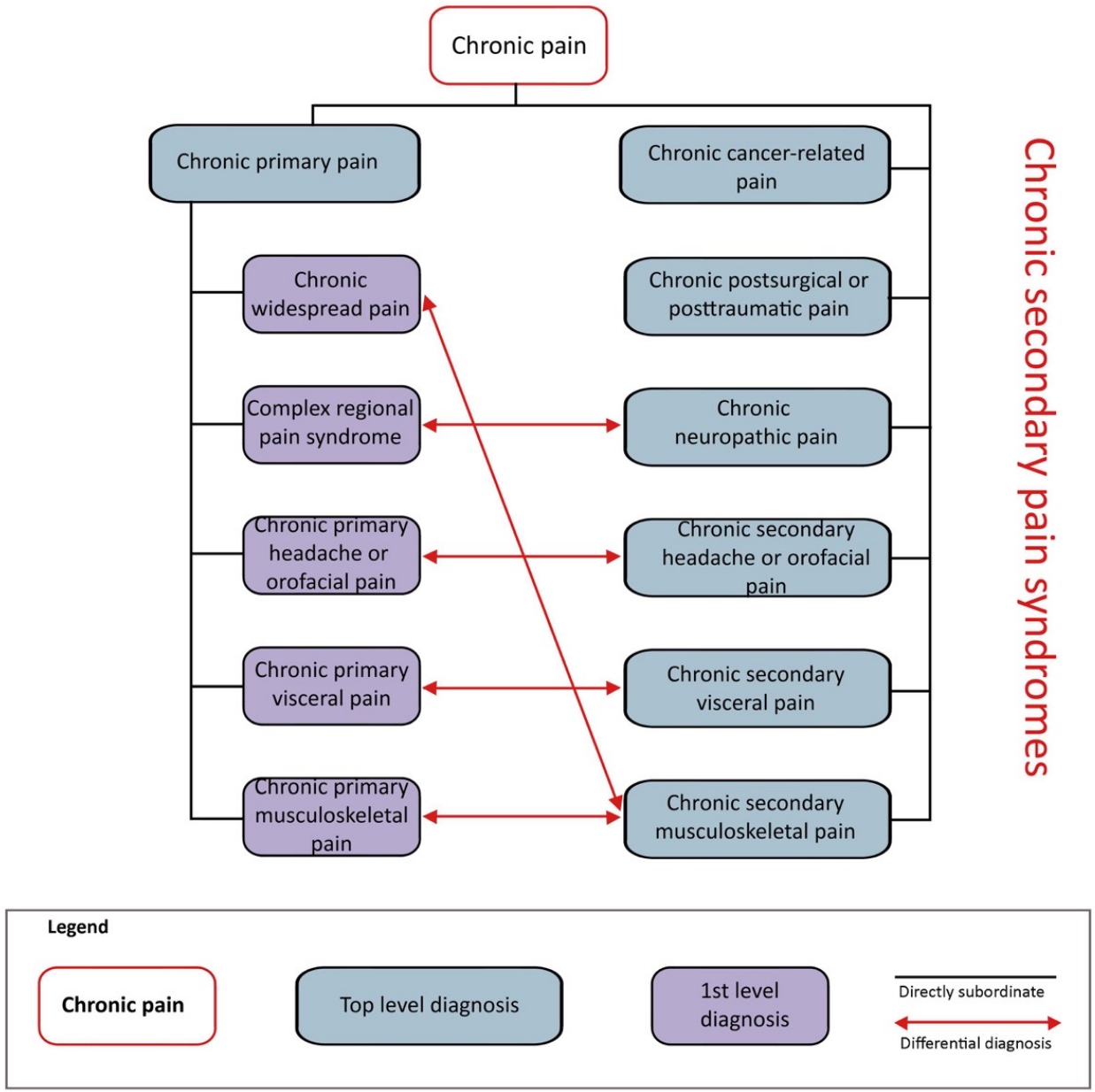
Chronic primary pain

- Chronic widespread pain
- Complex regional pain syndrome
- Chronic primary headache or orofacial pain
- Chronic primary visceral pain
- Chronic primary musculoskeletal pain

Chronic secondary pain syndromes

- Chronic cancer-related pain
- Chronic postsurgical or posttraumatic pain
- Chronic neuropathic pain
- Chronic secondary headache or orofacial pain
- Chronic secondary visceral pain
- Chronic secondary musculoskeletal pain

Fig. 2. Classification of chronic pain in ICD-11.



- Pain in ICD-11
- *A categorical rather than a mechanistic approach .*
- *And so in CPP a seemingly diverse range of pain conditions are lumped together with different probable pathophysiologies , treatment and prognosis.*

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MG30.0 Chronic primary Pain

MG30.1 Chronic cancer related pain

MG30.2 Chronic postsurgical or post traumatic pain

MG30.3 Chronic secondary musculoskeletal pain

MG30.3 Chronic secondary visceral pain

MG30.5 Chronic neuropathic pain

MG30.6 Chronic secondary headache or orofacial pain

- Pain in ICD-11
- *A categorical rather than a mechanistic approach .*
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Figure 1

Multiple parenting that is the pain process or entity –'the child' in a patient can simultaneously belong multiple parent categories. From Treede (2019). Redrawn

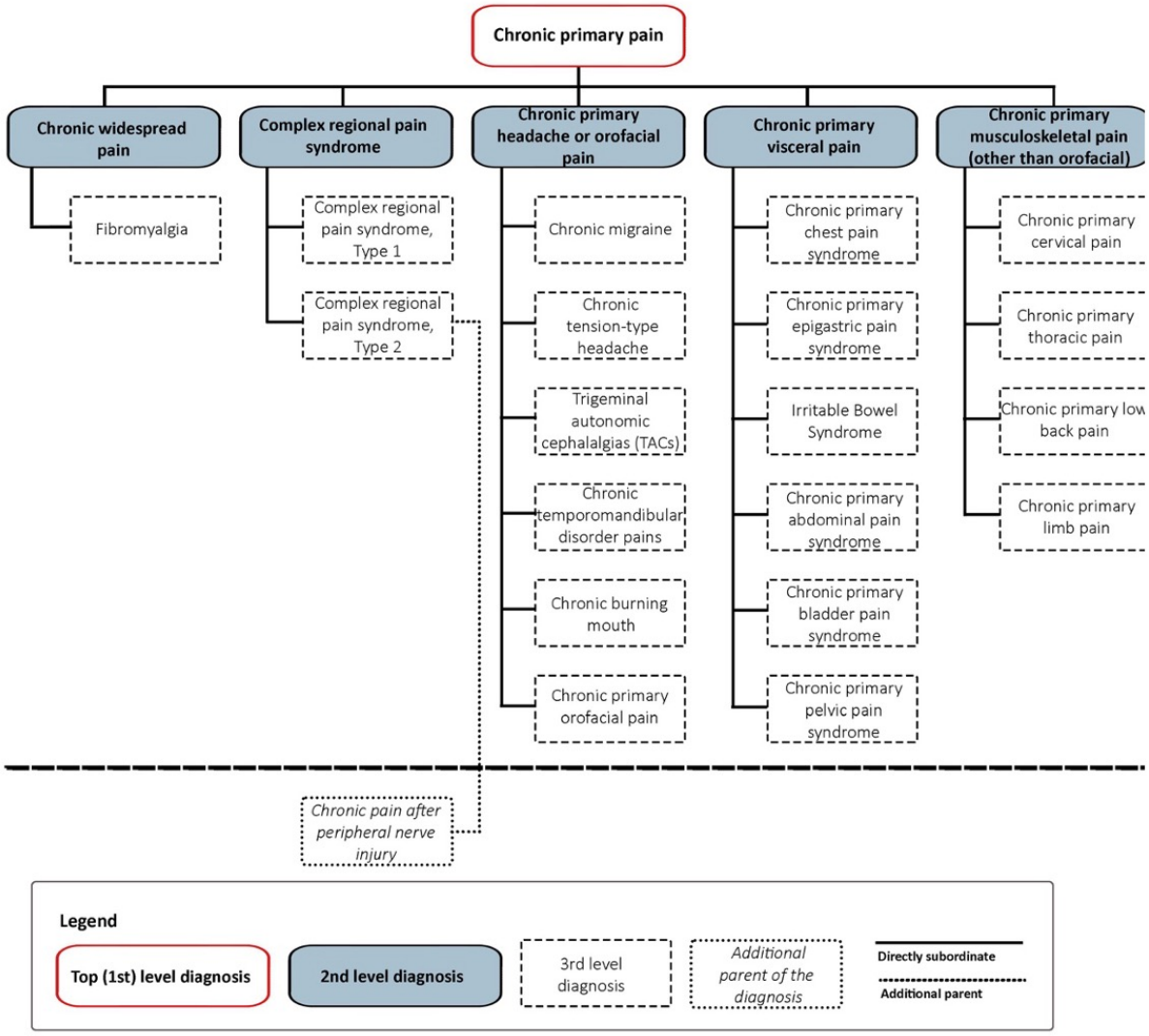

Figure 1. The general structure of the classification of chronic primary pain. Level 1 and 2 are part of the 2018 frozen version of *ICD-11*: level 3 has been entered into the foundation layer. According to the new concept of multiple parenting in *ICD-11*, an entity may belong to more than once group of diagnoses.

- Pain in ICD-11
- *A categorical rather than a mechanistic approach .*
- *And so in CPP a seemingly diverse range of pain conditions are lumped together with different probable pathophysiologies , treatment and prognosis.*

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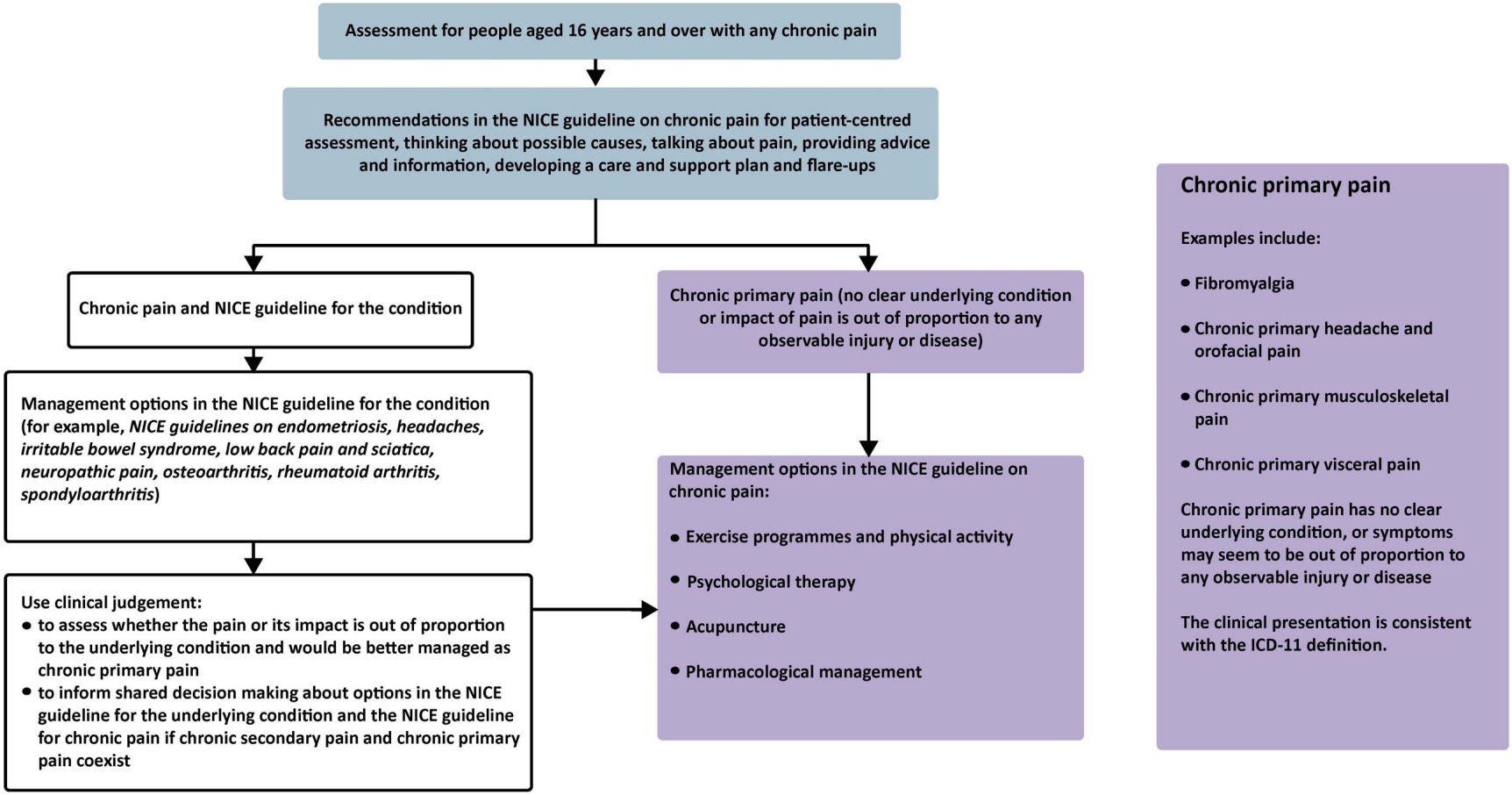
Chronic pain (primary and secondary) - using NICE guidelines for assessment and management



Chronic pain persists for more than 3 months. Chronic pain has no clear underlying condition or is out of proportion to any observable injury or disease.
Chronic secondary pain is a symptom of an underlying condition. Chronic secondary pain and chronic primary pain can coexist.

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Chronic Primary Pain: *so is it all just descriptive* ?

- Nociplastic pain refers to a physiologically based category that is particularly applicable to chronic primary pain conditions outlined in the new International Classification of Diseases 11th edition, published by WHO.

Chronic Pain 2

Nociplastic pain: towards an understanding of prevalent pain conditions

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See **Comment** page 2029

This is the second in a **Series** of three papers about chronic pain

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Nociplastic pain is the semantic term suggested by the international community of pain researchers to describe a third category of pain that is mechanistically distinct from nociceptive pain, which is caused by ongoing inflammation and damage of tissues, and neuropathic pain, which is caused by nerve damage. The mechanisms that underlie this type of pain are not entirely understood, but it is thought that augmented CNS pain and sensory processing and altered pain modulation play prominent roles. The symptoms observed in nociplastic pain include multifocal pain that is more widespread or intense, or both, than would be expected given the amount of identifiable tissue or nerve damage, as well as other CNS-derived symptoms, such as fatigue, sleep, memory, and mood problems. This type of pain can occur in isolation, as often occurs in conditions such as fibromyalgia or tension-type headache, or as part of a mixed-pain state in combination with ongoing nociceptive or neuropathic pain, as might occur in chronic low back pain. It is important to recognise this type of pain, since it will respond to different therapies than nociceptive pain, with a decreased responsiveness to peripherally directed therapies such as anti-inflammatory drugs and opioids, surgery, or injections.

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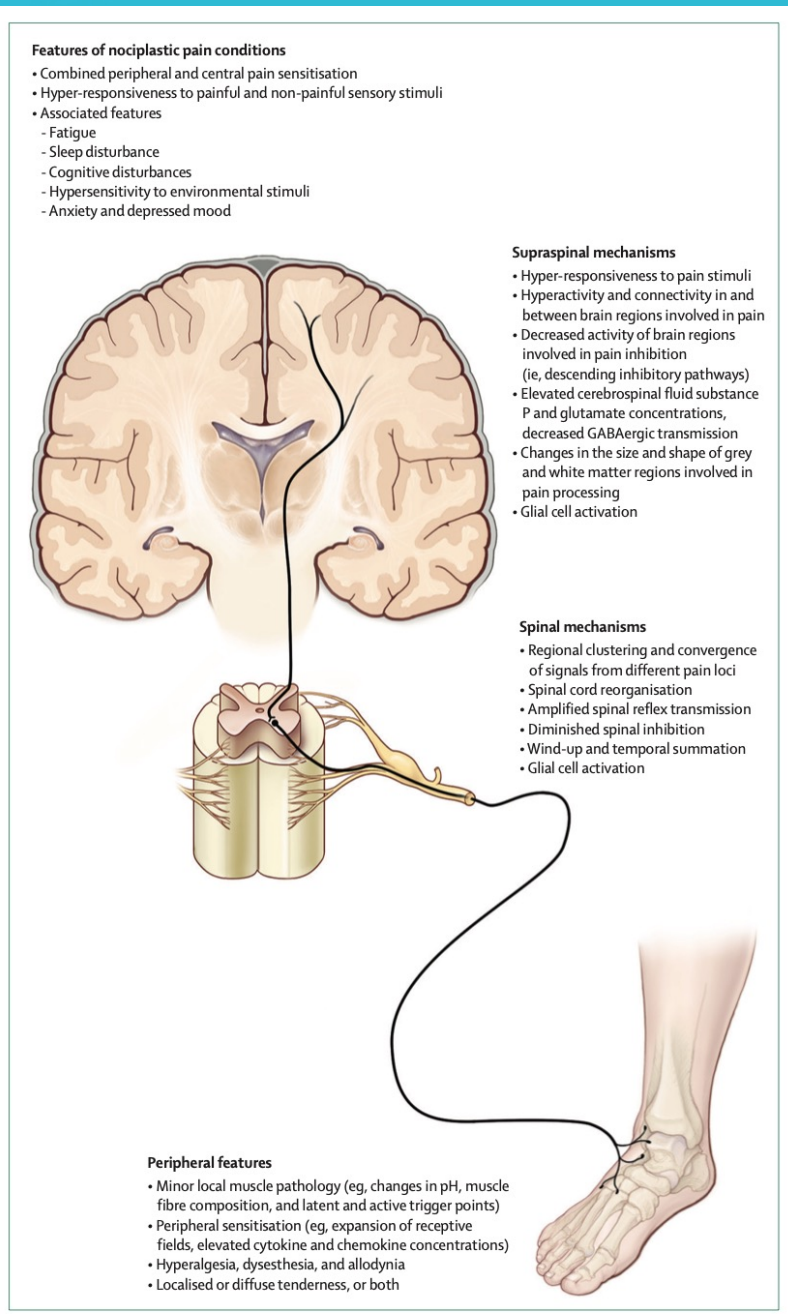

Figure: **Mechanisms and features of nociplastic pain**
Figure created by Joe Kanasz.

	Diagnostic criteria and source	Associated characteristics in history and examination	Epidemiological prevalence and sex ratio (female:male)
Chronic widespread pain	2016 criteria[40] and IASP;[5] musculoskeletal pain in four or five body regions, and in at least three or more body quadrants (upper-lower or left-right side of the body and axial skeleton, including the neck, back, chest, and abdomen)	Somatic diseases, mental health disorders and low socioeconomic status	8–11%; 2:1
Fibromyalgia	ACR[40] and AAPT;[41] chronic widespread pain and associated sleep disturbance, fatigue, and other cognitive and somatic symptoms	Fatigue, sleep disturbance, cognitive symptoms, environmental hypersensitivity, mood disorder, and post-traumatic stress; often associated with concomitant rheumatic disease; diffuse musculoskeletal tenderness	2–4%; 2:1 (in the general population)
Chronic low back pain of unknown causes (non-specific low back pain)[43]	IASP;[5] pain that is present for at least 3 months, with associated emotional distress and interference in daily activities; previously named non-specific low back pain	85% of chronic back pain is non-specific, with no clear pathoanatomic explanation; absence of red flags that suggest cancer, spinal inflammation or infection, cauda equina syndrome, major nerve root compression, vertebral fracture or abdominal aortic aneurysm[44]	Up to 10%; sex ratio influenced by country, socioeconomic status, and work activity
Chronic temporomandibular pain (TMJ) disorders	AAPT;[45] chronic orofacial pain for at least 2 h per day on at least 50% of days for at least 3 months; there are two distinct phenotypes: (1) myogenous, which includes pain in masticatory muscles; and (2) arthrogenous, which includes pain in the TMJ or associated tissues; patients might have mixed phenotypes	Stiffness, cramping, pressure, soreness, or aching, or a combination, in TMJ region; fatigue and incoordination associated with jaw movement; pain on palpation of temporalis or masseter muscle, or lateral pole of TMJ	10–15%, (only 5% seek treatment); 2:1
Irritable bowel syndrome	Rome IV criteria;[47] symptom onset at least 6 months before diagnosis; pain on at least 1 day per week in the last 3 months associated with two or more of the following: (1) related to defecation; (2) change in stool frequency; (3) change in stool appearance; variations include irritable bowel syndrome with predominant constipation; with predominant diarrhoea; or with mixed bowel habits	Onset may be after gastrointestinal infection or antibiotic treatment, or both	5–10%; 2:1

Nociplastic pain and CPP

Nociplastic Pain and Chronic Primary Pain

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Chronic primary pain category in ICD-11 is based on the physiological mechanism of nociplastic pain first proposed in 2016. The nociplastic mechanism may be responsible for a number of pain conditions. Nociplastic pain may provide an explanation for pain complaints previously described as dysfunctional pain or medically unexplained somatic syndromes. About 5-15% of the population are thought to suffer from pain which likely to involve nociplastic mechanisms. As a reference point, 20% of the population suffer from chronic pain.

Nociplastic pain and CPP

Prevalence of Nociplastic pain conditions

Table 1: Prevalence of conditions associated with nociplastic pain

Name	**Population Prevalence**	**F:M ratio**
CWP	10%	2:1
FMS	5%	2:1
Chronic LBP	40% (85% of which thought to be nociplastically driven)	
Chronic TMJ disorder	10%	
Irritable Bowel Syndrome	5-10%	2:1
Irritable Bladder Syndrome	3-6%	10:1
Chronic pelvic pain (M)	2-16%	
Chronic pelvic pain (F)	15% (60%-80% of which thought to be nociplastically driven)	

Clinicians and ICD-11

- What to ask your self?
- Chronic primary pain
  - What do you mean by that?
  - Implications for Diagnosis Treatment Prognosis
  - Co-existent chronic secondary pain more likely than not.
  - Is this just a subjective label (diagnosis) with no meaning?
  - Mechanistic clinical overlap with other nociplastic symptomology FND.

Plus ça change, plus c'est la même chose

- *The more things change, the more they stay the same.*

Jean-Baptiste Alphonse Karr

- Despite new developments or definitions , underlying issues or patterns remain constant.

- Pain medicine the tension between the natural desire to describe pain in terms of
  - a scientific pathophysiology
  - a constellation of clinically (and widely accepted) symptoms and disability

remain the same. Have we progressed?

- For lawyers and doctors: we can use the new classification but the underlying issue still need to define impact of the symptom complex, treatment and prognosis in an individual remain the same.
- For lawyers – causation .