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PRACTICE POINTER

Chronic pain: definitions and diagnosis

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What you need to know

- Acknowledging chronic pain as a diagnosis in its own right can help clinicians and patients move on from a mindset of searching for a diagnosis to discussing long term management strategies
- Consider non-pain features such as poor sleep, low mood, and reduced physical activity: these can be both a cause and a consequence of chronic primary pain
- Consultations where patients feel believed, listened to, and validated can enable a therapeutic relationship that forms the basis for subsequent management strategies, including supported self-management.

Pain related diseases are the leading cause of disability and disease burden worldwide.[1 2] Chronic pain affects between a third and half of the population globally,[3 -5] and high impact chronic pain—defined as pain experienced on most days or every day in the previous three months that causes restriction in at least one activity—has been found to affect 4.8% of the US adult population.[6] Furthermore, chronic pain is a common reason for accessing healthcare, with 22-50% of GP consultations being related to pain.[7] Patients often report a delay in diagnosis,[8] with a longer and more difficult journey to diagnosis being associated with reduced satisfaction with subsequent treatment.[9]

A lack of diagnostic biomarkers and universally effective treatment options for chronic pain often result in frustration for both patients and clinicians.[7 10] Consultations can sometimes focus on how to treat pain, without first naming the diagnosis of chronic pain. Creating space in the consultation for this can help patients to feel heard, reduce frustration, and refocus on supported self-management strategies rather than the clinician striving to fix the problem. This article offers an approach to identifying and discussing chronic pain with patients, drawing on formal guidance from the UK,[11 -14] patient voices, and our clinical experience.

What is chronic pain?

According to the International Association for the Study of Pain (IASP), chronic pain is defined as "pain that persists or recurs for longer than three months."[7 10 15] This distinguishes chronic pain (as that persisting beyond normal tissue healing time) from physiological, acute pain.[16] As this timeframe can be difficult to quantify, and a clear trigger or injury is absent in many cases, a somewhat arbitrary cut-off period of three to six months was originally adopted by IASP in 1994.[18] The most recent definition supported by IASP uses a cut-off time of more than three months [10 17], which has been incorporated into the classification system implemented in 2019 in ICD-11. This approach, which subdivides chronic pain into chronic primary pain and chronic secondary pain syndromes, has been developed to improve the ease and accuracy of data recording.[7 10] According to ICD-11, chronic primary pain conditions include a collection of syndromes such as fibromyalgia and chronic migraine, which are considered health conditions in their own right. In contrast, the pain in chronic secondary pain conditions initially manifests as the result of another condition—eg, rheumatoid arthritis or inflammatory bowel disease—but diagnosing chronic secondary pain marks the stage when the pain requires treatment in its own right. Although it can be challenging to disentangle chronic primary pain from chronic secondary pain (and they can coexist), this general shift towards acknowledging chronic pain in its own right can help clinicians and patients move on from a mindset of searching for a diagnosis to discussing long term management strategies.[19] Here, we will focus on chronic primary pain (particularly chronic widespread and musculoskeletal pain), although many of the concepts may also apply to chronic secondary pain and much of the literature to date does not yet distinguish between these two subcategories of chronic pain.

When to suspect chronic primary pain

Based on the literature and guidance from the UK in managing musculoskeletal pain, box 1 describes factors that may help alert the clinician to an underlying chronic primary pain condition.[11 20 21] The distribution of pain can help to distinguish chronic primary pain from other causes. Although patients often focus on the most prominent local or regional areas of pain at any one time, it is important to screen for pain elsewhere in the body, as widespread pain is a feature suggestive of chronic primary pain.[11 20 21]

Box 1: Factors suggestive of chronic primary pain[11 20 21]

- Pain related factors
  - Widespread pain (although only regional pain may be reported)
  - Pain longevity
  - Ineffective treatments so far
  - Already diagnosed with a chronic primary pain condition
- Non-pain related factors
  - Poor refreshment from sleep
  - Hypersensitivity to visual, auditory, and tactile stimuli

- Intrusive fatigue
- Poor concentration and poor short term memory

- Medical history
  - Numerous comorbid illnesses and allergies
- Consultation related factors
  - Feeling of being overwhelmed (patient, clinician, or both)

Several non-pain features—such as poor sleep, mood disturbance, low levels of physical activity, memory disturbance, and fatigue—can often occur as a consequence of living with chronic pain.[2 11 12 14 20 21] A bidirectional relation can be seen between poor sleep and chronic pain, whereby sleep disturbance causes chronic pain and poor sleep increases the intensity and duration of chronic pain.[22-24] Depression, anxiety, and negative beliefs about pain are also related to developing chronic pain, as well as worse outcomes from chronic pain.[25 26] Many people also experience an erosion of identity and experience problems in maintaining work, relationships, and social activities.[27 28] Ask about these aspects to understand the burden of symptoms as well as to identify potential areas to focus on when making shared decisions about management.

Co-existing hypersensitivity to non-pain stimuli, such as sound, light, temperature change, or touch are also suggestive of chronic primary pain rather than a local or regional structural abnormality.[11 20 21] In our experience, patients can feel validated when clinicians are able to group and offer a single diagnostic label for a vast range of debilitating and seemingly unrelated sensations.

The presence of a several comorbid illnesses or allergies may also be suggestive of a chronic primary pain condition.[21] Furthermore, an existing diagnosis of one chronic primary condition may also suggest an increased chance of developing another.[21]

What is the role of investigations in chronic primary pain?

In practice, investigations to identify or exclude potential coexisting conditions may be required, depending on clinical suspicion. The combination and timing of tests required will be patient specific and may evolve over time. However, clear communication of test results is important to consider in all cases, particularly when a patient receives normal results from an investigation.[12] Doctors may feel reassured because normal results mean the patient has no underlying pathology; however, patients can feel frustrated and dismissed as the normal result doesn't match their experience of pain. Box 2 gives some practical steps, drawn from our experience, to help minimise this risk.

Box 2: Practical tips for discussing the diagnosis of chronic primary pain

What is the cause of my pain?

Explain that, while our usual understanding of pain is as a response to the damage of tissues, it can be more helpful to think of pain as an early warning alert system. It makes us aware of potential danger, but doesn't necessarily wait for tissue injury to occur.

In chronic primary pain, the tissues may be normal but the pain processes are not working properly. For this reason, investigations may be normal but this doesn't mean there is not a problem.

An example, such as phantom limb pain in a patient who has had an amputation, may be helpful.

What is the best way to discuss chronic primary pain with patients?

Patients often report having to defend their experience of severe pain, and cite active listening by clinicians as a key success factor in building a good patient-clinician partnership.[8 27 29 30] Effective communication strategies help people with chronic primary pain feel listened to, validated, supported, and empowered as they develop strategies to help to improve their quality of life, often despite the ongoing pain. Feeling believed, being listened to, and the validation of a person's experience are key features of effective communication. This is highlighted by the National Institute for Health and Care Excellence (NICE) guidelines on chronic pain, which recommend fostering a collaborative and supportive relationship with the person with chronic pain.[12] The combination of multiple symptoms and a limited consultation time can be challenging for both clinicians and patients.[9] Over time, longer consultations and follow-up with the same clinician may help overcome these problems, to enable an improved therapeutic relationship.

People living with chronic pain value a specific diagnosis alongside an explanation of the cause of the pain.[12] The latter can cause clinicians to feel undue pressure, as much remains unknown about the mechanisms and specific causes. However, patients tend to be understanding about the difficulty in treating chronic pain and the lack of certainty involved.[12] Box 3 gives some suggested concepts, drawn from our experience, to consider when discussing the diagnosis of chronic primary pain.

Box 3: Considerations for shared decision making discussions about chronic primary pain

- Validate the patient's pain. Stress that normal results of investigations do not mean there is not a problem.
- Reinforce a positive diagnosis of chronic primary pain and discuss management strategies.
- Discuss how pain is a complex sensation and many factors can affect the sensitivity of the early warning alert system. Several parts of the brain, including those involved in learning, memory, mood, sleep, context, movement, and sensation, work together to try to accurately predict danger signals, and this is why other factors, such as stress, can trigger worsening of symptoms.
- Explain that no medication or procedure is likely to resolve the problem.
- Although the mechanisms are not fully understood and pain cannot always be explained, learning more about the pain can be helpful for some patients.

Prospective population cohort studies conducted in the UK,[31] US,[32] Norway,[33] and the Netherlands[34] suggest chronic pain tends to persist or fluctuate, rather than resolve. Explaining the difference in the prognosis of chronic pain (compared with acute pain) helps to ensure that patients have realistic expectations about future pain levels. In our experience, it can also be helpful to highlight that experiencing a better quality of life does not always depend on pain levels reducing in severity and that it often requires the use of strategies to improve wellbeing, despite the pain.

Education into practice

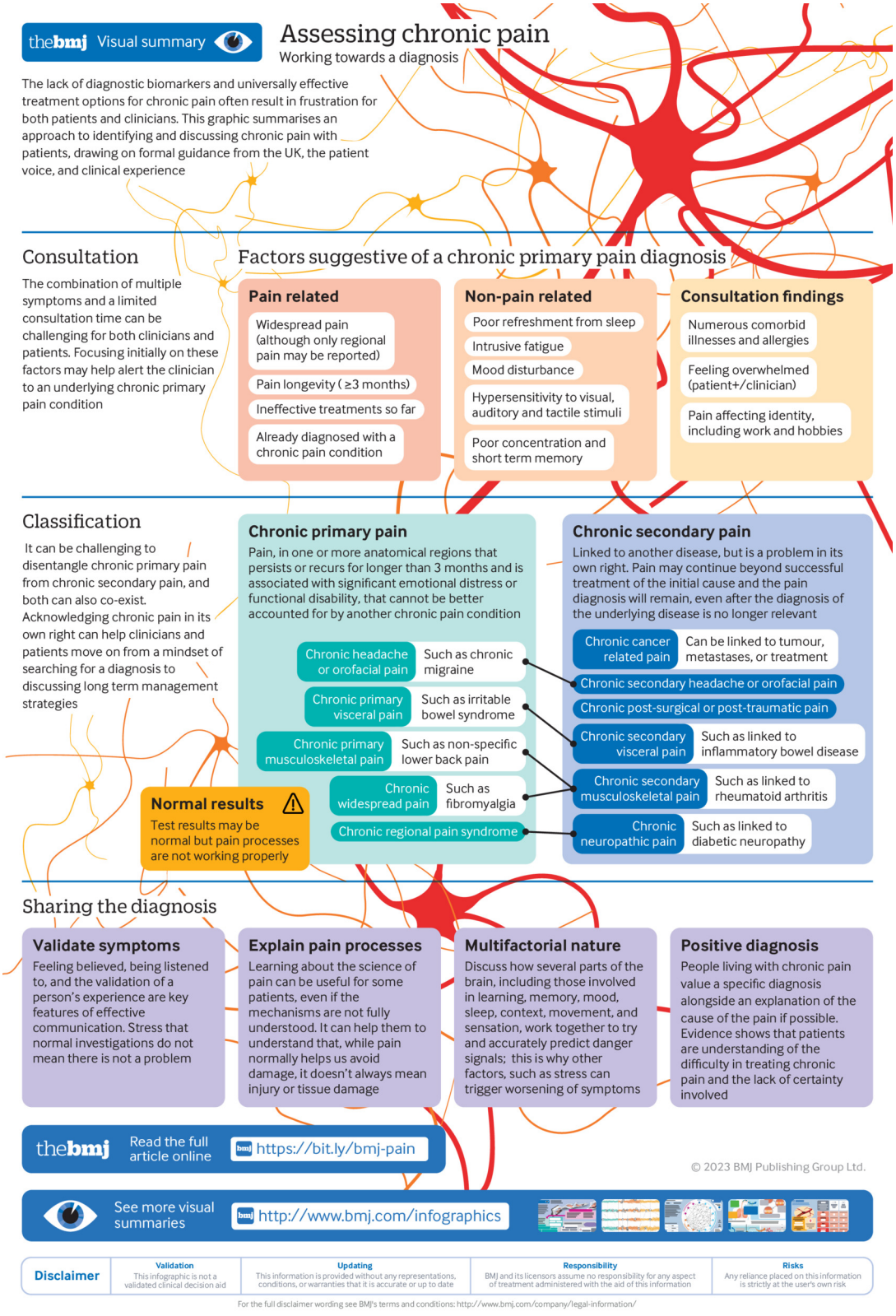
- How often do you assess non-pain symptoms in patients presenting with chronic pain?
- How do you explain chronic primary pain to patients?

How patients were involved in the creation of this article

Louise Trewern (chronic pain patient advocate, immediate past vice-chair of the British Pain Society Patient Voice Group, executive committee of the Physiotherapy Pain Association, chair of Get-Involved—Evolving Through Patient Experience Committee at Torbay Hospital Pain Service, lead lived experience trainer, Live Well With Pain Team) is a co-author of this article and provided key input from a patient perspective. Expert patient representatives from the Patient Voice and the Footsteps Festival Expert Patient Team provided feedback on the article content overall and provided specific advice regarding the role of communication skills.

How this article was created

A literature search was conducted across Ovid Medline, PubMed, Cochrane Collaboration, and NICE for chronic pain clinical guidelines and systematic reviews. The most recent guidelines and systematic reviews were selected to draft the initial outline, collating the most recent evidence. Finally, the clinical experience of senior authors was added alongside patient perspectives.



Contributorship and the guarantor: YK, JJ, LT, DM, and AS conceived the article and are guarantors. All authors wrote and reviewed the article, created the boxes, and helped with the figures. LT was the contact for patient involvement.

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