IASP and the Classification of Pain in ICD-11

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Disclosure Statement of conflict of interest in the context of the subject of this presentation

Within the past 12 months, I or my spouse/partner have had following financial interest/arrangement(s) or affiliation(s)

Affiliation/Financial Relationship	Company
Support for travel	Grunenthal
Honoraria for lectures	Berlin Chemie
Honoraria for advisory board activities	Astra Zeneca, Heel
Participation in clinical trials	Astra Zeneca, Heel
Research funding	………………….
Financial shares and options	………………….
……………………………..	………………….

Socioeconomic Relevance:
Some Aspects

❯ Pain is the major reason for health care use

❯ Back pain is the most expensive condition in Western cultures

❯ Pain as a disorder of its own: Major reason for worker's compensation and premature retirement

❯ Pain as a comorbid condition in cancer, diabetes, a.o. medical conditions: turns long-term course into a costly condition for the society and determines quality of life for affected patient

Providing adequate management for pain patients:

Major problems

›Pain is under-diagnosed all over the world

›Several pain diagnoses are not feasible in medical care, especially for GPs and other specialists

›Pain management is not satisfactory in most countries

›Financial coverage of pain management is unsatisfactory in many countries

›More efforts for pain research are needed

-> all these aspects depend on a proper classification of pain in medical classification systems

The different facets of pain

> **Pain as a warning symptom**

While treatment of the underlying medical condition is usually the primary focus, special pain treatment can be additionally warranted (to reduce stress, to prevent learning and memory mechanisms that can result in symptom persistence/chronification of pain, a.o.)

> **Pain as a disease of its own** or a unique disease as a comorbidity of other medical conditions

This is especially true for chronic pain conditions, where pain has no warning function. In these cases, special pain treatment is always warranted.

> **Pain can be both a warning signal and a disease of its own**

Again, in these cases special pain treatment is always required.
Examples: Diabetic Neuropathy

Classification systems must reflect treatment needs.

# Current shortcomings of pain classification: Some examples

› Pain diagnoses are dispersed over various categories -> hard to find; no clear rationale (sometimes organ-specific, sometimes rest categories -> not feasible for other expert groups)

› Pain diagnoses are in classification categories that are not relevant for health care compensation / Diagnoses Related Groups DRG (e.g., under „General Symptoms and Signs")

› Some pain diagnoses need improved or updated classification criteria in ICD-11, and proposals are available (e.g., fibromyalgia, low back pain, IBS, headache)

› Some pain diagnoses emphasize mind-body-dualism, although biobehavioral models are more adequate (e.g., somatoform pain disorder)

Specific examples for shortcomings:
Persistent somatoform pain disorder

› The predominant complaint is of persistent, severe, and distressing pain, which cannot be explained fully by a physiological process or a physical disorder, and **which occurs in association with emotional conflict or psychosocial problems** that are sufficient to allow the conclusion that they are the **main causative influences**. The result is usually a marked increase in support and attention, either personal or medical. Pain presumed to be of psychogenic origin occurring during the course of depressive disorders or schizophrenia should not be included here.

› (WHO, ICD-10, 2010 version)

Examples of Mechanisms of Symptom Development and Maintenance
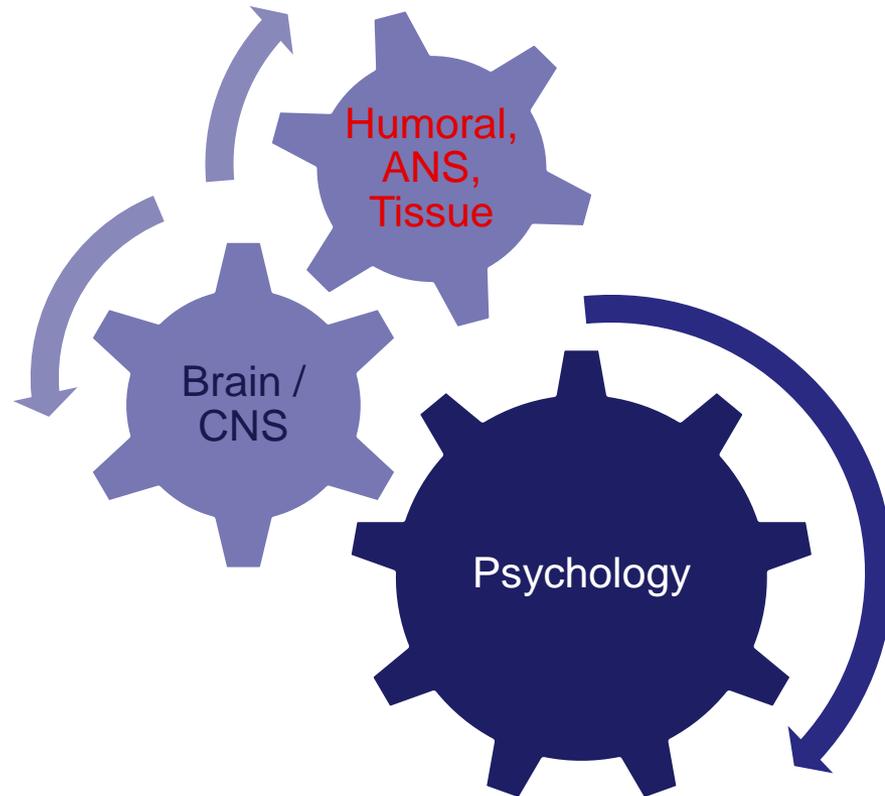
The American DSM-V approach:
Somatic Symptom Disorder

Criteria A, B, and C must all be fulfilled to make the diagnosis:

> A. **Somatic symptoms**: One or more somatic symptoms that are distressing and/or result in significant disruption in daily life.

> B. **Excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns:** At least one of the following must be present.

 (1) Disproportionae and persistent thoughts about the seriousness of one's symptoms.

 (2) Persistently high level of anxiety about health or symptoms

 (3) Excessive time and energy devoted to these symptoms or health concerns

> C. **Chronicity:** Although any one symptom may not be continuously present, the state of being symptomatic is persistent (typically >6 months).

Specifiers

Predominant Pain (previously pain disorder). This category is reserved for individuals presenting predominantly with pain complaints who also asatisfy criteria B and C of this diagnosis. Some patients with pain may better fit other psychiatric diagnoses such as adjustment disorder or psychological factors affecting a medical condition.

Further Examples for the Need for Improved Pain Classification: Cancer Pain

> After cancer treatment, pain and fatigue are the major determinants of disability, sickness leave, premature retirement etc.

> Cancer pain has a strong tendency to persist (Rief et al., 2011, Breast Cancer Res & Treatm)

> Pain diagnoses and adequate pain treatment are crucial for cancer patients to prevent disability and low role functioning.

The need to consider psychological features:

Will this patient develop persistent disabling low back pain?
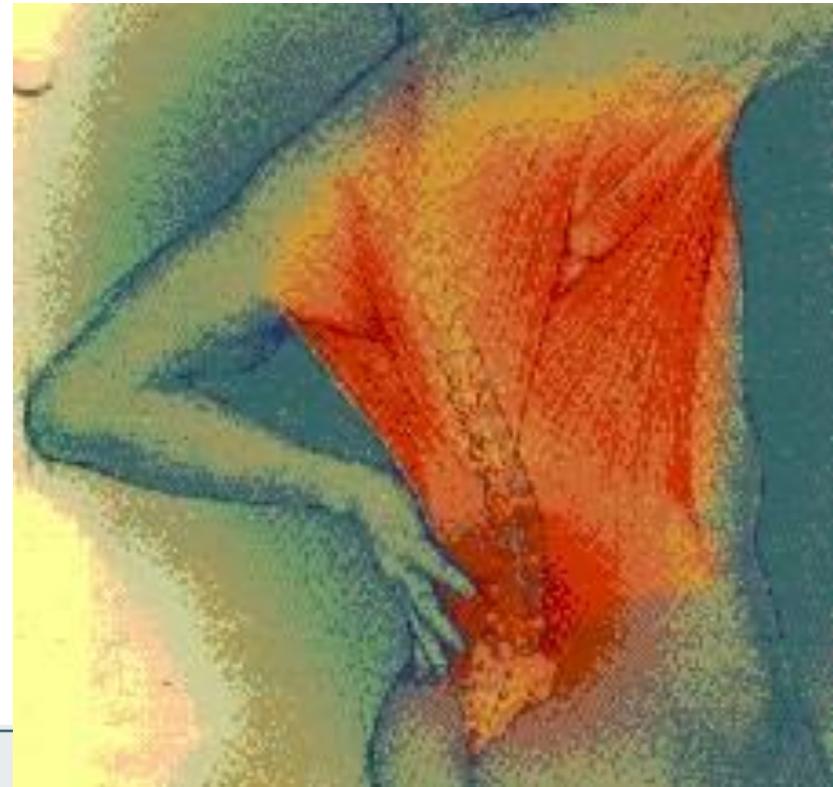**Chou & Shekelle, JAMA 2010**

> Meta-Analysis, 20 studies, 10,800 patients

What predicts recovery one year later?

> Low fear avoidance
> Low impairment at baseline

What predicts persistence?

> Non-organic signs
> Maladaptive pain coping
> High impairment
> Psychiatric comorbidity

How to revise the pain diagnoses in the ICD-11 proposal?

❯ Local improvements of criteria for pain diagnoses
(e.g., Chronic pain with psychological and somatic factors; F45.41 ICD-10 GM)

❯ Introduction of a new chapter or section on (chronic) pain

General Chronic Pain Conditions

> x1 Chronic pain with somatic and psychological factors

> x.2 Chronic pain, primarily psychological origin (former somatoform pain disorder)
> (Psychological factors that contribute to onset and/or maintenance of disorder must be identified).

> x.3 Chronic pain in the context of other medical conditions, but requiring specific medical attention
> x.31 Cancer Pain
> x.32 Neuropathic Pain

Specific Pain Conditions

> Y.1 Headache

> Y.2 Back Pain/ Dorsopathy

> Y.3 Fibromyalgia, chronic widespread pain

> Y.4 Temporomandibular pain, atypical odontalgia

> Y.5 Neck Pain, Whiplash Syndrome

> Y.6 Chronic pelvic pain

> Y.7 Chronic noncardiac chest pain

> Y.8 Chronic joint pain (not head)

> Y.9 Other Specific Chronic pain syndromes

Potential partners in a new chapter: (Other) functional somatic conditions

> V.1 Multiple Bodily Distress Disorder

> V.2 Complex Irritable Bowel Syndrome (IBS with associated psychological features)

> V.3 Chronic Fatigue Syndrome, Neurasthenia
>   V.31 Chronic Fatigue in the context of Cancer

> V.4 Environmental Sensitivity Syndromes

> V.5 Health anxiety disorder

> V.9 Other Bodily Distress Disorders

-> Overlap of symptoms, several psychological and biological mechanisms

Summary

› Adequate classification of pain is the basis for adequate treatment, integration in health care systems, and focussed research programs

› Tackling the economic consequences of pain requests adequate classification

› ICD-11 should be developed with the participation of pain experts / IASP / EFIC

› ICD-11 should consider new developments of pain research, classification (e.g., headache), and treatment

› Pain classification in ICD-11 must be also feasible for other specialists (-> pain chapter?)

Thank you for your attention...

Reference:

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