Debate & Analysis

Persistent pain:

not a medically unexplained symptom

INTRODUCTION

At the same time as the study of pain is flourishing as a basic and applied science, and attention is paid nationally to reducing the gap between provision and need (chronic/persistent pain is a Royal College of General Practitioners priority for 2011–2013),[1,2] there are moves to categorise it as a medically unexplained symptom (MUS). This is puzzling on a scientific level, and seriously retrogressive at a healthcare level.

It is nearly 50 years since Melzack and Wall published their gate control theory,[3] presenting an integrated model of physiological and psychological processing, and challenging existing dualistic interpretations of many pain phenomena:

'The contemporary custom of assigning the cause of pain either to peripheral pathology or to mental pathology is too simple because it ignores the subtle dynamic properties of peripheral tissue and of the nervous system ... which could explain many ... diseases ... which have previously been attributed to mental disorders.'[3]

On the basis of that model, understanding of the mechanisms underlying pain — some of which involve psychological and social factors — has deepened, although effective treatments have been slower to emerge.

NEUROPHYSIOLOGY EXPLAINS THE 'UNEXPLAINED'

A minority of pains continue despite attempts to treat them: chronic or persistent pain. Whatever the (presumed) origin of the pain, there is increasing recognition that specific central nervous system mechanisms account for persistence through changes in structure and function of neurons at peripheral, spinal cord, and brain levels. Peripheral and central sensitisation facilitates and amplifies pain transmission and depresses its inhibition.[4] Again, almost regardless of origin or site of pain, imaging of brain processing and behavioural studies show consistent changes,[5] leading to serious suggestions that persistent pain may be considered a disease in its own right.[5]

Despite these consistent evidence-based explanations, reports of pain which are judged not to correspond to physical signs have long been classified as a 'somatisation' phenomenon (a recent review[6] exposes the poor scientific basis of this), and more recently as medically unexplained. Pain is very heavily represented in any of the varied lists of MUS.[7]

The concept of MUS has been criticised for its dualism and the fact that the term MUS is a barrier in itself to improved care.[8] Yet, the concept of MUS has been embraced by primary care commissioners and primary care mental health services (the Improving Access to Psychological Therapies [IAPT] programme), in whose documents chronic pain is described helpfully as a long-term condition (associated with anxiety, depression and disability) and unhelpfully as a MUS, attributable to anxiety and/or depression.[9] Although much of the clinical advice is appropriate, the attribution of patients' struggle with pain to psychological disorder undermines the therapeutic relationship.[10] Misunderstandings of pain as a danger signal underlie voluntary restriction of activity and withdrawal from normal activities.[11] The practitioner's role in explaining pain and its relationship with beliefs and emotions is key to engaging the patient in rehabilitative treatment.[1]

EVIDENCE-BASED TREATMENT

The crudest model of pain as a MUS appears in a document supporting London commissioning of services:[12] any presentation where 'symptoms do not fit with findings' should be considered 'medically unexplained'. GPs are encouraged to search electronic records for frequently attending patients, and to filter by report of chronic or multiple pains, or by prescription of opioids, pregabalin, or gabapentin, then to refer to mental health services. No reference is made to Cochrane reviews and NICE guidance which support the prescription of these drugs for chronic pain.

Any GP will tell you that interrogating databases using these parameters is likely to identify a multitude of patients: around 11% of adults have chronic pain and many consult frequently.[1] As for a diagnosis of MUS if a 'patient cannot give a clear or precise description'; welcome to a normal surgery. After all, general practice can be characterised as the art of unravelling the medically unexplained.

The Commissioning Support for London document[12] threatens to redirect patients with chronic pain to IAPT practitioners without adequate — or any — training in pain management. This will overwhelm the IAPT service, and commit patients to yet another inappropriate treatment. Pathways for assessment and treatment in primary care are currently in development under the auspices of the British Pain Society and Map of Medicine. Unlike the proposals based on pain as medically unexplained, these pain treatment pathways are evidence-based, practical, and take full account of patients' needs.

The ubiquity and familiarity of pain, and the difficulties of dealing with symptoms without signs, contribute to the failure to take seriously the phenomenon of persistent pain and the mechanisms which explain it.[1,2] The resurgence of an unscientific and patient-unfriendly MUS model for pain is to be deplored.

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"The practitioner's role in explaining pain and its relationship with beliefs and emotions is key to engaging the patient in rehabilitative treatment."

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Persistent pain:

the need for a cooperative approach

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INTRODUCTION

Williams and Johnson present a strong argument against seeing chronic pain as an example of somatisation or as a medically unexplained symptom.[1] They are concerned that such perspectives encourage undue psychologisation of physical complaints, and might be prejudicial to good patient care. They are particularly critical of documents produced by the Increasing Access to Psychological Therapies (IAPT) programme and Commissioning Support for London (CSL), as examples of initiatives which may lead to chronic pain sufferers being managed by practitioners without adequate grounding in the types of pain management strategies supported by NICE guidelines or by the Cochrane Pain, Palliative, and Supportive Care Group.

I have considerable sympathy with their position, especially their idea that the general practice consultation is the 'art of unravelling the medically unexplained'. I strongly agree about the dangers inherent in assuming that all complex symptom presentations indicate an underlying psychological problem. However, their arguments in favour of chronic pain as a disease entity and against MUS perspectives are both overstated.

OVERSTATING THE CASE

I am not convinced by their argument that chronic pain should be seen as a disease entity in its own right, for nosological and epidemiological reasons. First, at the level of nosology, evidence of changes in brain structure may be better seen as associative rather than causative. Notionally, a similar argument could be made that pyrexia of unknown origin should be awarded disease status, on the grounds that a persistent rise in temperature is associated with widespread physiological and functional changes: but a more reasonable view would be that pyrexia of unknown origin (like chronic pain) is not a disease state per se, but is rather a final common pathway for a heterogenous set of possible causative factors. Second, at the level of epidemiology, there is good long-term evidence against chronic pain syndromes all being the same problem with a common mechanism of persistence, and in favour of regional pain complaints tracking distinctively over time.[2]

Williams and Johnson's critique of the IAPT and CSL documents is too swingeing. Although simplistic in places, these documents do acknowledge that anxiety, depression, and psychological distress can be a consequence of physical symptoms such as pain, and that unexplained physical symptoms should not be assumed to be mental health problems. The CSL document does not advocate interrogating databases as a method of detecting clinical cases of MUS, but rather as a guide for commissioners seeking to establish the likely extent of persistent unexplained symptoms; and it does support pharmacological and neurological approaches for moderate and severe cases.

ALLEVIATING SUFFERING

We are still in a position where there is a great deal of work to be done, in understanding the complex inter-relationships between chronic pain and psychological distress, and in finding effective interventions. Our goal of alleviating suffering remains problematic whether we pursue physiological or psychological approaches. Williams and Johnson acknowledge that even in the pain management field, better understanding of underlying mechanisms has not yet led to the introduction of an array of effective treatments.

There is a need for further research into possible common antecedents of pain syndromes and psychological problems. Pain and depressive symptoms may share common pathogenic pathways, perhaps accounting for the effects of some antidepressants on both affective and

"In seeking to help people living with persistent pain, it may be more productive to focus on cooperation rather than conflict ..."