

Reply to Henningsen et al.

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Chronic primary pain: a pain-centered view of the world is too narrow

Letter to Editor:

We read with interest the IASP classification of chronic primary pain for *ICD-11*.⁵ It has been notoriously difficult to classify the symptoms of patients who suffer from chronic bodily distress such as pain. The new IASP proposal for *ICD-11* is an important step forward: It secures a space in the classification that is neutral concerning the misleading dichotomy of somatic vs mental disorders, and in the definition of chronic primary pain, it includes emotional distress and functional disability as important components. However, the focus on pain only is a major disadvantage of this proposal. Although pain is the most frequent, it is by no means the only bodily symptom for which the characteristics developed in the proposal apply: patients with dizziness, palpitations, indigestion, numbness, motor disturbances, and many other symptoms that often also occur together with chronic pain²⁻⁴ are in need of an improved classification as well. Even if chronic pain is one major symptom in some of the so-called primary pain syndromes such as fibromyalgia syndrome and irritable bowel syndrome, some of these patients suffer more from fatigue than from pain.^{1,3} A pain-centered view on somatic syndromes is therefore not appropriate.

In addition, the chronic pain proposal is not well aligned with the suggestions for bodily distress disorder and bodily stress syndrome in other parts of *ICD-11*.⁶ Hence, the fact that nonpain symptoms are left out by the IASP proposal unfortunately carries the risk of increasing separations and confusions in *ICD-11*.

In addition, the authors claim that the term “functional” is ambiguous.⁵ However, the term “functional disorders” is well established in gastroenterology, eg, in the Rome criteria for functional gastrointestinal disorders⁷ and should not be relinquished until a better term has been broadly accepted.

We agree with the IASP working group for *ICD-11* that the new version of the *International Classification of Diseases* should be easily applicable in primary care as well as improve accurate epidemiological investigations and characterization of patients for clinical studies.⁸ IASP cannot reach these goals single-handedly. A collaboration with other associations (general medicine, gastroenterology, psychiatry, and psychosomatic medicine) is necessary.

Conflict of interest statement

The authors have no conflict of interest to declare.

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Reply to Henningsen et al.

Letter to Editor:

We are grateful for the positive evaluation of our classification proposal on chronic pain disorders of Henningsen et al.,⁴ confirming that this is an important step forward and avoiding any artificial dichotomy of somatic vs mental disorders. However, the authors were concerned that we focused only on pain and overlooked the frequent overlap of pain symptoms with other bodily complaints, and that we did not harmonize our proposal with the new suggestions of “bodily distress disorder” in the psychiatric part of the *ICD-11* draft or with other “functional syndromes”.⁴

Indeed, we aimed to improve the classification of chronic pain conditions, but not to solve all classification problems in the large field of what are often referred to as “medically unexplained symptoms”.⁹ Many “functional disorders” are poorly defined, distributed over different categories of medical specialties, and use different frameworks for classifying these disorders. We strongly encourage the authors, all of them being acknowledged experts of psychosomatic medicine, to further advance the classification of the various functional somatic syndromes in medicine. If a comprehensive classification system for functional syndromes exists, we will be delighted to harmonize our proposal with it. However, we are currently not aware of such a comprehensive classification system of functional disorders, but only of specialized approaches (such as the ROME criteria in gastroenterology³).

Internationally, chronic pain conditions have been found to be among the most disabling medical conditions,^{2,7} and arguably, the widely recognised shortcomings of both *ICD-10* and *DSM-5* in the diagnosis of chronic pain have contributed to the suboptimal identification and treatment of these conditions.⁹ If various biopsychosocial influences are identified, and the chronic pain condition is not better accounted for by another primary medical condition, we recommend to use the diagnosis of “chronic primary pain”.⁵ We do not recommend that this should be considered a mental disorder, such as the recently suggested “bodily distress disorder” mentioned by the authors,⁴ because chronic pain is not a mental disorder, although it often has mental disorders, such as depression, as comorbidities. Moreover, we are very confident that chronic primary pain as a term will be highly acceptable to patients, pain experts, but also in general medicine. The initial data from field trials and surveys in patient health groups confirm this assumption.¹ The German predecessor of the chronic primary pain diagnosis, “chronic pain with somatic and psychological factors,” became one of the most frequently used diagnoses in tertiary care in Germany after its introduction⁶ and was far more frequently used than “bodily distress disorder” or any of its precursors, further underlining the high acceptability of this development. However, we agree with Henningsen et al.⁴ that many patients with chronic pain symptoms suffer from additional somatic complaints. We would contend that these are acknowledged in the different subtypes of chronic primary pain,⁵ and multiple parenting can be applied.^{9,11} Such overlaps are typical for many medical and psychiatric conditions, and are not unique for pain. After the rationale of *ICD-11*,^{10,11} this should be addressed using comorbidity diagnoses, until future classification systems address the issue of overlapping syndromes better than is currently the case.

Finally, in reference to the authors’ contention that IASP could not achieve the stated goals by itself and that we should be collaborating with other associations,⁴ we want to bring to the authors’ attention the fact that our classification proposal of chronic pain syndromes was developed by a large multidisciplinary expert group that included clinicians and researchers from various medical specialties (eg, rheumatology, neurology, pain medicine, and primary care⁸), dentistry, and psychology. Nevertheless, continuing this interdisciplinary perspective, we are looking forward to further improving our proposal through collaborations with other expert groups.

Conflict of interest statement

A. Barke reports personal fees from International Association for the Study of Pain during the conduct of the study. M. First

reports personal fees from Lundbeck International Neuroscience Foundation, outside the submitted work. R.-D. Treede reports grants from Boehringer Ingelheim, Astellas, AbbVie, Bayer, personal fees from Astellas, Grünenthal, Bauerfeind, Hydra, Bayer, grants from EU, DFG, BMBF, outside the submitted work. The remaining authors have no conflicts of interest to declare.

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