

CLASSIFICATION OF CHRONIC PAIN

IASP Subcommittee on Taxonomy 1986

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CLASSIFICATION OF CHRONIC PAIN
DESCRIPTIONS OF CHRONIC PAIN SYNDROMES
AND DEFINITIONS OF PAIN TERMS

Second Edition

prepared by the
Task Force on Taxonomy
of the
International Association for the Study of Pain

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INTRODUCTION

“You are not obliged to complete the work,
but neither are you free to desist from it.”

—Rabbi Tarphon, Talmud, Avot, 2:21

The first two, and largest, parts of this volume contain explanatory material and a collection of descriptions of syndromes. These parts have been updated from the first edition. In the third part, the opportunity has been taken now, as before, to present some definitions of pain terms that were published previously in *Pain* and revised in 1986. Two new terms have been added to these definitions—Neuropathic Pain and Peripheral Neuropathic Pain—and the definition of Central Pain has been altered accordingly. Small changes have also been made in the notes on Allodynia and Hyperalgesia. Notes on the terms Sympathetically Maintained Pain and Sympathetically Independent Pain have also been introduced in a separate section, in connection with revised descriptions of what were formerly called Reflex Sympathetic Dystrophy and Causalgia and are now called Complex Regional Pain Syndromes, Types I and II, respectively.

The list of those who have contributed with drafts or with revisions of drafts precedes this introduction. Some have provided descriptions of a syndrome or comments on it; others have described a whole group or groups of syndromes. Some have also made theoretical contributions in working out how we should proceed. Dr. John J. Bonica, in particular, was instrumental in providing ideas from which the present volume has grown. Many contributors gave substantial portions of their time to the work. The range of contributions was such that it would be impossible to set up a precise scale of gratitude in proportion to the different amounts of help given, but the editors believe they can express thanks to all contributors, not only from the Task Force on Taxonomy of the International Association for the Study of Pain (IASP), but on behalf of the association as a whole.

In addition, Ms. Louisa E. Jones, Executive Officer, IASP, Mrs. J. Duncan, Mrs. C. Hanas, Ms. G. Hudson, and Ms. P. Serratore have been unfailingly patient and helpful in the production of the manuscript and in the associated correspondence over several years. Ms. Mai Why, M.L.S., provided much bibliographical assistance. Mr. Bryan Urakawa un-

dertook the difficult task of merging the old and new material in an updated text. The production editor, Ms. Leslie Nelson Bond, has made detailed improvements to the wording and helped to establish the new format.

In the first edition it was observed that the volume was provisional. It contained gaps and, no doubt, some inaccuracies and inconsistencies. Its printing and distribution, however, marked the end of a stage in what is fundamentally a continuous process or sequence of scientific endeavor. It was offered as a provisional compilation for scrutiny and correction by all who have the expertise and the will to devote some effort to developing this statement of our existing knowledge of pain syndromes. Everyone who read it was invited to check it within his or her own field of knowledge for completeness and accuracy and to send any recommendations for additions or corrections to the chairperson of the Subcommittee on Taxonomy (now the Task Force on Taxonomy). The same invitation accompanies this edition, which in its turn should undergo development and modification.

THE NEED FOR A TAXONOMY

The need for a taxonomy was expressed in 1979 by Bonica, who observed: “The development and widespread adoption of universally accepted definitions of terms and a classification of pain syndromes are among the most important objectives and responsibilities of the IASP. It is possible to define terms and develop a classification of pain syndromes which are acceptable to many, albeit not all, readers and workers in the field; even if the adopted definitions and classifications are not perfect they are better than the Tower of Babel conditions that currently exist; adoption of such classification does not mean that it is ‘fixed’ for all time and cannot be modified as we acquire new knowledge; and, the adoption of such taxonomy with the condition that it can be modified will encourage its use widely by those who may disagree with some part of the classification. This in fact has been the experience and chronology of such widely

accepted classifications as those pertaining to heart disease, hypertension, diabetes, toxemia of pregnancy, psychiatric disorders, and a host of others. I hope therefore that all IASP members will cooperate and use the classification of pain syndromes after this is adopted by IASP to improve our communications systems. This will require that they be incorporated in the spoken and written transfer of information, particularly scientific papers, books, etc., and in the development of research protocols, clinical records, and data banks for the storage and retrieval of research and clinical data.”

It calls for very little special knowledge, actually, to recognize that we could benefit from a classification of chronic pain syndromes. The need arises because specialists from different disciplines all require a framework within which to group the conditions that they are treating. This framework should enable them to order their own data, identify different diseases or syndromes, and compare their experience and observations with those of others. Studies of epidemiology, etiology, prognosis, and treatment all depend upon the ability to classify clinical events in an agreed pattern. The delivery of medical services is also facilitated if both the type and number of conditions and patients to be treated can be established in a systematic fashion. In some centers, payment by insurance companies for medical care of the insured creates a demand for a classification system.

In regard to chronic pain, it is important to establish such a system of classification that goes beyond what is available in the general international systems such as the International Classification of Diseases. The need is not to replace but to supplement the new ICD-10. Specialist workers in various fields usually require a more detailed structure for classification than is provided by the overall system. The Ad Hoc Committee on Headache of the American Medical Association developed such an extensive system for one set of pain syndromes (Friedman et al. 1962), and the International Headache Society has now replaced that with another for headache disorders, cranial neuralgias, and facial pains (IHS 1988). Stroke has brought forth a schedule of its own (Capildeo et al. 1977), the American Rheumatism Association (1973) has produced its own system with criteria for diagnosis, hematologists have continuously developed the numbering of clotting factors, and so forth. In the field of chronic pain, two requirements spring readily to mind. The first is that we should be able to identify all the chronic pain syndromes we encounter. The second is that we should have as good a description of

each as can be obtained, at least with respect to the pain. It would be expecting too much and also would probably be unnecessary to hope for a complete textbook description. But the members of the IASP should obviously be the most suitable experts to describe in full the pains of the syndromes we so often seek to relieve. Accordingly, a classification system for pain syndromes has been attempted which, without being a textbook, will provide standard descriptions of all the relevant pain syndromes and a means toward codifying them.

The present descriptions and coding systems have been developed in the light of the above considerations. They should allow the standardization of observations by different workers and the exchange of information. In the first edition it was remarked that when articles began to appear that used them as a point of reference, they would have achieved their first aim, and that if other articles emerged that revised or criticized them, they would be achieving their second aim, which was to stimulate a continuing effort at updating and improvement. Both these developments occurred, but more revisions have been generated internally within the Task Force on Taxonomy, or in response to communications from members of the IASP. In the spirit of the quotation at the head of this introduction, the work will still not be complete and it will not be interrupted.

THE NATURE OF CLASSIFICATION

Reassurance may be needed for those who feel that the classification should reflect some sort of ultimate truth and universal consistency. It is indeed correct that classifications should be true, at least so far as we know, but complete consistency is beyond the hopes of any medical system of classification. In an ideal system of classification, the categories should be mutually exclusive and completely exhaustive in regard to the data to be incorporated. The classification should also use one principle alone. No classification in medicine has achieved such aims, nor can it be expected to do so (Merskey 1983). Classification in medicine is a pragmatic affair, and we may consider briefly how classifications can be devised. Classifications may be natural if they reflect or presume to reflect an order of nature. Alternatively, they may be artificial but convenient. The simplest type of classification into animate or inanimate objects is a natural one. An extreme example of an artificial classification is provided by a telephone directory (Galbraith and

Wilson 1966). The sequence of letters of the alphabet is used as the criterion for classification. That sequence bears little or no relation to the contents that it arranges, namely the people, their addresses, and their telephone numbers. By contrast, a phylogenetic classification by evolutionary relationships is a very superior form of classification. Impressive natural and phylogenetic classifications exist in chemistry, botany, and zoology.

Things are very different in medicine. In the ICD10, conditions are classified by causal agent, e.g., infectious diseases or neoplasm; by systems of the body, e.g., gastrointestinal or genito-urinary; by system pattern and type of symptom, as in psychiatric illnesses; and by whether or not they are related to the artificial intervention of an operation. They may be grouped by time of occurrence, such as congenital anomalies or conditions originating in the perinatal period, or even grouped as symptoms, signs, and abnormal clinical and laboratory findings. There is a code (080) for delivery in a completely normal case, including spontaneous breech delivery. Within major groups there are subdivisions by (a) symptom pattern, such as epilepsy or migraine; (b) the presence of hereditary or degenerative disease, e.g., Huntington's disease and hereditary ataxia; (c) extrapyramidal and movement disorders, e.g., Parkinson's disease and dystonia; (d) location, e.g., polyneuropathies and other disorders of the peripheral nervous system; and (e) infectious causes, e.g., meningitis. Overlapping occurs repeatedly in such approaches to categorization. Pain appears in the group of symptoms, signs, and abnormal clinical and laboratory findings as R52 Pain Not Elsewhere Classified. This code excludes some 19 other labels that reflect pain in different parts of the body and also "psychogenic" pain (F45.4) and renal colic (N23). Thus pain occurs at various levels of diagnosis and categorization in the ICD-10. In a sense this is inevitable. There must always be some provision for conditions that are not well described and which will overlap with others that are well described.

Operational considerations often have to be employed in classification, and indeed operational definitions are implicit in most classification activities in medicine. These definitions will suit one purpose and not another. Thus, in psychiatry we may diagnose operationally from biochemistry (phenylketonuria), serology (general paresis), genetics (Huntington's chorea), symptom pattern (schizophrenia, depression), mechanisms and site (tension headache), and even the presence or absence of irrationality (psychosis, neuro-

sis). With regard to internal medicine, the same applies. It has been said that "acute nephritis" may be diagnosed on the basis of etiology, pathogenesis, histology, or clinical presentation (Houston et al. 1975). Pain syndromes are distinguished particularly often on the basis of duration, site, and pattern, some of which are frequently similar to different conditions. Accordingly, we can aim only at practical categories, largely defined operationally, but these can nevertheless be very useful. For some further consideration of this see Merskey (1983). Here we have aimed especially at describing chronic pain syndromes and at coding them.

THE PRESENT CLASSIFICATION

It has been mentioned that the present volume is not a textbook. Instead it deals with syndromes of chronic pain. Chronic pain has gradually emerged as a distinct phenomenon in comparison with acute pain. First, studies were undertaken that explored the special features of patients with persistent pain. Later, specific emphasis was given to the distinction between the two situations (Sternbach 1974). Chronic pain has been recognized as that pain which persists past the normal time of healing (Bonica 1953). In practice this may be less than one month, or more often, more than six months. With nonmalignant pain, three months is the most convenient point of division between acute and chronic pain, but for research purposes six months will often be preferred. Those who treat cancer pain find that three months is sometimes too long to wait before regarding a pain as chronic. Moreover, the definition related to the time of normal healing is not sufficient, nor is it honored consistently. Many syndromes are treated as examples of chronic pain although normal healing has not occurred. Pain that persists for a given length of time would be a simpler concept. This length of time is determined by common medical experience. In the first instance it is the time needed for inflammation to subside, or for acute injuries such as lacerations or incisions to repair with the union of separated tissues. A longer period is required if we wait for peripheral nerves to grow back after trauma. In these circumstances, chronic pain is recognized when the process of repair is apparently ended. Some repair, for example, the thickening of a scar in the skin and its changing color from pink (or dark) to white (or less dark), may be painless. Other repair may never be complete; for example, neuromata in an amputation stump con-

stitute a permanent failure to heal that may be a site of persistent pain. Scar tissue around a nerve may be fully healed but can still act as a persistent painful lesion.

Many syndromes are treated as examples of chronic pain although it is well recognized that normal healing has not occurred. These include rheumatoid arthritis, osteoarthritis, spinal stenosis, nerve entrapment syndromes, and metastatic carcinoma. Others, such as persistent migraine, remit or heal and then recur. Moreover, the increasing knowledge about plasticity of the nervous system (Wall 1989) in response to injury indicates that CNS changes may prolong and maintain pain long after the usual time of response to acute lesions. Such changes can make it difficult to say that normal healing has taken place. Other less obvious failures to heal can last indefinitely (Macnab 1964, 1973); some of these lesions are not detectable even by modern imaging techniques (Taylor and Kakulas 1991) but will still give rise to persistent chronic pain. Chronic pain thus remains important, even if we must understand it slightly differently as a persistent pain that is not amenable, as a rule, to treatments based upon specific remedies, or to the routine methods of pain control such as non-narcotic analgesics. Given that there are so many differences in what may be regarded as chronic pain, it seems best to allow for flexibility in the comparison of cases and to relate the issue to the diagnosis in particular situations. As it happens, the coding system has always allowed durations to be entered as less than one month, one month to six months, and more than six months. This is probably the best solution for the purpose of comparing data within a diagnostic category, or even between some diagnoses.

In this volume only a small number of acute pain syndromes is included. Some are of theoretical importance or are helpful in pointing out a contrast (e.g., acute tension headache versus chronic tension headache) or are recurrent. Conditions have been selected where pain is prominent and pain management is also a leading problem—for example, causalgia. Sometimes, as with spinal stenosis, the main problem with the chronic syndrome is to recognize it reasonably early. After that, the treatment is specific and not one of pain management per se. Syndromes or states that do not meet one of the above characteristics are omitted. Thus, thyroiditis, which can be very painful, is not included, because its recognition and treatment are not usually problems for pain experts and do not present a major problem in acute pain management. Similarly, cerebral tumor is excluded because pain

associated with it is not a focus of attention once the patient has consulted a physician or surgeon and the condition has been properly diagnosed. Other conditions, like facet tropism, are included because they reflect the existence of a condition that may or may not be painless.

After quite protracted discussion and correspondence, it was agreed that there were a number of pain syndromes that were best seen as generalized conditions, for example, peripheral neuropathy or radiculopathy, causalgia and reflex dystrophies (now called complex regional pain syndromes), central pain, stump pain and phantom pain, and pain purely of psychological origin. The majority of pain conditions, even including some of the foregoing, have a fairly specific localization, albeit such localization may be in different parts of the body at different times. A root lesion may be anywhere along the spinal column, and postherpetic neuralgia may affect any dermatome. Nevertheless, it seemed worthwhile to divide the descriptions of pain into two groups. First a smaller one, in which there is recognition of a general phenomenon that can affect various parts of the body, and second, a very much larger group, in which the syndromes are described by location. As a result, there is some repetition and redundancy in descriptions of syndromes in the legs which appear also in the arms, or in descriptions of syndromes in abdominal nerve roots which appear in cervical nerve roots.

The present arrangement has been adopted because it offers a particular advantage. That advantage stems from the fact that the majority of pains of which patients complain are commonly described first by the physician in terms of region and only later in terms of etiology. An arrangement by site provides the best practical system for coding the majority of pains dealt with by experts in the field. After thorough discussion, the original Subcommittee on Taxonomy therefore agreed that the majority of syndromes would be described in this fashion.

The descriptions were elicited by sending out requests to appropriate colleagues, of whom enough replied to get this work underway. The pattern of descriptions requested was systematic. Although initially it did not begin with a request for a definition, this was added later. Each syndrome then was to be described in terms of the following items: definition; site; system involved; main features of the pain including its prevalence, age of onset, sex ratio if known, duration, severity, and quality; associated features; factors providing relief; signs characteristic of the condition; usual course; complications; social

and physical disabilities; specific laboratory findings on investigations; pathology; treatment where it was very special to the case; the diagnostic criteria if possible; differential diagnosis; and finally, the code. For this edition criteria have been sought for a variety of the conditions.

Emphasis was placed on the description of the pain. By contrast, this volume cannot provide a guide to treatment, but where the results of treatment may be relevant to description or diagnosis they are noted. Each colleague approached was asked to exchange his or her descriptions with others who were looking at the same topics. Accordingly, the majority of descriptions-but not quite all of them-have been scrutinized by colleagues in the same field. The descriptions vary in length. This reflects the decisions of the individual contributors. The senior editor's function was to seek relevance, adequate information, agreed positions, and clarity, and he has been content, within broad limits, to leave the judgment of the amount of detail required in the hands of the authors.

In this edition, as in the first, there are probably still some omissions. Some have occurred, as before, because the conditions in question either have been overlooked by the senior editor or do not seem to be important. In one or two cases help was not obtained in time and it was felt better to proceed with the published volume than to wait indefinitely. It must be emphasized, however, that the editors cannot decide on their own which conditions to incorporate and which to reject. They have had to reach conclusions on the basis of advice from others in most instances. Full descriptions of some conditions are not included, but codes are given. Referred pain from the chest to the abdomen provides an example. At the point where it is mentioned, a reference back to the chest is provided because the main features are to be found in the descriptions of chest conditions. The new sections on spinal and radicular pain, discussed later, provide only titles and codes for many conditions.

SOME CONTROVERSIAL ISSUES

Occasionally terms that are quite popular have been deliberately rejected. One such term is Atypical Facial Pain. The senior editor believes that this term does not describe a definite syndrome but is used variously by different writers to cover a variety of conditions. Some, but not all, of his advisors have accepted this position. It is suggested that what is often called Atypical Facial Pain may better be diag-

nosed under terms like Temporomandibular Pain Syndrome, Atypical Odontalgia, or Odontalgia Not Associated with Lesions. Some cases may even be variants of the primary headache syndromes such as Classical Migraine. Others should be diagnosed as pain of psychological origin. Alternatively, pain in the face, or anywhere else, for which a diagnosis has not yet been determined can be given a regional code in which the second digit will be 9 and the fifth digit 8, as follows: Code: X9X.X8.

The myofascial pain syndromes have presented obvious difficulties. In this field we are short of properly validated information with agreed criteria and repeatable observations. The amount of well-established knowledge is small compared with the frequency and troublesome quality of the disorders. Accordingly, the material offered on soft tissue pain in the musculoskeletal system is based on views which seem to have empirical justification but which are not necessarily proven. Overall, it has been accepted that there are some general phenomena, described as fibromyalgia, fibrositis, or generalized myofascial pain. These have been grouped together (Group 1-9), while some but not all of the more localized phenomena have been given individual identities, under the spinal categories of trigger point syndromes. Sometimes also a prominent regional category such as acceleration-deceleration injury (cervical sprain) may be used, covering several individual muscle sprains, some of which are also described separately.

It is common in North America to find that patients are described as having "Chronic Pain Syndrome." In this case the words are being used as a diagnosis that usually implies a persisting pattern of pain that may have arisen from organic causes but which is now compounded by psychological and social problems in behavioral changes. The Task Force was asked to adopt such a label, particularly for use in billing in the United States. There was general agreement that this would not be desirable. Such a category evades the requirement for accurate physical and psychiatric diagnoses. It was considered that where both physical and psychological disorders might occur together, it was preferable to make both physical and psychiatric diagnoses and to indicate the contribution, if any, of each diagnosis to the patient's pain. In this approach pain is seen as a unitary phenomenon experientially, but still one that may have more than one cause; and of course the causes may all vary in importance. It was also noted that the term Chronic Pain Syndrome is often, unfortunately, used pejoratively.

CHANGES IN THE SECOND EDITION

This edition contains a number of additional descriptions in various sections. These include scattered descriptions, e.g., recurrent abdominal pain in children and proctalga fugax, which represent an effort to include some chronic painful syndromes that were not described in the first edition. This approach is particularly evident in the section on headache, which has been substantially revised and enlarged. This section has been much influenced by recent advances in the identification and description of different types of headache. We have not, however, adopted the classification of the International Headache Society, for three main reasons. The first is that the IHS classification is more extensive in one respect, since it covers acute headaches comprehensively, whereas our focus is much more on chronic headache and is more detailed. Second, it was necessary, or at least highly desirable, that the IASP coding system be used throughout the whole classification. Third, some of the categories of the IHS classification require further attention. It is hoped however, that nearly all the categories we have used will be translatable into IHS codes for those who require that facility. In fact, a crosswalk has been provided from the IASP codes to the IHS codes where possible, and we hope for increased agreement in time.

Among the new conditions described in the headache sections and elsewhere, the following may be noted: Guillain-Barre Syndrome; Tolosa-Hunt Syndrome; SUNCT Syndrome; Raeder's Syndrome; Chronic Paroxysmal Hemicrania: Remitting Form; Syndrome of Jabs and Jolts; Headache Associated with Low CSF Pressure; Post Lumbar Puncture Headache; Hemicrania Continua; Cervicogenic Headache; Brachial Neuritis; Cubital Tunnel Syndrome; Internal Mammary Syndrome; Recurrent Abdominal Pain in Children; Proctalga Fugax; and Peroneal Muscular Atrophy. Reflex Sympathetic Dystrophy and Causalgia are now described as Complex Regional Pain Syndromes, Types I and II, respectively, and the description of the former reflex sympathetic dystrophy has been substantially revised.

The largest changes have been made in the sections on spinal pain and radicular pain. The least satisfactory aspect of the first edition, acknowledged at the time, was the lack of an adequate way to organize the musculoskeletal syndromes related to spinal or radicular dysfunction and pain, particularly in the low back. The regional arrangement of pain was a start in this direction, but back pain remained amorphous, and

we had not found a satisfactory approach to describing it comprehensively and in detail, according to the contributions of spinal features, radicular effects, and myofascial changes.

Within the Task Force on Taxonomy, a Subcommittee on Back Pain adopted schedules for back pain and root pain, which were originally drawn up by Dr. Nikolai Bogduk. These schedules provide a systematic and comprehensive organization of the phenomena of spinal and root pain and have been incorporated in the overall scheme. As in the rest of the classification, they require recognition of the site, system of the body, and features on all the existing five axes (see Scheme for Coding Chronic Pain Diagnoses, (pp. 3-4). However, the descriptions of the pain are relatively limited, for these are taken to be similar for spinal pain in most locations, and for root pain likewise. Further, not all the categories are described, simply because many are rarely responsible for chronic pain. On the other hand, those descriptions that are given are accompanied by criteria for the diagnosis. As with all criteria, the aim is to improve reliability and validity in diagnosis, which is particularly desirable for conditions where loose standards of diagnosis can lead to wide divergences in the meaning of terms in common use. A more detailed discussion of the principles employed in this revision of spinal and back pain is provided on pages 11-16 in the list of Topics and Codes, but that discussion applies to pain arising throughout the vertebral column.

The development of criteria has also been followed in other locations. This process has not been comprehensive, but with the updating and revision of many descriptions, the opportunity has been taken to incorporate criteria when possible. The most notable example of this is the revised description of fibromyalgia (fibrositis) by Dr. Fred Wolfe, which followed the criteria of the American College of Rheumatology, developed on the basis of an exceptional multicenter study.

THE CODING SYSTEM

The coding system is shown in the Scheme for Coding Chronic Pain Diagnoses (pp. 3-4). Particular thanks are due to Dr. Arnoud Vervest for his assistance with the coding system. In order to ensure that there was no overlap between codes, it was necessary to enter all the codes, provide a computer challenge between them, and identify all cases of overlap. Because of the use of variable axes, particularly the first

and fourth axes, where as many as ten different entries were possible per diagnosis, there were numerous cases of overlap which required reconciliation before the codes could be adopted, and Dr. Vervest undertook the very demanding work of identifying these problems.

CONCLUSION

The purpose of this chapter has been first to introduce the reader to the considerations which led to the development of the present set of descriptions and codes. Second, the rationale is offered for the pattern chosen for the descriptions in the main body of the text. Third, the ideas behind the present coding system and its details are elucidated. In all this the positions taken are provisional-although of course some of them will not be lightly changed. Members of the Task Force on Taxonomy, those who have contributed so far, and anyone else who has the necessary skill and interest are all earnestly entreated to review the material provided and offer additions or improvements for later editions by writing to the editors (see Future Revisions).

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FUTURE REVISIONS

It is expected that corrections, additions, and other possible revisions will occur to different readers and users of this volume. Anyone who wishes to offer suggestions for improvements is warmly invited to submit these suggestions to the editors for consideration. In doing so, please use the following arrangement. Identify yourself and your address and discipline at the head of a sheet of paper. Then identify the topic, its page in this volume, and the group number and coding. Then offer any or all suggestions on the specific topic on that page and any subsequent pages that may be necessary.

For a fresh topic please provide a new page identified in the same fashion as for the first one.

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ABBREVIATIONS

CPK	creative phosphokinase
CT	computerized tomography
ECG	electrocardiogram
EEG	electroencephalogram
EMG	electromyogram
ESR	erythrocyte sedimentation rate
GI	gastrointestinal
LDH	lactate dehydrogenase
SGOT	serum glutamic acid oxaloacetic transaminase
TENS	transcutaneous electrical nerve stimulation