A New Way of Classifying Pains.

John D  Loeser

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I started my career trying to look at things from a new direction and to push pain management and medicine beyond its status quo. I retired from clinical practice 13 years ago and I have no patient responsibilities today but although this gives me a lot of freedom I certainly miss the patient interaction.

I have been thinking about how we organise our thoughts about the world of pain, and I want to share with you my latest conceptual change. This has been accepted for publication in Pain so you will get a chance to read about it in years to come.

I entered the world of pain under the shadow of John Bonica, and I can’t resist putting some of his sayings into everything I do.

The proper management of pain remains, after all, the most important obligation, the main objective and the crowning achievement of every physician”

 From the first edition of *The Management of Pain*

That is quite a challenge and an important one to keep in mind as we proceed through the world of pain.

Conventional wisdom

I shall be arguing that the traditional construct of acute versus chronic pain is arbitrary and obscures fundamental differences in clinical pain phenomena . A more powerful dichotomy between peripherally generated pains and centrally maintained pains can facilitate advances in both pain research and clinical care.

I remember well when Bonica first proposed that we should look at acute pain as different from chronic pain and in the early days there was considerable debate as to whether this transition took place at 30, 60 0r 90 days. But IASP sanctified the 90 day transition. Sholtz flatly stated that “the classification is dedicated exclusively to chronic pain syndromes, defined as persistent or recurrent pain lasting for more than three months”. The reason why they picked 90 days was that “*There is no viable alternative.”*

I think this is absurd, as I shall explain.. I think we should abandon the temporally based classification scheme, as it does not accurately reflect the underlying principles inherent in the phenomena of pain. I am not naïve and I accept that this is going to be a difficult task to accomplish in order to get people to change the way they think about the pain problem.

The traditional scheme which almost everybody accepts today is that after 30, 60 90 ot 120 days the pain situation changes from acute to chronic. Chronic pain includes cancer and end-of-life (needing palliative care) pain, nociceptive pain, nociplastic pain and ‘central’ pains. I believe that there is ample evidence of conventional thinking that time elapsed is the sole variable in this progress but I am reminded of my colleague Bill Fordyce’s memorable spelland insightfull saying: “Conventional wisdom is often wrong”. What happens at 30, 60 or days that causes a pain to move from acute to chronic? … *nothing!* There is no evidence that something changes in the human body at some time-point that causes this change.

Getting smart about pain

I propose a new scheme: of *pains of peripheral origin* and *centrally maintained pain,* in which duration is not a relevent or meaningful basis for categorising or classifying pain. For example, my wife has severe degenerative changes in both hips but she was in pain for five years before she decided to take some action. You will probably say that five years of pain is a chronic pain problem. She had one hip replaced and in the recovery room she said: “Wow! – I have a lot of incisional pain but my hip pain is gone”. It certainly was chronic but it was cured by a peripheral operation. If you call her pain chronic with all the garbage associated with the word you would have a hard time explaining why her pain went away; she was clearly not analgesic because she had bad incisional pain which she coulc discriminate from the joint pain.

There are many pains of peripheral origin, including laceration, fracture, closed trauma, infection, strain and sprain, inflammation and burns. The interesting things about such pains is that nature usually heals them.

 “Nature heals, and doctors get the credit”

 Voltaire

I am still thankful for that phenomenon! What do we do to manage peripherally generated pains? We facilitate nature’s healing and provide temporary pain relief, for instance by immobolising a fracture, neither of which does anything to actually heal the problem, and in almost all cases the pain goes away before the trauma has completely healed.

Nociceptive pain is always peripherally generated and is not a centrally maintained pain. It is the normal response to tissue damage, it ceases as the wound is healing and there are pretty good treatments for it; and there is no evidence that I am aware of that nociception is responsible for centrally maintained pain.

Cancer pain is also of peripheral origin, with ongoing tissue damage. It certainly may persist for a long time. The treatment itself may lead to a new pain such as the neuropathic pain that may result from chemo- or radiotherapy which is centrally maintained and not due to nociception.

 Management of pain at the end of life inovolves managing all symptoms, not just pain. Our goal is to give enough pain medicine and adjunts to produce comfort, not to restore function. But the use of high dose opioids can be a slippery slope. Social support is of course critically important. This is regardless of whether the pain is of peripheral origin or central, or both.

I think that we have to concede that deep knowledge of the nociceptive process, and the relationship between tissue damage and transduction of information into the central nervous system, does not adequately explain the phenomena of clinical pain, whether peripherally generated or centrally maintained. There is more to human pain than this. It has been apparent for some time that human experimental pain paradigms have not generated clinically useful information. They do not reprocuce the clinical situation because unlike clinical pain the stimulus can be terminated on request and there is no clincal significance or meaning attached to experimentally generated pain. Meaning is very important to people with pain.

A new terminology - a new approach to chronic pain

Chronic pain, then, is best described as centrally maintained pain, and I would like to abolish the terms acute and chronic because they obscure fundamental differences in how they come about and how they should be treated. One important issue that I feel strongly about is that the idea of centrally maintained pain evolving from a peripheral pain leads to attacks on the periphery which never succeed in a centrally maintained pain. If you think that a peripheral pain generates a central pain then your focus is on the periphery. There are some amazing chapters in the annals of neurosurgery showiing the futility of this. For example it was once thought that post-herpetic neuralgia could be alleviated by denervating the apparent source of the pain, so the first thing that was done was to excise the ‘painful’ skin. But the pain persisted even though the skin that used to hurt was gone. So next people tried cutting the peripheral nerves from the region of pain which became completely numb … but the pain persisted. So next a cordotomy was done leadiing to a loss of pain and temperature sensation on the opposite side of the body … *and the pain persisted!* Some went as far as thalamalotomy or even excision of sensory cortex with similar results. This was because neurosurgeons as a group were fixated upon the periphery as the source of pain. In his bible of pain neurosungery William Sweet summarises this very neatly and says something to the effect that we now know enough about the anatomy of the nervous system to be able to relieve pain anywhere in the body *but it doesn’t always work.* These people didn’t recognise the crucial difference between the two sorts of pain.

There is a wide array of centrally maintained pains, including headaches (some), TMJ disorders, non-cardiac chest pain, RSD, fibromyalgia, CFS, IBS and non-specific back pain,

of which the commmonest and the best studied is fibromyalgia. What characterises this group is that there is no pathology where it hurts. That is a hard concept to get across to many healthcare providers. Indeed every specialty has what I call a non-disease disease which justifies them in performing their activities be it medical or surgical. For instance the urologists have non-specific prostatitis: these patients never have any evidence of inflammatory disease but it has been given this name because it validates the actiivities of the urologists. The analogous sydrome of cystitis in women leads to the relentless pursuit of peripheral causes, which has even led to people doing cystectomies to remove the painful bladder, without ever relieving pain.

Pains After Injuries to the peripheral or central nervous system

With peripheral nerve injuries, typically the patient is numb in the region of denervation but it hurts. The pain may spread to the region around the nerve injury territory. For unknown reasons the sensory radial and saphenous nerves are the most common to create pain aafter injury. Surgeons have tried cutting a nerve proximal to the injury to relieve the pain but it never works because after a few weeks you get a new neuroma at the site of the neurectomy producing pain. So peripheral nerve injuries produce a central pain because of change in the afferent connections, but it is not a peripheral pain.

Spinal cord injury pains are usually divided into pain below the level of the injury, pain at the level of the injury, pain from nerve root compression resulting from the spinal injury and mechanical pain. Those require careful management. Years ago Ron Melzack and I wrote a paper about spinal cord injury and pain; we had a group of patients who had sustained complete transection of the thoracic or lumbar cord and on the theory that the pain was supposedly due to something wrong at the level of the injury we did an operation to raise the level two of three segments and the numbness by two or three inches. But it did not alter the pain. So the pain is not due to something going on at the region of the injury. Brain injuries can procuce pain. They are usually associated wth loss of pain and temperature sensation in the region of pain. The pain is always contralateral to the lesion so the spinothalamic system is involved and it usually persists indifinitely. Pain after brain injuries is relatively rare and only seen with deep brain injuries and not after cortical injuries.

Nociplastic Pain\*

I don’t like this unproven concept which is based on the premise that nociceptive pain can change central functioning and lead to long-term pain independent of the peripheral problem. Quantitative Sensory Testing changes show that skin sensory function has changed. But you can see these changes in people who have had a peripheral nerve injury and do not reveal a mehanism for long-term pain or provide evidence of long-term change in the CNS. We know that ‘plastic’ phenomena are not required for long-term pain. If you have a stroke that involves the spinothalamic system you you have a pain for a very long time and nothing has changed; there is no peripheral input that is modified. And with fibromyalgia, a prototypic nociplastic pain the problem now is that there is no known nociception leading to it. So I think that this is not a helpful concept. There are centrally maintained pains but they are not due to conversion of an acute problem into a chronic one. And what does ‘plastic’ mean in this context?

Treatment implications

 Anything you know that works for peripherally generated pain is likely to harm a patient with centrally maintained pain. The only thing they have in common is the four-letter word pain. I don’t think there is adequate recognition in the healthcare community of this distinction, and in part this is due to the acutge/chronic dichotomy. Peripherally generated pains can be treated by removing the source, no matter how long the pain has been present. I have used the example of my wife’s arthritis; and I have seen patients with a chronic osteomyelitis who had pain in their femur for several years until somebody tumbled to the fact that they had a bone infection, and draining it relieved the pain in a matter of a day or two. So I want to get away from the idea that just because a peripherally generated pain is ‘chronic’ , i.e. it has been there a long time, doesn’t mean it can’t be treated by removing the source, as is the case with centrally maintained pain.

 Sensitization can occur with pains of both peripheral and central origin and does not necessarily imply a centrally maintained pain. It is common to find changes in skin sensitivity around a region of a nociceptive process but this does not mean that it is centrally maintained.

 We need treatments that alter brain function to succesfully deal with centrally maintained pains. The actions of the brain are amenable to modulation by both internal and external events, some of which are physiological and others psychological.

Conclusion

One of the best books I have ever read on pain is a novel: *Ingenious Pain* by Andrew Miller, which is the story of a child with congenital indifference to pain, his bizarre childhood and later lif experiences. He failed as a physician because he lacked the ability to empathise with patients. Miller writes: “All pain is real enough to those who have it; all stand equally in need of compassion.” (regardless of the basis of their pain)

So I tell our students that *they need to treat the patient, not the pain.* There is more than biology to a human being.

\*Nociplastic pain is defined by the IASP as “pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain”

Discussion

*Are you able to link this in with some of the social factors that Ernie talked about? [Webinar October 2021] You mentioned psychology right at the end there. I agree that acute and chronic pains (to use the conventional terminology) are very different phenomena. I see a lot of people with medicolegal claims after injury and it is usually the case that there were chronic pain issues that existed before the injury, and it often seems that the injury ‘brings out’ problems. I am reminded of the diagrams you have popularised of the intersecting rings of factors contributing to pain and suffering with nociception in the middle. I wonder if you can connect this up socially to the wider world of pain medicine.*

We can do that. There is a very interesting recent publication by two Princeton economists, Case and Deaton (the latter has won the Nobel prize for his prior work) who have identified what they call the ‘diseases of dispair’. They point out that in the US chronic pain, suicide, psychiatric disorders and drug addiction all seem to be correlated with socio - economic status. Our country has changed in the way it offers opportunities for people who feel that they have no options for moving upwards (the great American myth). They develop diseases. Things like opioid abuse are symptoms of the lack of social support and their social environment. You can play the medical geography game of superimposing the incidence of drug abuse by Zipcode on the percentage of people who voted Republican in those areas which were solidly for Trump. There there is a much higher incidence of diseases related to stress.

 We can overlook the social issues and we don’t have a system to address them. The average doc in his office has little ability to alter the social problems that are impinging on his patients. We have separated the medical from the social to the great detriment of the patient. This is one reason why many of us think that we have to go back to primary care physicians to take responsibility for dealing with not only the biology but also the psychology and sociology. But there has to be some method of empowering them. The UK has a much better system than the US of primary care for dealing with this.

 Indeed we need to change from a bio-psycho-social to a socio-psycho-social approach.

*The Marmot review from Bristol in about 2010 was about the connection between poverty and illness.*

 *If you suffer trauma as a child you are likely to suffer chronic pain in later life. I have heard the predictiion that the children separated from their families at the Mexican border will possibly go on to becoming chronic pain sufferers.*

The actions of the US government with reference to the border are an unconscionable atrocity. Traumatic childhood leads to many illnesses including chronic pain. And then we have all these infants borne into opiate withdrawal who are treated in the neonatal period with opioids which are gradually tapered down. What does that do to your nervous system? – and predisposes to what dysfunction?

*Is it something to do with inflammation? Stress seems to generate more cytokynes and inflammatory processes in the body*

The problem is that our healthcare providers are trained to look at the person in front of us or the society from which the patient comes. We have no leverage on society to change these things. When you see a child that comes from an abusive family, if it is extreme the child might be taken away from the family but we don’t have a handle on that as we do with presribing antibiotcs

*I am a pain nurse. I want to start a project next year for children who live with a parent with chronic pain and who are more likely to develop it as well. I have also been going into schools and teaching about pain in general.*

 *My question is whether opioids are ever indicated in chronic pain. When doctors first started using them for this they probably ignored the safety aspect, but we know that a lot of the time surgery to the periphery doesn’t help the pain, or of it does go it comes back, so for chronic pain which is centrally sensitised with no peripheral stimuli would you think that opioids could be useful; but if never what alternative can you suggest?*

Opioids would be highly unlikely to be useful for any centrally maintained pain. They have two primary actions: one is reducing the nociceptive input into the CNS working in the spinal cord and brainstem, and the other is the role they play in modulating our interpersonal relations. The problem with exogenous opioids is that they swamp out our endogenous opioid system so you lose the benefits of reacting with people. Long term opioids are very pernicious; they don’t usually provide long-term pain relief and they dramatically alter the interpersonal relationships. There do seem to be some people who do exceptionally well on a small dose of opioids, but in my opinion although they are excellent for treating pain of peripheral origin, in part because nature usually heals the problem so the noxious input ceases and the opioids can cease, with centrally maintained pain there is no noxious input to be blocked.

*But this seems to imply that if a chronic pain involves a continuing painful stimulus opioids should be helpful? [rest of contribution inaudible – something about pain problems and their treatment never being simple]*

*I think that was one of the most important contributions to these sessions that we have ever had and it is barely an exaggeration to say that if this suggestion is adopted widely it should revolutionise attitudes to the management of persistent pain.*

 *That said, I remain a little bit confused. I wonder if you have run this idea past the neurophysiologists and what their response has been and whether there is always a clearly cut-off distinction between nociceptive and centrally maintained pain. Of course all pain perception involves central mechanisms, form the dorsal horn of the cord to the brain, and I am not clear as to whether there is a clear-cut distinction in all cases between pain peripherally* ‘triggered’ (*and amplified) in this way and pain* maintained *by central processes.*

 *If I may I would like to tell you a little story about myself. A few years ago I was suddenly smitten by an excruciating pain in my knee which turned out to be due to a spontaneous rupture of a meniscus associated with severe arthritis. This must have been developing for several years* but I had never had any pain whatsoever in this knee. *The pain subsided a little but continued and was not relieved by arthroscopic*  *removal of the offending disc. I eventually had a knee replacement which cured the pain. I don’t think you can say that noxious input from the arthritis per se ‘caused’ the pain and central mechanisms must surely have been involved in maintaining the pain (but apparently were ‘turned off’ by the TKR but not by the meniscectomy) So which of your new categories does this story belong to?*

I think that is a classical example of a peripherally generated pain. These can produce alterations in central performance in the region of a peripherally generated pain. It is peripheral even though you had pain for a long time which would have been called chronic pain. I would argue that it was peripherally generated and at any point when you remove the offending tissue, in your case the knee joint, the pain goes. You would have had incisional pain for a while; it’s not that you became analgesic in the knee region but the peripheral generator has gone.

*I forgot to mention that my pain was not relieved by meniscectomy, and if the arthritic joint was the ‘peripheral generator’ why had I had never had any pain until the acute incident? And incidentally the other knee is radiologically very arthritic but rarely gives me more than relatively minor discomfort – not enough to justify surgery.*

I have run it past the neurophysiologists, but I never know in my institution if they are telling me the truth! – or are terrorised by my saying something. I don’t think the issue has been adequately addressed which is why I submitted an article to Pain, and my expectation is that I will be the target of many missiles when it is published. I am waiting to see what happens.

*My experience is that my pain never changed – it was on a continuum and there was never a point when it changed and I have always thought that the distinction between acute and chronic pain was pretty arbitrary; at any rate any demarcation point at 60 or 120 days or whatever was very arbitrary. So my question is how do physicians make that distinction between peripheral and central? - so as to avoid that potentially harmful continual search for peripheral mechanisms, with patients continually failing treatments. But the automatic assumption that a pain is centrally generated because it has been there so long can also harm patients and add to their suffering if a potentially treatable cause for their pain has been missed. So how can this distinction be made in the clinic?*

I can’t speak for all clinicians but as is often the case everything goes back to one’s education. In our country the public in general is still uninformed about pain and physicians in general are inadequately educated about it. Roughly half the people that walk into a primary care doctor’s office have pain as their chief complaint. So it is very common. But if you ask what fraction of medical education is given to pain, the answer is that it is one or two percent. So we have a mismatch between the prevalence of the problem and the education of our primary care health care providers. We need to educate the public so that all their information doesn’t come from the marketing of some product. We need to change the medical school curriculum, which in my country at least is the last refuge of the feudal system in the modern world, so changing it is a massive task. You’re not going to have more hours in the classroom so if you want to put something new in the curriculum you have to take something out. And if you want to see a faculty member going to war tell him or her that you are reducing the amount of time devoted to their subject or specialism. So we really have not addressed this issue adequately. As a lifetime academic I do think that education is vitally important and would be the first step towards improving the problem. We just need to keep hammering away at the message that some pains are centrally generated. Even if it hurts some place – an interesting thing to think about as all pains are located some place in the body; nobody ever comes to you and says “I have a pain but I don’t know where it is”. - that fixation on the body confuses health care providers who think that if this guy’s leg hurts there can only be something wrong with the leg. So we simply have to keep educating at all levels.

*I totally agree with the limitations of the acute/chronic classifications because you see patients with CRPS who wake up from their acute trauma surgery and obviously have it right from the start, but it is quite hard to recognise that and treat it. They don’t respond to opioids and seem to have a neglect of their limb right from the start. CRPS is a central pain that starts with a peripheral injury be it a fracture or a small finger injury which is repaired surgically, and they wake up with unresponsive pain which is obviously different. And you never get on top of it. It is obviously central as it continues after the healing, which is where I think that three months came from as you would expect the tissues to have healed by then, but it develops right from the start. But I am not sure if you would call that peripheral or central , because it includes both.*

That is a very challenging question. Clearly it did start at the time of an injury in the periphery, and  *something* happened in the CNS – but nothing at 30,60 or 90 days. It could be that the peripheral injury led immediately to a central pain problem but it remains central. It is vital to recognise from the word go that this pain is not going to be relieved by amputating the offending part. That is a refinement of the crude idea that I have been setting out. In the next edition I will include it!

*It was a relatively – and surprisingly – common problem in the small town in New Zealand where I was practicing, and very distressing for the people suffering from it.*

*[not clearly audible] I would like to add a little to the central/peripheral distinction … Nature is rarely clean-cut* *and the lines of distinction are usually smudged. So the sociology comes in to it … I think that back pain usually starts peripherally but then the sociological factors come in at some stage – not an arbitrary number of days - and help to maintain it. It’s not by chance that we have a pain in the back because there is a nociceptive process going on there but the social factors gradually enter into it.*

I already said I would like to change to a socio-psycho-biologic model. But I am not sure how it integrates with a working person who does something to their back and develops pain, and I wish I knew whether that is nociceptive or not. But we force it to become nociceptive because the patient goes to see a physician who just assumes that they must have done something to their back and advises them about lifting etc. I don’t really know if there is a nociceptive process at the start. But it is certainly centrally maintained.

*Of course we do see people with acute disc injuries, for example, who respond very well to surgery, and even people have had back problems for a long time who respond well to surgery – not necessarily as a result of it but it does confuse the issue.*

I have gone into this issue of the relentless search for a peripheral cause which is prevalent across our culture, with patients who have been bounced from the primary care doctor to the orthopaedic surgeon to the neurosurgeon and others, every one of whom have reinforced the assumption that there is something the matter with their back: ruptured discs and hairline fractures etc. - but I am not sure what fraction of the pain population starts that way. You often see patients who insist that their pain started on the day they did such-and- such but when you look at picture of the spine there are changes which must have been present for years.

*I want to come back to something you said earlier. Clearly there is no peripheral traumatic damage in many centrally mediated pains yet still people feel pain in a specific peripheral area. Could the trauma or noxious event be psychological trauma and things like Adverse Childhood Events or chronic stress How can we begin to look at those insults? and could these things be resolved rather than pursuing the peripheral?*

I think the answer is yes but I am not sure how. I know psychological processes can create images that are not based on the real world. We can imagine … we can recall … But I just don’t know how we can go after that problem. Things like ACE’s and stress are factors that are likely to lead to long term pain but the mechanism is not at all clear. And I don’t know how to lead from population-based data to any particular person.

*I am a clinical psychologist working with pain and I believe there are answers as to the psychological mechanisms underlying many peripheral pains including musculoskeletal pains like back pain. I say this because I use EMDR (eye movement desensitisation and reprocessing) which is dramatic in allowing the person to access what is underlying pain but not available to consciousness. This way you can actually ‘flush out’ the links to previous traumatic events in life which may or may not be in early childhood. Sometimes these are symbolic and sometimes seem to be completely bizarre and unguessable. EMDR enables the person to access the inner mind which does the sorting out and healing just as the body does the healing physically - a good analogy. If you let the mind heal itself you can speed the whole thing up and I would expect the back pain to be resolved within three or four sessions. When we talk about nerve pains and central pains that is a different animal: there are techniques such as imagination techniques that can soothe such pain but we haven’t the same ability to vaporise it as we have with back pain.*

We call back pain musculoskeletal because we assume that the pain is in the major things in your back: muscles and skeleton without any evidence. It is human nature to expect the explanation of the pain to be found in the site of the pain.

*If I can be a bit trivial about it: you can go into stress with a desire to kill someone but you have to stop yourself which is expressed in tension which you aren’t necessarily aware of especially if you are working for a boss for a long time and you want to kill him you become numb in that area …. [laughter]*

*Some people are very convinced that they have sustained some physical injury to the back or whatever and I find it very hard to introduce these concepts. If you suggest that their pain is rooted in their emotions they get pretty het up … “you think I’m making it up … you think it’s all in the mind….”*

When I run into that kind of patient I tell them that the brain is the organ for pain and decapitation always cures it! So then I say “until I mentioned it you didn’t feel the collar on the back of your neck … or - until I mentioned it you weren’t aware of the air-conditioning making a noise …” Our brains focus on what is of greatest interest to us, and we can teach peoples’ brains to focus on some things rather than others. So I don’t think that your pain is all in your head, but I do think there are strategies you can learn to help you to resist the pain.” Sometimes that works.

*There are a lot of people who are not in pain who when you scan them have physical changes which you would usually link to pain, like joint pathology or a disc bulge. So with central pain: although we often don’t find anything sometimes we do. I’m not sure if there is a tidy way of explaining pain on the acute/chronic or even the peripheral/central classifications that is always adequate for the individual person in front of you. There are so many paradoxes: I have met people with awful lives who don’t have chronic pain and conversely some people who have wonderful lives who do.*

 *I work in Blackpool and my population has masses of chronic diseases and chronic pain so there is an undeniable link between poverty and long-term disease, pain and medication problems …*

Human beings are exquisitely sensitive to their environment and environmental factors are very important but often overlooked. Our healthcare system is so focussed on the individual and the surround of the individual that we fail to identify things we could do to improve things. Years ago Bill Fordyce and a large group did a study of the Boeing airplane manufacturer here in Seattle. They asked the workers what they thought of their job: whether they liked of disliked it, if it was physically stressful etc. etc. Then they asked the supervisors to assess the workers in a large range of categories. They found that if you looked at the people in the workforce who made a claim for back pain it had nothing to do with the physical factors of the job, but was primarily related to what the supervisor thought of the worker and what the worker thought of the job and the workplace environment. So social factors were the primary determinants of whether you submitted a claim for back pain.

 There is one more variable in the pain population which is what they do about it. If you go to a shopping mall and ask people if they ever have back pain 80% of them will say yes. But only 5% will say they have ever sought help for back pain. So what’s going on? How do you incorporate that in your understanding of the prevalence of back pain and its importance?

*Everybody responds differently to different life or social situations so it’s a very messy picture. I like your model; I think it’s still too simplistic for what we see when we try to help people – but it is much better than acute/chronic*

*It ties in a lot with the idea of pain as a protective system. It should help to lessen the sense of danger associated with pain and ways for patients of making things safer so we can improve their pain and their movement.*

*Talking about education: lifting and handling training in industry is a great opportunity for OT’s to reassure people that the back is really strong and difficult to damage*

*I think one answer to my earlier question about neurophysiologists and subsequent ones suggesting that the new model might be too simplistic because it doesn’t necessarily cover every variant of pain is that that doesn’t really matter much because it is of such tremendous practical value.*

 *I wonder what the reaction will be in the medicolegal world? My experience of lawyers is that they want to establish an unbroken line of cause and effect from a minor injury seven years ago to the fact that the poor chap seems to be totally crippled now without any intervention of other factors, which is of course a total nonsense. So I wonder what will be their reaction to your new classification?*

I don’t know the answer to that. My hunch is that at least with American jurisprudence they are looking for a peripheral cause and will not like the idea that this is a central pain maintained by activities which are unrelated to the injury.

*It is now well established in the medicolegal world in the UK that conditions such as fibromyalgia can be triggered, uncovered or made worse by the stress of trauma and many cases are settled on that basis.*

Ironically physical exercise is often a very good treatment for FMS. Patients face this paradox that activity makes it worse but the doctors tell me that it makes me better.

*Neurostimulation, neuromodulation, is becoming more popular as a treatment as other treatments dry up. I can see you shaking your head as you probably have the same reservations about it as I do but stimulation of the nervous system would seem to be a good thing based on our experience of exercise based therapies: keeping the body moving and nature ticking over.*

I spent 40 years putting in spinal cord and peripheral nerve stimulators if I thought they would help and I have an inherent bias in the matter based on my experience. But the marketing world has totally overwhelmed the scientific world in terms of efficacy, likelihood and duration of success and potential problems. I am aware of the literature on the various types of stimulation and its proponents claim a very high utility. Time will tell: SCS has been around since the 70’s and they are much better now in terms of the electronics and the electrodes. I would argue that although some carefully selected patients do have good long-term benefits the question remains what fraction of the world that is true about. But remember: in many of those cases we are treating what went wrong at the time of surgery and we need to go back one step and question why they needed that initial surgery. If surgery works you are home free but if it doesn’t you are in for a long-term problem.

*Thinking about the terminology: I just wonder if chronic pain coming from the periphery but perpetuated by central sensitisation would be best defined if each individual person had their own landmark as to when it becomes chronic as in some patients there is still healing at three months.*

I don’t like the acute/chronic dichotomy; I would prefer long-term peripherally generated pain from, for instance an arthritic knee , as removal of the pain generator, the joint, can cure the pain. But the surgical approach can lead to a new peripheral pain problem, namely muscle pain. There is some interesting evidence related to hip replacement that the surgical approach, whether lateral of posterior, is a major determinant of the occurrence of post-operative pain. But this has nothing to do with the original hip joint.