



UNIVERSITY OF LEEDS

This is a repository copy of *Ms. A.M. Taylor, et al reply*.

White Rose Research Online URL for this paper:
<http://eprints.whiterose.ac.uk/109502/>

Version: Accepted Version

Article:

Taylor, AM, Taylor, JO, Singh, JA et al. (7 more authors) (2016) *Ms. A.M. Taylor, et al reply*. *Journal of Rheumatology*, 43 (4). pp. 826-827. ISSN 0315-162X

<https://doi.org/10.3899/jrheum.151456>

Reuse

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.



eprints@whiterose.ac.uk
<https://eprints.whiterose.ac.uk/>

Response to comment on: Is Chronic Pain a Disease in Its Own Right? Discussions from a Pre-OMERACT 2014 Workshop on Chronic Pain

We thank Drs Ruan and Kaye for their comments on our paper. The topic, we feel, is important so further debate around what chronic pain is helps to refine our thinking.

Voting was undertaken using a computerised, button press system and the responses were therefore accurately recorded. Rather than being surprised at the 9% response rate that chronic pain is a 'disease', we felt the 31% who responded 'none of the above' was more puzzling. On reflection, it may be that the cases presented around what chronic pain actually is could have been stronger or that it was a relatively new concept to ask participants to change their existing opinion, that chronic pain is a symptom, to one that embraces pain as a disease and hence participants were left wanting more information before they decided. As you have correctly suggested, the response may also reflect how 'disease' was defined. A 'blanket' definition of chronic pain as a disease also may not be appropriate and the definition may depend on the chronic pain condition. Indeed, in someone with new-onset rheumatoid arthritis for instance, pain could be seen as a symptom of this condition and managing the condition may lead to the symptom of pain being reduced. However, in chronic low back pain, the individual may have large psychosocial issues mediating the pain experience and the lack of a specific diagnosis and the chronic nature of the experience may render this as a disease. This supports your contentions that persistent pain is multifaceted and can be considered to have different impacts on individuals and may be related to different rates of progression and the impact the pain has on function, mood, lifestyle etc. We agree that there is a spectrum where persistent pain could range from being a symptom of a disease to a disease in itself depending on its impact and peripheral and central neuroplasticity.

The term 'long term condition (LTC)' was used because in the UK, the British Pain Society, Chronic Pain Policy Coalition, Pain UK and other chronic pain stakeholders have worked hard to raise the profile of those living with or experiencing chronic and persistent pain. Having persistent pain mandated as a LTC meant that services for persistent pain could become more equitable to those for other LTCs and would no longer be dismissed as a symptom. In 2008, the Welsh Government accepted that persistent pain was a LTC, and this was followed by other countries within the UK. The consideration, in the UK, that pain is a LTC should mean that those living with persistent pain are managed using multidisciplinary models of care and that most management centres around community and primary care, yet as with other LTCs, still have access to specialist multidisciplinary teams (see Fig 1).

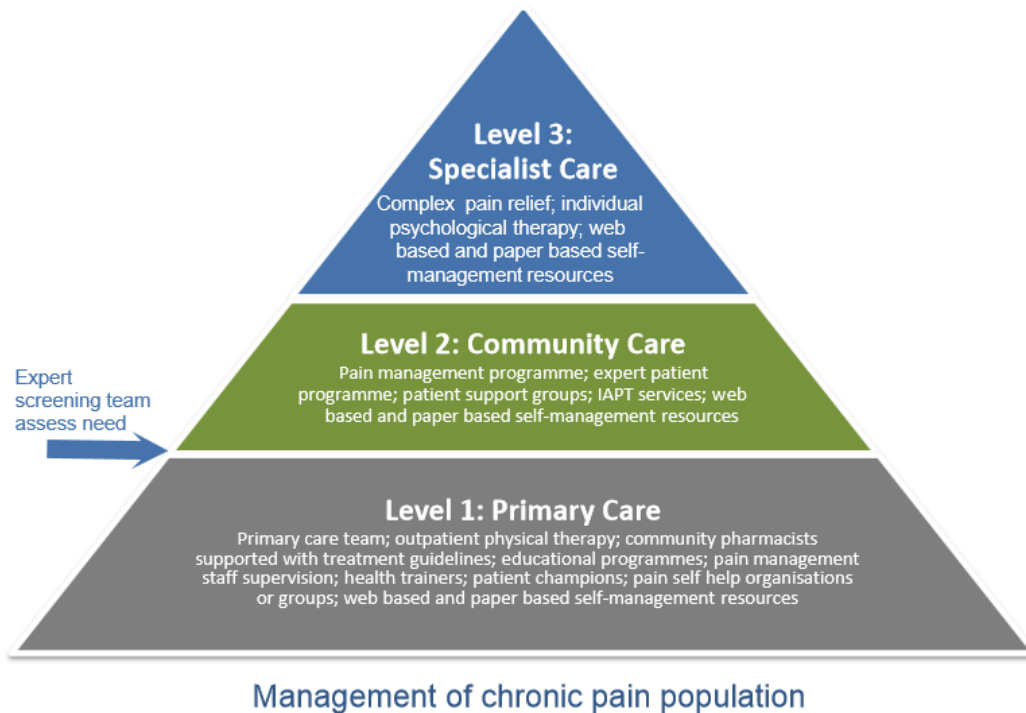


Fig.1. How pain services will be delivered (5)

We agree that it is important to define persistent pain in a scientific, yet practical way but do not agree that biological measures have had almost no impact on psychiatric practice. Neuroscience has made a number of contributions using fMRI techniques and brain markers for diagnosis in a number of psychiatric conditions (1-4). However, as you state, there exists a large body of evidence now illustrating peripheral and central neuroplastic reorganization underlying the *disease* of chronic pain which is influenced by biopsychosocial factors.

There are advantages for using the ‘multifaceted disease’ model of persistent pain as you rightly address. Seeing persistent pain as a LTC and/or a disease is a relatively new concept and conversations such as these help to encourage clinicians to think about the individual living with persistent pain holistically rather than as a symptom which needs to be medically managed with, say for example drug therapy. In closing, we applaud the final sentence in your letter, that we should do anything within our power to help those living with persistent pain and would add the importance of shared decision making and evidence-based practice to this power.

References

1. Bleich-Cohen M, Jamshy S, Sharon H, Weizman R, Intrator N, Poyurovsky M, et al. Machine learning fMRI classifier delineates subgroups of schizophrenia patients. *Schizophr Res.* 2014 Dec;160(1-3):196-200.
2. Agarwal N, Port JD, Bazzocchi M, Renshaw PF. Update on the use of MR for assessment and diagnosis of psychiatric diseases. *Radiology.* 2010 Apr;255(1):23-41.
3. Koutsouleris N, Meisenzahl EM, Davatzikos C, Bottlender R, Frodl T, Scheuerecker J, et al. Use of neuroanatomical pattern classification to identify subjects in at-risk mental states of psychosis and predict disease transition. *Arch Gen Psychiatry.* 2009 Jul;66(7):700-12.

4. Fu CH, Mourao-Miranda J, Costafreda SG, Khanna A, Marquand AF, Williams SC, et al. Pattern classification of sad facial processing: toward the development of neurobiological markers in depression. *Biol Psychiatry*. 2008 Apr;63(7):656-62.
5. Johnson M, Hart O, Taylor AM, et al (2013). *Pain Management Services: Planning for the Future Guiding clinicians in their engagement with commissioners*. Royal College of General Practitioners: London.