A new working definition for pain

The understanding of pain has developed dramatically in the past 70 years. Among the many developments, we now understand and accept that the brain is central to the pain experience.

Colleagues at Macquarie University in Sydney have produced an infographic that summarises six tenets of the contemporary understanding of pain (Figure 1). Our work here at NeuRA integrates and builds upon these principles. We think that this graphic is a meaningful clinical tool for patient education and a useful reminder to busy clinicians.

The understanding of pain continues to progress. Recently, the International Association for the Study of Pain (IASP) adopted a third working definition for pain – nociplastic pain. This accompanies the now familiar nociceptive pain and neuropathic pain as ‘mechanistic descriptors’ of pain. The concept of nociplastic pain is intended to cover those pain experiences that are not well explained by the nociceptive or neuropathic descriptors.

To read more, please visit: https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=6862

Kosek et al. (2016). Do we need a third mechanistic descriptor for chronic pain states?

There have been 3 interesting ‘Letters to the Editor’ published in PAIN in response to this proposal to adopt a third working definition for pain:


In other news, the RESOLVE team has been celebrating as we reached, and passed the 50% recruitment mark. However, we still have 121 participants remaining to recruit! We will be very appreciative of you continuing to refer your patients with chronic low back pain to the trial.

Participant Eligibility

- Patients with non-specific CHRONIC low back pain (this episode of LBP for greater than 3 months)
- No known or suspected serious spinal pathology
- Pain between 12th rib and buttock crease (with or without accompanying non-radicular leg pain)
- Age 18 - 70
- Live in the Sydney Metropolitan area and able to travel to Randwick for treatments
Although most people with a new episode, or acute, LBP recover in a few weeks or months, around one-quarter of patients who present to primary care develop chronic LBP (pain lasting for longer than 3 months). There are important differences between the management approaches for persistent and acute low-back pain, as endorsed by both the US and UK guidelines for the management of non-specific low back pain. Recent evidence suggests that non-pharmacologic options (see below) may provide modest effects on pain intensity as well as function for persistent low back pain.

**MANAGEMENT RECOMMENDATIONS**

**Nonpharmacologic**
- Exercise
  - Structured
  - Group
- Spinal manipulation
- Psychological therapies
  - Cognitive behaviour therapy
  - Behaviour therapy
- Multidisciplinary therapy
  - Combining physical and psychological therapies

**Pharmacologic**
- Consider pharmacological therapies* if non-pharmacological therapies (as above) are unsuccessful
  - Non-steroidal anti-inflammatory drugs
  - Opioids (see Box 1)
    - Not endorsed by UK guidelines
    - Only as last resort by US guidelines
  - *Lowest effective dose/shortest period of time possible

**Not recommended for chronic non-specific LBP**
- Surgery, injections and denervation procedures
- Routinely offering imaging including x-ray, CTs or MRIs
- Bed rest, electrotherapy, traction, orthoses

**Box 1**

**Opioids and chronic low back pain**

The issue of choosing opioids can be a confusing, and potentially dangerous decision for patients—they need reliable information and a good medical team to help with decisions.

A possible starting point for a conversation about opioids could go like this:

“Most people get a few hours of pain relief from an opioid medication. However, when it comes to persistent pain, an opioid is a bit of a problem. There are two reasons for this—one is that it is addictive and some people start to crave it. The other reason involves the biological effects that opioids have on our danger pathways. While an opioid dampens down danger messages in the central nervous system, thus decreasing pain, it also activates immune cells that can make the danger pathways more efficient. This will normally increase pain. Over time, the balance between the anti-danger effect and the pro-danger effect shifts towards an overall danger effect. In this situation, the opioid is actually making the pain worse.”

1. Hush, Julia et al (2018). Embedding the IASP pain curriculum into a 3-year pre-licensure physical therapy program: redesigning pain education for future clinicians PAIN Reports Volume 3(2)p e645