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Letter to Editor

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Conflicts between IASP´s new criteria for primary chronic pain and ACR´s fibromyalgia classification criteria

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Letter to editor

In 2015, the new classification of chronic pain for ICD-11,[1] developed by the International Association for the Study of Pain (IASP), were published[1] and they have begun a kind of revolution in the field of medicine for those of us dedicated to treat patients suffering from chronic pain, which has been accentuated by the introduction of the concept of chronic pain as a disease and not merely as a symptom.[2] Although virtually no author has declared themselves a fan of the taxonomic aspect that such a subjective and scarcely measurable pathology has acquired, we did acknowledge the need to adopt a stance regarding painful pathologies that exhibit or may develop central sensitization, now framed within the so-called "primary pain" or "nociplastic pain". This is in order to legitimize its existence and management in the consultations of any reputable health specialist, without undermining the attention to a patient often mistreated by the system. For clarity, chronic pain has been defined as pain that persists or recurs for longer than three months and has been divided into 7 codes. First of all include all chronic primary pain syndromes, where pain is considered as a disease and the other 6 codes include all chronic secondary pain syndromes where the pain manifests as a symptom due to other diseases as the underlying cause: chronic cancer related pain, post-surgical or posttraumatic pain, neuropathic pain, headache or orofacial pain, visceral pain and musculoskeletal pain.[2]

Chronic Primary Pain (CPP) is defined as "pain in one or more anatomical regions that persists or recurs for longer than 3 months, is associated with significant emotional distress (eg, anxiety), and/or significant functional disability (interference in activities of daily life and participation in social roles) and the symptoms are not better accounted for by another diagnosis".[1–3] That means that the pain is not due to a nociceptive process and has characteristics of nociplastic pain, defined as pain that arises from altered nociception despite there being no clear evidence of actual or potential tissue damage that would cause the activation of peripheral nociceptors, nor evidence of disease or injury of the somatosensory system that would cause pain.[4] As CPP, various diagnostic categories have been grouped: generalized chronic pain, complex regional pain syndrome, primary orofacial or cranial pain, primary chronic visceral pain and primary chronic musculoskeletal pain.[1–3] Generalized chronic pain seems to be the main category, within which fibromyalgia (FM) has been included as the only heading. Here lies the moment when the contradiction between the IASP definition of CPP in general, and fibromyalgia in particular, and other classification criteria for Fibromyalgia, which I consider now outdated, becomes apparent.

As contemplated by the IASP definition, the diagnosis of widespread chronic pain, and consequently, fibromyalgia, is appropriate when the pain is not directly attributable to a nociceptive process and there is no actual or potential tissue damage to the somatosensory system.[3] Similarly, the ACR 2010 criteria also stipulate that for the diagnosis of FM "the patient does not have a disorder that would otherwise explain the pain".[5,6] However, the 2016 ACR argue that "a diagnosis of FM is valid irrespective of other diagnoses and it does not exclude the presence of other clinically important illnesses".[6] While I do not disagree with this assessment, the elimination of the exclusion criterion means that any disease or overlap of diseases that cause widespread pain and somatic symptoms will lead to a diagnosis of FM, regardless of the underlying pathology causing or accompanying the aforementioned symptoms. Thus, the 2016 criteria, or even the new modification made at the beginning of 2019, contradict the new IASP classification and under my point of view they overdiagnose FM.[5–7]

At the Interdisciplinary Unit for the Study and Treatment of Primary Chronic Pain and Fibromyalgia that I coordinate at the Barcelona Clínic Hospital, we receive a large number of patients from the consultation of other specialists (primary care physicians and rheumatologists above all) diagnosed with FM using the 2016 or 2019 criteria mentioned earlier.[6,7] To confirm or rule out the diagnosis, we use a dual approach. On one hand, we use the sensitivity points from the ACR1990 criteria, solely with the goal of determining if the patient suffers from widespread hyperalgesia (when pain occurs applying 4 kg of pressure or less with an algometer at least in 11 of the 18 predetermined points);[8] this allows us to rule out FM since hyperalgesia is a sine qua non condition.[9] If these are positive, we apply the ACR 2010 criteria,[5] which do include the exclusion criterion and do not contradict the current IASP CPP classification, and if the patient meets them, we confirm that it is indeed fibromyalgia. If they do not met, we use these latest to assess what kind of pathology associated with chronic pain the patient presents. Of the 481 patients referred and attended over the past two years in our specialized Interdisciplinary Unit, only 30% of patients diagnosed with 2016

and/or 2019 criteria, met true criteria for FM, meaning that they met 2010, 1990 and IASP criteria. We confirmed that the remainder of the patients suffered from secondary, primary, or mixed musculoskeletal pain (such as chronic myofascial syndromes or hyperalgesia with a spinal origin); autoimmune diseases that went unnoticed (particularly Behçet's disease, Sjögren's syndrome and autoinflammatory syndromes), inflammatory diseases (mainly the enthesitic phenotype of spondyloarthritis, or mild psoriatic arthritis), celiac disease, small fiber neuropathy in the context of metabolic, autoimmune or hormonal diseases, neuropathies due to toxins (after chemotherapy, for example), arthralgias due to tamoxifen or aromatase inhibitors, neurological diseases (incipient Parkinson's, multiple sclerosis that goes unnoticed), Asia syndrome, opioid-induced hyperalgesia, etc.[10]

What should we do, then, those of us dedicated to diagnosing FM? Among the recommendations of EULAR (European League against Rheumatism) and GEFISER (Fibromyalgia Group of the Rheumatology Spanish Society) is, of course, the premise that when the disease is suspected, the diagnosis should not be avoided, as this saves visits to multiple specialists, unnecessary tests and invasive procedures. I agree with this point. But what happens if the existing criteria are leading to an overdiagnosis of the disease? Being cautious seems most appropriate and, from my experience, I lean towards the new IASP classification, and the ACR1990 and 2010 criteria together, which respect the premises of the previous ones, as they bring greater specificity and thus more precise diagnostic criteria to patients presenting with central sensitization. This allows for a more targeted approach when applying new therapies, based on the origin of the symptom as well as a more simplistic prognostic orientation. As an example, our interdisciplinary therapy on a patient with FM does not yield the same prognostic outcome as on a patient with extensive chronic pain (secondary to central sensitization) of spinal origin (50% improvement after treatment in the first group versus 67,9% improvement in the second one). Now that the paradigm of chronic pain is changing and booming, we should review the diagnostic or classification criteria for Fibromyalgia.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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