

To the Editor:

We thank Drs. Ruan and Kaye for their comments¹ on our paper². The topic is important, so further debate over what chronic pain (CP) is helps to refine our thinking.

Voting was undertaken using a computerized, button-press system and the responses were therefore accurately recorded. Rather than being surprised at the 9% response rate that CP is a “disease,” we felt that the 31% who responded “none of the above” was more puzzling. On reflection, it may be that the cases presented around what CP actually is could have been stronger or that it was a relatively new concept to ask participants to change their existing opinion that CP 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 CP as a disease may also not be appropriate and the definition may depend on the CP 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 regarded as having different effects on individuals, and may be related to different rates of progression and the effect that the pain has on function, mood, lifestyle, etc. We agree that there is a spectrum in which persistent pain could range from being a symptom of a disease to a disease in itself depending on its effect and peripheral and central neuroplasticity.

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

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 effect on psychiatric practice. Neuroscience has made a number of contributions using functional magnetic resonance imaging techniques and brain markers for diagnosis in a number of psychiatric conditions^{3,4,5,6}. However, as you state, there exists a large body of evidence now illustrating peripheral and central neuroplastic reorganization underlying the disease of CP, 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 an LTC and/or a disease is a relatively new concept and conversations such as these

help to encourage clinicians to think holistically about the individual living with persistent pain, rather than regarding pain as a symptom that needs to be medically managed with, for example, drug therapy. We applaud the final sentence in your letter: we should do anything within our power to help those living with persistent pain. We add to this power, the importance of shared decision making and evidence-based practice.

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