A Classification of Chronic Pain Syndromes for ICD-11

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Background
Chronic pain is a major source of suffering and affects c. 20% of the global population,1,2 accounting for 15-20% of physician visits.1,2 Despite its importance, chronic pain syndromes currently are not represented in the International Classification of Diseases (ICD) in a systematic manner. The IASP has long advocated improvements in the classification system. In 2013, the IASP founded a Task Force chaired by Rolf-Detlef Treede and Winfried Rief and – in co-operation with the WHO – began working on a proposal for the classification of chronic pain.5

Definition of Chronic Pain
Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.6 Often, pain serves as a symptom warning of a medical condition or injury. In these cases, treatment of the underlying medical condition is crucial and may resolve the pain. However, pain may persist despite successful management of the condition that initially caused it, or because the underlying medical condition cannot be treated successfully.

Chronic pain is pain that persists or recurs for longer than 3 months. Such pain often becomes the sole or predominant clinical problem in some patients.6,8 As such it may warrant specific diagnostic evaluation, therapy and rehabilitation. Chronic pain is a frequent condition, affecting an estimated 20% of people worldwide.1,2,7,8

Specifiers
The chronic pain diagnoses can be combined with optional specifiers coding the temporal course, the presence of psychosocial factors and pain severity. Severity will be coded by a three-digit code, reflecting pain intensity, distress and disability, each assessed on a standardized rating scale (numerical or visual analogue).

Structure of the Pain Diagnoses

1 Chronic primary pain

1.1 Chronic widespread pain

1.2 Complex regional pain syndrome

1.3 Chronic primary headache and orofacial pain

1.4 Chronic primary visceral pain

1.5 Chronic primary musculoskeletal pain other than orofacial

2 Chronic cancer-related pain

2.1 Chronic cancer pain

2.2 Chronic post-chemotherapy pain

2.3 Chronic post-radiotherapy pain

3 Chronic postsurgical and posttraumatic pain

3.1 Chronic postsurgical pain

3.2 Chronic posttraumatic pain

4 Chronic neuropathic pain

4.1 Chronic peripheral neuropathic pain

4.2 Chronic central neuropathic pain

5 Chronic secondary headache and/or orofacial pain

5.1-5.8 Headache/orofacial pain attributed to... [various causes]

5.9 Chronic dental pain

5.10 Chronic headache/orofacial neuropathic pain

5.11 Headache/orofacial pain attributed to chronic secondary temporomandibular disorders

6 Chronic secondary visceral pain

6.1 Chronic visceral pain from persistent inflammation

6.2 Chronic visceral pain from vascular mechanisms

6.3 Chronic visceral pain from mechanical factors

7 Chronic secondary musculoskeletal pain

7.1 Chronic musculoskeletal pain from persistent inflammation

7.2 Chronic musculoskeletal pain associated with structural changes

7.3 Chronic musculoskeletal pain associated with a disease of the nervous system

References

Implementation and Expected Benefits
The diagnoses will form a virtual chapter of the 11th revision of the ICD. The ICD-11 supports so-called ‘complete coding’, enabling the user to code the chronic pain syndrome together with the etiological condition (if such a condition is identifiable). Rather than simply coding an etiological condition, this will permit explicit coding of chronic pain syndromes that constitute important health problems in their own right. The new classification will increase the visibility of chronic pain as a condition that requires special consideration and adequate – often multimodal – treatments.

In addition, hitherto neglected chronic pain conditions, such as e.g. chronic cancer-related pain, chronic neuropathic pain and chronic postsurgical and post-traumatic pain will be represented. The inclusion of the new diagnostic entity of chronic primary pain recognizes conditions affecting a broad group of patients with chronic pain who would not be adequately represented by etiologically defined categories.

Finally, the formulation of pain-specific specifiers taking into account the trias of pain intensity, pain-related distress and pain-related disability, allows an easy expression of these important parameters. It is hoped that this will strengthen the representation of chronic pain conditions in practice and research.

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The proposed classification of chronic primary pain for ICD-11

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Background

The etiology is unknown for many forms of chronic pain. These include: back pain (excluding those with specific musculoskeletal, like arthritis, and neuropathic bases), chronic widespread pain, fibromyalgia, and irritable bowel syndrome. The term “primary pain” was chosen in close liaison with the ICD-11 revision committee, for widespread acceptability, in particular, from a non-specialist perspective. It was also proposed that classifications of pain conditions should be cast in “positive” terms, in “observable” concepts, and that definitions by exclusion should be avoided.

Definition of Chronic Primary Pain (CPP)

CPP is chronic pain in one or more anatomical regions that is characterized by significant emotional distress (anxiety, anger/frustration or depressed mood) and functional disability (interference in daily life activities and reduced participation in social roles). CPP is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless a specific diagnosis would better account for the presenting symptoms. Specific diagnoses to be considered are chronic cancer pain, chronic postsurgical or posttraumatic pain, chronic neuropathic pain, chronic headache or orofacial pain, chronic visceral pain and chronic musculoskeletal pain.

Body System, Sites, & Dimensional specificity

CPP can occur in any body system (e.g. nervous, musculoskeletal, gastro-intestinal, & immune systems) or in any body site (face, low back, neck, upper limb, thorax, abdominal, pelvis, urogenital region), or in a combination of body sites (Widespread pain). Dimensional specificity: 3 dimensions: pain severity (intensity), emotional distress (negative affect), and functional disability (interference in daily life activities and social participation) are proposed. Each rated on a 0-10 scale to yield a severity code (0-3) for each dimension.

Chronic Primary Pain (CPP)

1 Chronic widespread pain
   1.1 Fibromyalgia

2 Complex regional pain syndrome
   2.1 Complex regional pain syndrome type 1
   2.2 Complex regional pain syndrome type 2

3 Chronic primary headache and orofacial pain
   3.1 Chronic migraine
   3.2 Chronic tension type headache
   3.3 Trigeminal autonomic cephalalgias (TACs)
   3.4 Chronic temporomandibular disorder pains
   3.5 Chronic burning mouth
   3.6 Chronic primary orofacial pain

4 Chronic primary visceral pain
   4.1 Primary (functional) chest pain
   4.2 Epigastric pain syndrome
   4.3 Irritable bowel syndrome
   4.4 Chronic primary abdominal pain syndrome
   4.5 Bladder pain syndrome
   4.6 Chronic pelvic pain

5 Chronic primary musculoskeletal pain
   5.1 Chronic primary low back pain
   5.2 Chronic primary cervical pain
   5.3 Chronic primary thoracic pain
   5.4 Chronic primary limb pain

x Other chronic primary pain
z Chronic primary pain, unspecified

Expected Benefits

• A neutral (non-pejorative) term for chronic pain when it does not meet criteria for a more specific diagnosis.
• Is categorical AND dimensional (which should facilitate research and outcome studies – with clearer specification of patients).
• Encourages clinicians to consider contributions of multiple dimensions to presenting features, rather than assumption of homogeneity associated with a single term (e.g. low back pain)

Case example (50 year old, injured male worker with low back pain for more than 3 months)

Diagnosis: 5. Chronic primary musculoskeletal pain

Characterization:
• Pain intensity: 6/10 (code = 2, moderate)
• Pain-related distress: 8/10 (code = 3, severe)
• Pain-related disability: 4/10 (code = 2, moderate)

Contributing psychosocial factors noted:
• Family dependent on his being fit and working
• Financial difficulties
• Fears pain might stop him working

Contributing physiological factors noted:
• Central sensitivity

Behavioural factors noted:
• Avoidance of activities expected to be painful

References

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The proposed classification of chronic cancer-related pain for ICD-11

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**Background**

A large number of people are affected by cancer and the prevalence is rising. For 2020, 17 million new cases are projected. In addition, treatment options for many cancer types have improved so that the survival rates have increased: 66% of people diagnosed with cancer survive for at least five years and 40% will be alive more than ten years after their diagnoses. Pain is one of the most feared aspects of cancer with a strong impact on the quality of life of those affected. In acute cancer, an overall prevalence of pain of 84% was estimated across different types of cancer, with 56% reporting moderate to severe pain last month at a frequency of several times per week. One third (33%) to 40% of cancer survivors (after curative treatment was completed) suffer from chronic pain.

Persisting pain following the acute phase of cancer can stem from the original neoplasm or its treatments. In ICD-11 a dedicated chapter caters for the classification of the neoplasms themselves. However, no codes are available for the classification of chronic cancer-related pain. In response to this and other shortcomings, the IASP established a Task Force for the Classification of Chronic Pain for ICD-11. The Task Force comprises pain experts from across the globe and has developed a new and pragmatic classification of chronic pain for the upcoming 11th revision of the ICD, which also proposes codes for chronic cancer-related pain.

**Chronic Cancer-related Pain**

1. **Chronic cancer pain**
   1.1 Chronic visceral pain from cancer-related pain. The chronic pain condition receiving the most attention in chronic pain research is pain caused by the cancer itself (primary tumor and metastases) or its treatment. It is distinct from pain caused by co-morbid disease. On average, each cancer patient will identify two distinct pains. In many patients, careful assessment is therefore required to distinguish pain caused by cancer from pain caused by cancer treatment or co-morbid conditions.

2. **Chronic post-chemotherapy pain**
   2.1 Chronic painful chemotherapy-induced polyneuropathy
   2.2 Chronic post-chemotherapy pain, unspecified

3. **Chronic post-radiotherapy pain**
   3.1 Brachial plexopathy
   3.2 Painful lumbar-sacral plexopathy
   3.3 Chronic post-radiotherapy pain
   3.4 Chronic post-radiotherapy pain, unspecified

x Other chronic cancer-related pain
z Chronic cancer-related pain, unspecified

**Chronic Treatment-related Pain**

Pain due to cancer surgery will be classified under chronic postsurgical pain. Chronic post-chemotherapy pain (including painful chemotherapy-induced polyneuropathy, CIPN) and chronic post-radiotherapy pain will revere their own diagnoses in the section on cancer-related pain. CIPN is a frequent side effect of several types of drugs commonly used to treat the cancer and the effects persist in 30% of treated patients beyond 6 months. Radiotherapy has many effects on subject tissue that continue long after the treatment has ceased. Chronic post-radiotherapy pain is rare, but few epidemiological data exist. When it occurs, post-radiotherapy pain is usually irreversible and progressive.

**Expected Benefits**

In the proposed classification, the original neoplasm can be coded independently of the different types of chronic cancer-related pain. The chronic pain condition receiving its own ICD-11 code will lead to several benefits:
- For research, uniform definitions will improve epidemiological and clinical research.
- For planning / public policy, the ICD-11 codes will increase the visibility of chronic cancer pain.
- For practitioners, ICD-11 codes for chronic cancer pain may facilitate reimbursement of long-term care for these chronic pain conditions.

Important prior work has been done to develop a consensus for assessment tools for cancer pain, mainly with the aim to improve the comparability of measures for clinical and research. This previous work has converged towards the Edmonton staging system, which focuses on measurement of the pain characteristics and can be integrated with the ICD-11 codes and in particular the specificers available for all codes.

**References**


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Background

There is a continuum of acute to chronic pain, with many chronic pain states starting after an acute pain episode, often initiated by surgery or trauma. There is increasing recognition that such chronic postsurgical and posttraumatic pain is more common than previously thought. The consequences of such pain are significant and result in considerable suffering, impaired quality of life and disability as well as having a huge economic impact.

Definition of Chronic Postsurgical and Posttraumatic Pain

Chronic postsurgical and posttraumatic pain is pain developing or increasing in intensity after a surgical procedure or a tissue injury and persisting beyond the healing process, i.e. at least 3 months after surgery or tissue trauma. The pain is either localized to the surgical field or area of injury, projected to the innervation territory of a nerve situated in this area, or referred to a dermatome (after surgery/injury to deep somatic or visceral tissues). Other causes of pain including infection, malignancy etc, need to be excluded as well as pain continuing from a pre-existing pain problem. Dependent on type of surgery, chronic postsurgical and posttraumatic pain often may be neuropathic pain. Even if neuropathic mechanisms are crucial, the type of pain should be diagnosed here. The postsurgical or posttraumatic etiology of the pain should be highly probable; if it is vague, consider using codes in the section of chronic primary pain.

Chronic Postsurgical and Posttraumatic Pain

1 Chronic postsurgical pain

1.1 Chronic pain after amputation

1.2 Chronic pain after spinal surgery

1.3 Chronic pain after thoracotomy

1.4 Chronic pain after breast surgery

1.5 Chronic pain after cholecystectomy

1.6 Chronic pain after herniotomy

1.7 Chronic pain after hysterectomy

1.x Other chronic postsurgical pain

1.z Chronic postsurgical pain, unspecified

2 Chronic posttraumatic pain

2.1 Chronic pain after amputation

2.2 Chronic pain after burns injury

2.3 Chronic pain after peripheral nerve injury

2.4 Chronic pain after central nervous system injury

2.5 Whiplash injury associated pain disorders

2.6 Chronic pain after musculoskeletal injury

2.x Other chronic posttraumatic pain (automatic)

2.z Chronic posttraumatic pain (unspecified)

Diagnostic Criteria

Conditions A – D are fulfilled:

A. Pain that began after surgery or a tissue trauma is experienced.

B. The pain is in an area of preceding surgery or tissue trauma.

C. The pain persisted for at least three months after the initiating event.

D. The pain is not better explained by an infection, a malignancy, a pre-existing pain condition or any other alternative cause.

Expected Benefits

The incidence of chronic postsurgical and posttraumatic pain is widely underestimated. Depending on type of surgery, between 2 and 15% of patients have pain with an intensity of >5/10 three months after their operation. The incidence of chronic pain after multitrauma lies in the range of 46 to 85%. Introducing the entity ‘chronic postsurgical and posttraumatic pain’ into ICD-11 will make this neglected health issue more obvious and permit collection of public health data related to this diagnosis.

Due to the different causality (surgical intervention vs. accidental injury) and also from a medico-legal perspective, a separation between postsurgical pain and pain after all other trauma was regarded as useful despite the fact that similar processes may underlie the ensuing pain syndrome. The new diagnoses will allow these pain syndromes to be coded in a comprehensive and straightforward manner, thereby improving their recognition. It is hoped that this increased recognition in time will translate into improved pain relief and access to multimodal treatments.

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The proposed classification of chronic neuropathic pain for ICD-11

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Background

Neuropathic pain is responsible for chronic pain in up to 10% of the general population. Because neuropathic pain is difficult to treat, patients are often referred to qualified specialists in pain management, pain clinics or multidisciplinary centers for advanced diagnostic evaluation and therapy. Considering its epidemiological significance and the therapeutic challenges associated with neuropathic pain, a systematic classification with unambiguous codes for the relevant disease entities is urgently needed in the next revision of the International Classification of Diseases (ICD).

Definition of Chronic Neuropathic Pain

Chronic neuropathic pain is chronic pain caused by a lesion or disease of the somatosensory nervous system. The somatosensory nervous system provides information about the body including skin, musculoskeletal and visceral organs. A lesion or disease causing neuropathic pain may involve peripheral or central structures of the somatosensory nervous system. Persistence or recurrence over ≥3 months defines chronic pain. The pain may be spontaneous (continuous or episodic) or evoked as an increased response to a painful stimulus (hyperalgesia) or a painful response to a normally nonpainful stimulus (allodynia). The diagnosis of neuropathic pain requires a history of nervous system injury, e.g., a stroke or nerve trauma, or disease, e.g., diabetic neuropathy, and a neuroanatomically plausible distribution of the pain. Negative (e.g., decreased or loss of sensation) and positive sensory symptoms or signs (e.g., allodynia or hyperalgesia) must be compatible with the innervation territory of the affected nervous structure. Demonstration of the lesion or disease involving the nervous system, e.g., by imaging techniques neurophysiological or laboratory tests, confirms the diagnosis of definite neuropathic pain.

Chronic Neuropathic Pain

1 Chronic peripheral neuropathic pain
   1.1 Trigeminal neuralgia
   1.2 Chronic neuropathic pain after peripheral nerve injury
   1.3 Painful polyneuropathy
   1.4 Postherpetic neuralgia
   1.5 Painful radiculopathy
   1.x Other chronic peripheral neuropathic pain
   1.z Chronic peripheral neuropathic pain, unspecified

2 Chronic central neuropathic pain
   2.1 Central neuropathic pain associated with spinal cord injury
   2.2 Central neuropathic pain associated with brain injury
   2.3 Central post-stroke pain
   2.4 Central neuropathic pain associated with multiple sclerosis
   2.x Other chronic central neuropathic pain
   2.z Chronic central neuropathic pain, unspecified

x Other chronic neuropathic pain
z Chronic neuropathic pain, unspecified

Levels of Diagnostic Certainty

The Special Interest Group for Neuropathic Pain (NeuPSIG) within the IASP has proposed a grading system to indicate the level of certainty with which neuropathic pain is determined in an individual patient. History, physical examination and confirmatory tests are the diagnostic underpinnings of possible, probable, and definite neuropathic pain (Fig. 1). An adaptation of this grading system was recently introduced for trigeminal neuralgia. Definitions of neuropathic pain entities in ICD-11 will incorporate these criteria of diagnostic certainty to support harmonization of the classification system with diagnostic criteria applied in epidemiological research, mechanistic studies and treatment trials.

Expected Benefits

Neuropathic pain is a major source of physical impairment, emotional and psychosocial distress. It requires multimodal treatment with a specific pharmacological component. However, precise information about its epidemiological impact and the treatment need in clinical practice is difficult to find, because relevant disorders are either inaccurately or not at all represented in ICD-10. The proposed systematic classification of neuropathic pain enables a better assessment of its prevalence and economic burden so that ICD-11 will provide a solid foundation for healthcare planning and resource allocation.

References


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The proposed classification of chronic headache and orofacial pain for ICD-11

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Background

• Chronic primary headache has a major impact on activities and participation in day-to-day life including mobility, interpersonal relations, life activities and social participation. Headache and migraine are listed by the WHO among the top 10 of most disabling conditions worldwide.
• Chronic orofacial pain (OFP) also has a significant impact on activities and participation in daily life, in particular stable employment, intimate and interpersonal relations, life activities, socialization, and eating.

Definition of Chronic Headache and/or OFP

• Chronic primary headache or OFP is defined as headache or OFP that occurs on at least 50% of the days during at least three months.
• Chronic primary headache or OFP is multifactorial: biological, psychological and social factors contribute to the pain syndrome. The diagnosis is appropriate independently of identified biological or psychological contributors unless another diagnosis would better account for the presenting symptoms.
• Other chronic headache or OFP diagnoses to be considered are listed under chronic secondary headache and OFP.
• The duration of pain per day is at least 4 hours (untreated) or several shorter attacks per day occur.

Detailed description

Temporal Properties

• Chronic primary headache or OFP may manifest at any age and largely depends on the specific diagnosis and its propensity for chronification. The exact temporal properties are defined at the level of the subtypes.

Investigation Findings

• There are no causal treatments for primary headache or OFP. Management protocols include acute and prophylactic drugs, psychological and behavioral interventions, physical therapy, bite splints, and more rarely intervention procedures. The precise management recommendations depend on the specific headache subtype or OFP diagnosis, and are specified at that level.

Expected outcome

• The new chronic pain classification for ICD-11 including chronic primary and secondary headaches and OFP is expected to increase awareness in clinic and research and improve care of these patients with disabling conditions.

References


The proposed classification of chronic visceral pain for ICD-11
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Background
Chronic visceral pain is persistent or recurrent pain that originates from the internal organs of the head/neck region and the thoracic, abdominal and pelvic cavities [1-4]. The pain is usually perceived in the somatic tissues of the body wall (skin, subcutis, muscle) in areas that receive the same sensory innervation as the internal organ at the origin of the symptom (referred visceral pain) [5]. In these areas, secondary hyperalgesia often occurs [6]; the intensity of the symptom may bear no relationship with the extent of the internal damage/noxious visceral stimulation.

Definition of Chronic Visceral Pain
Chronic visceral pain is persistent or recurrent pain originating from internal organs of the head/neck region and of the thoracic, abdominal and pelvic cavities [1,3,5,6,7]. The pain is perceived in the somatic tissues of the body wall (skin, subcutis, muscle) in areas that receive the same sensory innervation as the internal organ at the origin of the symptom (referred visceral pain) [1]. In these areas, secondary hyperalgesia (increased sensitivity to painful stimuli in areas other than the primary site of the nociceptive input) often occurs [1,5,7]. The visceral genesis of the pain should be highly probable; if it is vague, consider using codes in the section of Chronic primary pain. The intensity of the symptom may bear no relationship with the extent of the internal damage/noxious visceral stimulation [1].

Diagnostic Findings
Physical examination may demonstrate anatomical location concordant with the distribution of pain from a specific organ. Investigations are negative and may include blood/urine tests, endoscopies, X-rays, CT and MR scans. Sensory evaluation (measurement of pain thresholds) in visceral structures (e.g., balloon distension of GI tract) and/or somatic tissues may demonstrate decreased pain thresholds to different stimuli.

Chronic visceral pain
Categorized as chronic primary pain in the relevant section:

Chronic primary visceral pain
1 Primary (functional) chest pain
2 Epigastric pain syndrome
3 Irritable bowel syndrome
4 Chronic primary abdominal pain syndrome
5 Bladder pain syndrome
6 Chronic pelvic pain
x Other chronic primary visceral pain
z Chronic primary visceral pain, unspecified

Chronic secondary visceral pain
Categorized as chronic secondary visceral pain in the relevant section:

Chronic secondary visceral pain
1 Chronic visceral pain from inflammation
1.1 .... in the head/neck region
1.2 .... in the thoracic region
1.3 .... in the abdominal region
1.4 .... in the pelvic region
2 Chronic visceral pain from vascular mechanisms
2.1 .... in the head/neck region
2.2 .... in the thoracic region
2.3 .... in the abdominal region
2.4 .... in the pelvic region
3 Chronic visceral pain from mechanical factors
3.1 .... in the head/neck region
3.2 .... in the thoracic region
3.3 .... in the abdominal region
3.4 .... in the pelvic region
x Other chronic secondary visceral pain
z Chronic secondary visceral pain, unspecified

Expected Benefits
The ICD-11 supports so-called ‘complete coding’, enabling the user to code the chronic pain syndrome together with the etiological condition (if such a condition is identifiable). Rather than simply coding an etiological condition, this will permit explicit coding of chronic visceral pain syndromes that constitute important health problems in their own right. The new classification will increase the visibility of chronic visceral pain as a condition that requires special consideration and adequate – often multimodal – treatments.

The inclusion of the new diagnostic entity of chronic visceral pain recognizes conditions affecting a broad group of patients with chronic pain who would not be adequately represented by etiologically defined categories. A multidisciplinary approach involving physicians with expertise in viscera (e.g. specialists in internal medicine or gynecology) together with pain management specialists, psychologists and physiotherapists may be helpful in the management of complex functional and central pain conditions.

References

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The proposed classification of chronic musculoskeletal pain for ICD-11

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**Background**

Musculoskeletal pain - pain that is experienced in bones, joints, muscles, ligaments, tendons and spine - is one of the most common types of pain. It can be widespread or localized, acute or chronic. The proposed classification for chronic musculoskeletal pain aims to fuse concepts of underlying rheumatological disease and of pain pathophysiology, noting the poor correlation between pain and disease severity.

**Four Types of Chronic Musculoskeletal Pain**

**Chronic primary musculoskeletal pain** refers to chronic pain of uncertain pathogenesis manifest as (a) pain related to spinal structures for which there is no other explanation, and/or (b) pain experienced in musculoskeletal tissues, in regional or widespread distribution for which there is no other explanation.

**Chronic musculoskeletal pain from persistent inflammation** refers to pain conditions where inflammatory mechanisms in joints, bones or tendons are predominant. It is characterized by clinical features of inflammation, including increased sensitivity of the part to stimuli.

**Chronic musculoskeletal pain associated with structural changes** refers to pain of unclear mechanism(s) that is considered to be associated with anatomical changes in joints, bones or tendons. The structural change needs to be inferred from clinical examination and/or be demonstrable on imaging.

**Chronic musculoskeletal pain due to diseases of the nervous system** refers to pain experienced in joints, bones, tendons or muscles, but primarily related to peripheral or central neurological disorders. This category includes pain referred to musculoskeletal tissue from other somatic structures.

**Proposed ICD-11 Classification of Chronic Musculoskeletal Pain**

**Chronic primary musculoskeletal pain** (other than orofacial)

- 1 Chronic primary low back pain
- 2 Chronic primary cervical pain
- 3 Chronic primary thoracic pain
- 4 Chronic primary limb pain
- x Other chronic primary musculoskeletal pain
- z Chronic primary musculoskeletal pain, unspecified

**Chronic secondary musculoskeletal pain**

1 **Chronic musculoskeletal pain from persistent inflammation**
   1.1 ... due to infection
   1.2 ... due to crystal deposition
   1.3 ... due to autoimmune disorders
   1.x Other chronic musculoskeletal pain from persistent inflammation
   1.z Chronic musculoskeletal pain from persistent inflammation, unspecified

2 **Chronic musculoskeletal pain associated with structural changes**
   2.1 ... associated with osteoarthritis
   2.2 ... associated with spondylosis
   2.3 Chronic pain after musculoskeletal injury
   2.x Other chronic musculoskeletal pain associated with structural changes
   2.z Chronic musculoskeletal pain associated with structural changes, unspecified

3 **Chronic musculoskeletal pain associated with disease of the nervous system**

4**x Other chronic secondary musculoskeletal pain**

4**z Chronic secondary musculoskeletal pain, unspecified

**Expected Benefits**

Musculoskeletal pain represents a large number of painful conditions, that should be described independently from any underlying musculoskeletal disease or damage, since there is no good correlation between musculoskeletal disease and pain.

For the first time chronic musculoskeletal pain syndromes will be represented in the ICD in a comprehensive and systematic manner, including all dimensions and pain mechanisms, thereby improving their recognition.

This new classification provides a link between pain specialists and all specialists involved in musculoskeletal disease management. It will help to share new concepts and develop new approaches for pain, adapted to both pain mechanisms and the pathophysiology of musculoskeletal diseases. It emphasizes the fact that chronic pain is not a unique condition, and that pain mechanisms should be analyzed for optimal individual management.

It is hoped that in time this will translate into improved assessment for patients and access to multimodal management towards relief of pain and improvement in function.

**References**


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**ICD-11***
Towards Functioning Properties for Chronic Pain in ICD-11

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Background
The World Health Organization (WHO) has been working on the revision of 11th version of International Classification of Disease (ICD-11) since some years ago. This ICD-11 has a new content model. One of the sections in the content model contains the so-called functioning properties1,2,3. The functioning properties are derived from the component of activities and participation of the International Classification of Functioning, Disability and Health (ICF)4. Functioning properties are also applied for chronic pain. Thus, within the framework of the mutual recognition agreements, the International Association for the Study of Pain (IASP) collaborate closely with the International Society of Rehabilitation Medicine (ISPRM), particularly with ISPRM-WHO Liaison Committee and developed a proposal for the functioning properties for chronic pain.

Content Model of ICD-11

1. ICD Entity Title
2. Classification Properties
3. Textual Definitions
4. Terms
5. Body System/Structure Description
6. Temporal Properties
7. Severity of Subtypes Properties
8. Manifestation Properties
9. Causal Properties
10. Functioning Properties
11. Specific Condition Properties
12. Treatment Properties
13. Diagnostic Criteria

Parameters 1-7 are essential requirements for all categories [...] parameters 8-13 are essential for all new categories in alpha phase*1.

Acknowledgement
We thank Melissa Selb for her help in providing methodology approaches.

Methodology

- Working Basis: ICF Generic Set and additional item from IASP Experts
- Working Basis: ICF Core Set for chronic widespread pain
- Consensus meeting in Kuala Lumpur during the 10th World Congress of ISPRM 2016
- Results from consensus
- Re-discussed within IASP Task Force
- Re-discussed within ISPRM Team
- Combined of new proposal
- List of Functioning Properties for Chronic Pain in ICD-11 for field testing

Results

Functioning Properties for Chronic Pain in ICD-11 for field testing
1. Carrying out daily routine (d 230)
Carrying out simple or complex and coordinated actions in order to plan, manage and complete the requirements of day-to-day procedures or duties, such as budgeting time and making plans for separate activities throughout the day.

Results (continued)

2. Lifting and carrying objects (d 430)
Raising up an object or taking something from one place to another, such as when lifting a cup or carrying a child from one room to another.

3. Walking (d 450)
Moving along a surface on foot, step by step, so that one foot is always on the ground, such as when [...] walking forwards, backwards or sideways.

4. Moving around
Moving the whole body from one place to another by means other than walking, such as climbing over a rock or running down a street, [...] or running around obstacles.

5. Intimate relationship
Creating and maintaining close or romantic relationships [...] such as husband and wife, lovers or sexual partners.

6. Remunerative employment
Engaging in all aspects of work as an occupation, trade, profession or other form of employment, for payment [...] such as seeking employment and getting a job, doing the required tasks of the job [...] supervising other workers or being supervised, and performing required tasks alone or in groups.

7. Recreation and leisure (d 920)
Engaging in any form of play, recreational or leisure activity, such as informal or organized play and sports, programmes of physical fitness, relaxation [...] going to [...] museums, cinemas or theatres; engaging in crafts or hobbies, reading for enjoyment, [...] and travelling for pleasure.

References

Task Force Members
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Results of preliminary Field Testing of the proposed classification for chronic pain
Antonia Barke, Beatrice Korwisi, Winfried Rief, Rolf-Detlef Treede
& The IASP Task Force Chronic Pain Classification for ICD-11*

The IASP is an NGO in official relationship with the WHO

Background
As chronic pain syndromes currently are not represented adequately in the current edition of the International Classification of Diseases (ICD), the IASP has founded a Task Force chaired by Rolf-Detlef Treede and Winfried Rief. Over the last years, the Task Force has developed a proposal for the classification of chronic pain. It was decided to submit the proposal’s main diagnostic categories to a preliminary field testing.

Objective
The preliminary assessment of:
1) Exhaustiveness of the basic categories:
Are the proposed categories able to capture the majority of chronic pain syndromes?
2) Clarity of the category boundaries:
How many cases of chronic pain would be allocated more than one category?
3) Perceived utility of the categories:
How do clinicians rate the usefulness of the categories?
4) Diagnostic confidence:
How easy to use is the new classification? How confident do the coders feel regarding their choice of category?

Material and Procedure
Centers were provided with the definitions and diagnostic criteria of the seven top level categories:
1 Chronic primary pain
2 Chronic cancer-related pain
3 Chronic postsurgical and posttraumatic pain
4 Chronic neuropathic pain
5 Chronic secondary headache and/or orofacial pain
6 Chronic secondary visceral pain
7 Chronic secondary musculoskeletal pain

Tasks:
→ Allocate the new diagnoses to 100-150 consecutive patients
→ Rate usefulness and confidence:
How useful was the diagnosis? 0 = not at all to 3 = completely
How confident was your choice? 0 = not at all to 3 = completely

Utility of the proposed diagnoses and subjective confidence

Conclusion
The categories were exhaustive with less than 3% of cases regarded as unclassifiable. The categories were also mutually exclusive in that the coders were able to allocate single categories to the vast majority of cases. All categories were judged useful with particular emphasis on the newly introduced categories of chronic cancer-related pain, chronic neuropathic pain and chronic postsurgical and posttraumatic pain. The subjective confidence in allocating the diagnoses was good.

The classification performed extremely well and comprehensive field testing will commence in 2017.

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References

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Task Force Members

Participating Centers

<table>
<thead>
<tr>
<th>Institution</th>
<th>Country</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidisciplinary Pain Centers Nagakute, Tohon, Fukuoka, Tokyo, Osaka</td>
<td>Japan</td>
<td>151</td>
</tr>
<tr>
<td>Pain Medicine Center Royal Perth Hospital</td>
<td>Australia</td>
<td>62</td>
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<tr>
<td>DRK Pain Center (Mainz)</td>
<td>Germany</td>
<td>150</td>
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<tr>
<td>Oslo University Hospital, Dept. of Pain Management and Research</td>
<td>Norway</td>
<td>103</td>
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<tr>
<td>Edda Medical Center/ EF Leangen LS / Heimdal Helsehus, Trondheim</td>
<td>Norway</td>
<td>101</td>
</tr>
</tbody>
</table>

Total cases coded: 567