Physicians in the chronic pain field should participate in nosology and diagnostic criteria of medically unexplained pain in the Diagnostic and Statistical Manual of Mental Disorders-6 -Difference of diagnosis between psychiatric and chronic pain fields in nosology and diagnostic criteria of medically unexplained pain-

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text

Physicians in the chronic pain field should participate in nosology and diagnostic criteria of medically unexplained pain in the Diagnostic and Statistical Manual of Mental Disorders–6
-Difference of diagnosis between psychiatric and chronic pain fields in nosology and diagnostic criteria of medically unexplained pain-

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Abstract

In fact, a diagnosis of medically unexplained pain (MUP) is quite confused. The most common cause of the confusion is that psychiatric fields and chronic pain fields independently determine nosology and diagnostic criteria of MUP without exchanging views. Patients with MUP are diagnosed with having somatoform disorder (somatization disorder and pain disorder) or adjustment disorder in psychiatric fields. Patients with MUP are diagnosed with having fibromyalgia, chronic widespread pain, or chronic regional pain. When diverse medical theories collide, the solution is easy. Medicine is not a science that ascertains whether a medical theory is correct or not. Rather, medicine is a science that pursues a better treatment outcome. We should choose the medical theory that provides a better treatment outcome. It is necessary to compare the treatment outcome between somatoform disorder and FM. Psychotherapy is effective for both disorders, but the greatest difference is in pharmacological therapy. FM has many drugs whose efficacy has been confirmed with a double-blind study; however, somatoform disorder lacks effective treatments.

It is hoped that the American Psychiatric Association develops nosology and diagnostic criteria with central sensitivity syndrome such as FM in mind and in conjunction with physicians in the chronic pain field. When Diagnostic and Statistical Manual of Mental Disorders (DSM)-6 is developed, the nosology and diagnostic criteria of medically unexplained pain should be decided with physicians in the chronic pain field.

If a blood examination, imaging test, and physical examination are normal and pain distribution is not neuroanatomycally plausible, it is defined as medically unexplained pain (MUP). In fact, a diagnosis of MUP is quite confused. The most common cause of the confusion is that psychiatric fields and chronic pain fields independently determine nosology and diagnostic criteria of MUP without exchanging views. Previously, patients with MUP were referred to psychiatry based on the hypothesis that MUP is not physical disease but a psychiatric disorder or psychogenic pain. Psychiatry then had to determine a disease name. The disease name was altered to somatoform disorder (somatization disorder and pain disorder) or adjustment disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-Text Revision (TR).

Since the concept of burning mouth syndrome, fibromyalgia (FM), and restless legs syndrome developed from MUP, nosology and diagnostic criteria have largely changed in the chronic pain field, because specific treatment of these disorders improves the treatment outcome. The concept of central sensitivity syndrome (CSS) has been proposed [1] [2-3]. CSS is a syndrome that is caused by some sort of dysfunction or central sensitization. CSS includes chronic pain that was said to be MUP, major depression and anxiety disorder, etc.

If pain in five areas of the body (pain in the left side of the body, pain in the right side of the body, pain above the waist, pain below the waist, and axial skeletal pain) is present for at least 3 months with tenderness in at least 11 of the 18 specified tender points, the presence of a second clinical disorder does not exclude the diagnosis of FM [4]. There is not one diagnostic criterion of chronic widespread pain (CWP), but the diagnostic criteria [4] by the American College of Rheumatology are usually applied. According to the criterion, CWP is pain in five areas of the body that is present for at least 3 months. This is broadly-defined CWP, whereas narrowly-defined CWP excludes FM. Chronic regional pain (CRP) is usually pain that is broader than low back pain or stiff neck and does not satisfy the diagnostic criteria of CWP. If another clinical disorder accounts for the symptoms, it usually excludes the diagnosis of CWP and CRP.

FM usually occurs from low back pain and/or stiff neck (stiff shoulders) through CRP and CWP. Although reverse movement sometimes occurs, the prevalence of FM increases with age [5]. The relative severities of the clinical symptoms in each diagnosis group are FMS>CWP>CRP [6]. The prevalence of FM is approximately 2%[5]. Although the

prevalence of CWP is reported to be 5-18% [7] [8-13], the prevalence is usually over 10% (including 8.7% in males [13]) [7] [10] [11-13]. The prevalence of CRP is 1-2 times as frequent as CWP [7]. Treatment for CWP is usually identical to FM treatment throughout the world [14]. In all likelihood, the treatments are identical. If patients with CWP or CRP undergo FM treatment, the treatment outcome is better than the treatment outcome of FM [15] although there is no significant difference; therefore, CRP and CWP are thought to be gray areas or incomplete forms of FM.

As described above, the prevalence of FM, including gray areas or incomplete forms, is suspected to be at least 20%. CRP, CWP, and FM are typical disorders of CSS in terms of the prevalence, severity and/or area of pain, and diverse symptoms. CRP, CWP, and FM are often associated with various symptoms or disorders, such as anxiety disorder, major depression, fatigue, and impaired ability to concentrate.

The greatest confusion is in the diagnosis of CRP, CWP, and FM that were formerly MUP and are now included in CSS. CRP, CWP, and FM were named on the basis of nomenclature in the chronic pain field. Physicians who do not know or accept them often refer patients to a psychiatrist. Psychiatrists usually diagnose these patients with somatoform disorder (somatization disorder or pain disorder), and sometimes with adjustment disorder. I think the confusion is because nosology and diagnostic criteria in psychiatric fields have probably been developed by psychiatrists alone. Somatization disorder and pain disorder are actually CRP, CWP, and FM or their comorbidity. Basically, the diagnostic criteria of adjustment disorder do not include pain; however, pain is sometimes regarded as being due to adjustment disorder if patients are diagnosed with adjustment disorder. It is unacceptable for psychiatrists and physicians in chronic pain fields, such as rheumatologists and pain clinicians, diagnose the same patient with a different disease or disorder. This confusion is of a great problem in countries such as Japan where FM is not prevalent. Almost no Japanese psychiatrists know about or accept FM.

When diverse medical theories collide, the solution is easy. Medicine is not a science that ascertains whether a medical theory is correct or not. Rather, medicine is a science that pursues a better treatment outcome. We should choose the medical theory that provides a better treatment outcome. It is necessary to compare the treatment outcome between somatoform disorder and FM. Psychotherapy is effective for both disorders, but the greatest difference is in pharmacological therapy. FM has many drugs whose efficacy has been confirmed with a double-blind study; however, somatoform disorder lacks effective treatments

[16]. Psychiatrists usually prescribe a selective serotonin reuptake inhibitor (SSRI) over a tricyclic antidepressant (TCA) in patients with somatoform disorder (somatization disorder and pain disorder). In terms of the analgesic effect, TCA is superior to SSRI; therefore, although no study has compared directly the treatment outcomes of somatoform disorder and FM, it is speculated that the treatment outcome of FM is better than that of somatoform disorder. Much the same is true for adjustment disorder with severe pain. There are few or no drugs whose efficacy has been determined with a double-blind study of adjustment disorder.

Dr. Merskey, who is an authority in the chronic pain field, expressed the hope that both somatization disorder and pain disorder would be dropped in the forthcoming DSM-V [17]. Unfortunately, his hope is unlikely to be realized [18]. It would appear that the outline of DSM-5 has been determined. It is hoped that the American Psychiatric Association (APA) develops nosology and diagnostic criteria with CSS such as FM in mind and in conjunction with physicians in the chronic pain field. When DSM-6 is developed, the nosology and diagnostic criteria of MUP should be decided with physicians in the chronic pain field.

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