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Editorial

Can Addressing Somatisation Prevent Pain from Becoming Intractable?

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When pain persists past normal healing time [1], i.e., more than 3 to 6 months, it is termed chronic [2]. Chronic pain no longer has the 'safety warning' function of acute pain, and it therefore requires treatment in its own right [3]. Chronic pain affects an estimated 20% of people worldwide, and for this reason, its treatment should receive greater attention as a global health priority [4].

So-called "intractable pain" is generally considered to be a state of pain whose source cannot be removed, or which persists despite a long history of various interventions to control it, including surgery, nerve blocks, physical rehabilitation, and weak opioids [5]. Intractable pain is constant, debilitating and interferes with daily life, and without effective treatment may represent a considerable burden on the healthcare system, foreseeably for the lifetime of the patient. Furthermore, a history of associated treatment failures often leads people to display great emotional discomfort, maladjustment and psychiatric complications [6], which exacerbate physical disability and suffering, and therefore make pain even more difficult to treat. Nevertheless, a multidisciplinary approach has been shown to be effective in the treatment of intractable pain [7]. However, few studies conducted to date report useful criteria for intractable pain; Torrance., *et al.* [8] discussed the "refractory" terminology of neuropathic pain, and, using the international Delphi survey definition [9], defined the "refractoriness" of neuropathic pain for epidemiological research through the following key criteria: 1) at least 4 drugs of known effectiveness in neuropathic pain should have been tried; 2) each of these drugs should have been tried for at least 3 months, or until adverse effects have prevented adequate dosage or continued treatment; and 3) despite this treatment, the intensity of pain should not have been reduced by more than 30%, or should remain at a level of at least 5 on a 0 – 10 scale, and/or it should continue to contribute significantly to poor quality of life.

Poor treatment outcomes have been linked to somatisation in chronic lower back pain (LB) [10], and a greater association between somatisation and pain has been documented in subjects with LB [11], headache [12], migraine (HP) [13], and fibromyalgia (FM) [14]. In fact, the overlap of clinical and somatisation features in FM is so great that some researchers have suggested that FM is in fact a somatoform disorder [15]. Indeed, a retrospective study investigating 758 subjects with chronic pain found a close relationship between intractable pain and somatisation dimensions [16], and that somatisation changes the perception of pain, making it poorly controllable by common analgesic therapies. In this study intractable pain was defined as that meeting all of the following criteria: 1) pain persisting for over 6 months (chronic pain); 2) resistance to at least three common analgesic drug treatments for pain (or two in the case of opioid-based drugs); and 3) failure of at least one surgical or invasive procedure (nerve block, cortisone infiltration, facet joint injection, trigger point injection, local anaesthetic injection etc.), and/or a specific physical rehabilitation programme. Five hundred and twenty-six of the patients consecutively referred to our psychosomatic medicine centre (PMC) during the period 2002 – 2014 met these eligibility criteria for intractable pain, whereas 123 did not. In eligible patients, there was a prevalence of LB (46.57%), and the duration of pain of an intensity greater than 7 (0 – 10 range) was an average of 106.13 months (SD 129.54). The somatisation dimension, measured via the Symptom Checklist-90 (SCL-90) questionnaire [17], correlated with increased sensorial and affective dimensions of pain, increased intensity of pain, and reduced tolerance to cold pain stimulus.

High levels of somatic amplification (Somatosensory Amplification Scale; SSAS) [18] have also been correlated with increased sensorial and affective dimensions and intensity of pain, but in an age- and gender-related fashion. Specifically, older females tend to have a greater link between somatic amplification and the perception of pain. In addition to changing the perception of pain, somatisation dimensions have been correlated with higher pain duration and more widespread pain. Indeed, our unpublished data [16] show a statistically significant correlation between SCL 90 Somatisation scores and both pain duration (Pearson coefficient correlation: cc = 0.274; $p < 0.05$) and an increased number of tender points (cc = 0.369; $p < 0.05$). Moreover, SSAS showed a positive correlation with these parameters, which express a worsening of pain (cc = 0.183; $p < 0.01$ and cc = 0.293; $p < 0.01$ respectively).

A surprising secondary finding of this study was that people who continue analgesic therapy tend to do so not to ameliorate pain – in fact they do not report lower pain scores than those who stop using analgesic drugs – but instead to reduce psychological distress and somatisation. Indeed, those who continue analgesic drugs report lower levels of anxiety, affective disturbance and irritability [16]. Thus it appears that psychological components of pain, especially somatisation, are relevant factors in the management of chronic pain, and therefore need to be addressed in the management of chronic pain, especially in treatment-resistant cases. Self-management programmes have been proposed with this in mind [19], but their outcomes have thus far not been entirely promising. Hence the question remains: in order to lessen the burden on patients and the healthcare system, should we not bring forward psychological assessment and treatment, perhaps even to the onset of chronic pain, before it becomes intractable?

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