




Persistent Spinal Pain Syndrome: New Terminology for a New Era

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Pain medicine and treatment of chronic pain have evolved, with many new treatment options developed just in the past decade. Leaders in pain medicine recognize that terminology needs to keep up with our understanding of disorders, their pathophysiologies, and their treatment. In the 1990s, the term “complex regional pain syndrome” (CRPS) emerged from the work of an expert group convened by the International Association for the Study of Pain (IASP). The goal was an improved term for the conditions previously labeled “reflex sympathetic dystrophy” and “causalgia” that was more general and not specific to a certain pathophysiology. This effort also delineated the subtypes of complex regional pain syndrome. Despite the expert recommendation, there were objections from several fronts to the terminology, and adoption of the term was slow.¹ An analysis of publications from 2001 to 2012 identified that 79% used the new terminology, with a gradual increase over the time period.²

The terms “post-laminectomy syndrome” and “failed back surgery syndrome” (FBSS) were coined in the 1970s and then gained traction in the 1980s amid a discussion in the literature of approaches to treat persistent pain after spinal surgery. However, the terms are ambiguous, addressing a heterogeneous group of disorders that share the commonality of chronic pain and the experience of prior surgery after which pain either recurs or persists.

In a 2015 analysis, Al-Kaisy et al noted that the term “failed back surgery syndrome” is pejorative and ought to be changed.³ Without doubt, the term is rife with ethical implications. Progressively, it is apparent that patients with nonspecific back and other types of chronic pain are stigmatized and marginalized.⁴⁻⁶ Compounding matters, it has been argued that this stigmatization and marginalization has likely been exacerbated by the ongoing COVID-19 crisis.⁷ The impact of stigmatization and marginalization of these unfortunate patients has been devastating, including the deterioration of pain sufferers’ trust in health care professionals,⁸ quality of the pain care that patients receive,⁹ perceived injustice (which has recently been empirically related to greater pain severity and increased functional impairment),¹⁰ and exacerbated psychological distress¹¹ including increased depression and anxiety.¹²

Many patients whose pain is not substantially reduced by low back surgeries, irrespective of the reason, have few treatment options other than chronic opioid therapy. That there exists a copious body of literature demonstrating that opioid reliance exacerbates the stigmatization and marginalization¹³⁻¹⁷ of these patients is

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not surprising. Society uses a number of unflattering terms for those who are opioid-dependent, irrespective of whether they are medical or recreational users. Those who have a negative opinion on opioid use have done their best to influence policymakers and shame medical opioid users in a misguided effort to curb the illicit opioid crisis with which the United States is currently faced.^{18,19}

Additionally, the word “failed” in “failed back surgery syndrome” is ambiguous, which creates another ethical imbroglio. Due to its ambiguity, the question of whether the surgeon or the patient is “responsible” for the “failure” is not clearly answered. In the American pain care system, there exists the perception that blame for an inability to achieve symptom management is generally placed on the patient by the clinician.²⁰ Carr noted that, “Patients with pain need less stigma, not more.”²¹ Perhaps by replacing the rather draconian term, “failed back surgery syndrome” with a less pejorative and more accurate one will help Dr Carr’s beliefs regarding pain patients’ well-being become a reality.

In 2019, the IASP published a new classification of chronic pain, which will be incorporated within the International Classification of Disease (ICD-11).²² The IASP recommendations eliminate certain terminology such as FBSS in favor of “chronic pain after spinal surgery” (CPSS). As with the unveiling of the CRPS terminology in 1994, concerns have arisen about the categories and subdivisions within the IASP framework for chronic pain. While the elimination of the FBSS terminology may be welcome, the new framework does not fully account for all patients with chronic spinal pain. Therefore, an expert group of pain practitioners and neurosurgeons undertook its own process to identify better delineated labels that would specifically address the insufficiency of terminology to address surgical status of patients with spinal pain while replacing the problematic terminology of “failed back surgery syndrome”.²³ The proposed replacement terminology, “persistent spinal pain syndrome,” (PSPS) is divided into Type 1 (no surgery performed) and Type 2 (post-surgery). The IASP task force recommendations, while rejecting the non-sensical and non-diagnostic term FBSS, seem to fall short. The consensus committee makes an improvement with PSPS and the recommended subtypes and coding strategy.

The shift in medical culture required for the transition in terminology related to chronic pain will require time, and there are many issues as identified in the IASP article. Christelis et al state it clearly:

The wide and well-established use of the term FBSS by clinicians, in the published literature and by insurance carriers, the biomedical industries, commissioning and regulatory bodies, and government agencies will make its replacement complex and challenging.

Actually, that is an understatement. All of the existing literature uses a cohort defined in the traditional sense of FBSS beginning with seminal works of North²⁴ and Kumar et al²⁵ and carrying through to all of the more recent studies.

Access to some treatments is dependent on the diagnosis. For example, patients who are candidates for spinal cord stimulation often must carry a diagnosis of FBSS for insurance to cover the procedure. While many insurers may use the ICD-10 term “post laminectomy syndrome”, it is viewed as synonymous with FBSS and remains the requirement for payment by many. Because payers require this specific diagnosis for access to many advanced pain treatments such as neuromodulation, patients may be directed inappropriately towards surgery when it is not clinically prudent, yet is the only available covered option. There is an opportunity to improve access to treatment if diagnostic specificity is improved. By changing terminology, we better describe the clinical circumstance of the patient and his/her appropriateness for a specific treatment. Consider, for example, a patient who may have undergone all reasonable minimally invasive non-surgical spinal procedures and is not a candidate for spinal surgery. In these cases, because the patient has not undergone a laminectomy—and even though all medically appropriate interventions have been exhausted—the patient may not be able to access a trial of spinal cord stimulation due to insurance restrictions. The outmoded definition of FBSS impedes patient access to another avenue of pain treatment, for which the patient might be eligible if he or she were PSPS Type 1. Unfortunately, the converse is also likely. The potential unintended consequence of updating the ICD may be that payers will have new opportunities to deny coverage for patients currently covered but not so when the diagnoses become more granular.

The arrival of the new ICD-11 terminology will provide further clarity in communicating patients’ clinical circumstances. The recent proposal to adopt PSPS to describe patients with persistent spinal pain that may be amenable to interventional pain and neuromodulation treatments is valid and offers some benefits over the more general IASP terminology. Regardless of whether it

is CPSS (it has been adopted for implementation, but not until January 2022) or PSPS that becomes the final rubric, it will take some time to integrate. It is our obligation to design trials with better alignment of trial cohort characteristics to these diagnosis terms and to understand the cohorts of chronic spinal pain patients using these terms as effectively as possible. As such, the Journal of Pain Research and the American Society of Pain and Neuroscience support the new terminology of PSPS to improve the research and treatment, and reduce the stigmatization of this patient population.

Disclosure

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