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# Not really nice: a commentary on the recent version of NICE guidelines [NG193: chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain] by the Pain Net

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**Summary**
The National Institute for Health and Care Excellence should revise their recent guideline to take into account all the available evidence on the treatment of chronic primary pain.

**Keywords:** Chronic primary pain, NICE guidelines, Treatment approaches, Evidence-based, ICD-11

On April 7, 2021, the National Institute for Health and Care Excellence[14] published new guidelines to assess chronic pain (chronic primary pain, chronic secondary pain, or both) and to manage chronic primary pain (CPP) in persons at least 16 years old.[8] These guidelines will guide clinical practice in the United Kingdom (with the exception of Scotland) and provide the basis for what treatments can and cannot be offered within the National Health Service to a patient who presents with CPP.[9] Although aimed at informing the National Health Service, the new guidelines may precipitate international changes on how CPP is treated. Worldwide, NICE is regarded highly as an institution offering evidence-based advice. Their influence is evident in that other national guidelines often use them as a starting point.[11,17] In the context of CPP, these changes may be pernicious.

Chronic primary pain is the term that has been implemented in the latest revision of the International Classification of Diseases (ICD-11), which will come into effect in 2022 for global mortality reporting.[12,19] The diagnosis is part of a comprehensive new classification of chronic pain that also includes 6 categories of chronic secondary pain, in which the pain originally developed as a symptom of another disorder or disease process (eg, cancer, rheumatoid arthritis).[15,16] Chronic pain is defined as pain that lasts or recurs for longer than 3 months.[15,16] The syndromes that can be subsumed under CPP are characterized by significant functional interference or emotional distress, and they are not better accounted for by another (chronic secondary) pain condition.[10] As any pain, CPP is multifactorial: biological, psychological, and social processes all contribute to the pain.[10,12,15,16]

For the management of CPP, the new NICE guidelines foremost suggested nonpharmacological interventions, such as physical activity, and cognitive behavioral therapy. Biofeedback, transcutaneous electrical nerve stimulation, and ultrasound were not recommended for pain management. Although antidepressants may be suggested additionally, other medications such as benzodiazepines, antiepileptic drugs, nonsteroidal anti-inflammatory drugs, and opioids should not be offered.[14]

We welcome the foresight and vision with which NICE based their current guideline for pain treatment on the new ICD-11 chronic pain classification. However, and adding to the already voiced criticism,[3,13,14] we have 3 major points of concern.

First, NICE stated that there is no evidence regarding treatments for CPP.[14] This is not true. CPP is still a novel concept, and it cannot be expected that the term CPP is used in

*Sponsorships or competing interests that may be relevant to content are disclosed at the end of this article.*

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*PR9 6 (2021) e961*

*http://dx.doi.org/10.1097/PR9.0000000000000961*

studies that investigated treatments before the introduction of the term. Taking the absence of the term in earlier studies as an indication of the absence of evidence for CPP treatments is an anachronism that discards the available evidence. In this regard, the process of evidence synthesis that is applied by our team the Pain Net, an international network of researchers interested in the safety and efficacy of treatment approaches for CPP, is a good counterexample.[5] In our series of network meta-analyses on available interventions for chronic pain syndromes that are now subsumed under CPP, we have identified more than 60,000 publications and clinical trials. We question whether as part of the evidence review, a thorough investigation has been carried out for each individual condition classed under CPP.[18]

Second, the "one-size-fits-all" approach of the new CPP guideline disregards the unique demands put forth by the different syndromes. CPP is a broad diagnostic category that encompasses distinct diagnoses such as chronic primary low back pain (previously termed "chronic nonspecific low back pain"), irritable bowel syndrome (IBS), chronic migraine, and complex regional pain syndrome.[10] The similarities shared by these syndromes have guided their classification under a single diagnostic term. Their differences, however, inspire individualised treatment approaches. This is apparent when considering treatment recommendations for 2 highly prevalent CPP conditions: chronic migraine and IBS. For chronic migraine, the new CPP guideline contradicts the existing condition-specific NICE guidelines. There, NICE had previously advised the use of topiramate.[7] According to the new CPP guideline, only antidepressants should be offered to patients with CPP.[14] For IBS, the previous NICE guideline recommended diet changes[6] but this tailored advice has not been included in the latest CPP guideline. We recognize that the NICE committee strived to examine the assessment and management of chronic pain that is not addressed by the existing NICE guidance.[14] The move to a single broad universal guideline has given rise to confusion in both researchers and clinicians alike. Instead, we argue that the guideline should take into account that—although the individual CPP diagnoses share several features—treatments should also address the differences between them. Preceding recommendations across chronic pain syndromes point to the importance of individualized and interdisciplinary treatment as the gold standard for the treatment of CPP.[4] Related to that, the age cutoff chosen by NICE (ie, age 16) seems arbitrary, considering that—depending on the developmental stage—different age groups require tailored support.[1,11] Evidence that supports tailored pediatric pain management programs (eg, psychological pain treatment[2]) was not considered by NICE.

Third, it seems that NICE misrepresents the concept of chronic secondary pain, which also impacts the conceptualization of CPP. In the explanatory figure, NICE listed IBS as an example of chronic secondary pain,[14] whereas international experts who advised the ICD-11 update categorised IBS under CPP, more specifically, under chronic primary visceral pain.[10] By doing so, NICE failed to recognize that biological contributors do not exclude a CPP diagnosis.[10,15] CPP is not a diagnosis of exclusion but a condition in its own right where psychological, biological, and social factors all contribute to the pain, as also highlighted by other commentators.[1,3,10,14,15] Furthermore, in the abovementioned figure, NICE points out that in cases of chronic secondary pain, the NICE guideline for the respective underlying disease should be followed.[1] Although chronic secondary pain can be conceptualized as a symptom of an underlying disease, it still requires specialized interdisciplinary pain treatment in many cases.[15]

In conclusion, we call on NICE to revisit the wealth of existing CPP research, which up until recently has been performed under different nomenclature, and to change the guideline to reflect all available evidence. In line with the NICE Strategy Plan 2021 to 2026,[9] "up-to-date guidance that integrates the latest evidence" determine the decisions to make treatments available to patients or to withhold them. The fact that more research is needed that is based directly on the diagnostic formulations for the diagnoses in the new category of CPP does not justify disregarding the—clearly ontologically continuous—existing diagnoses and the vast body of evidence that exists regarding their treatment. Neglecting these fails the patients suffering from CPP and the community who NICE aspires to serve.

## Disclosures

B. Korwisi reports other from IASP, outside the submitted work. C. Locher received funding from the Swiss National Science Foundation (SNSF): P4P4PS_194536. H. Koechlin is sponsored by the Swiss National Science Foundation (SNSF) fellowship P400PS_186658. The remaining authors have no conflicts of interest to declare.

## Acknowledgements

The authors thank all members of the Pain Net for their ongoing work in the described network meta-analysis project. Members of the Pain Net are (in alphabetical order) A. Barke, C. Bruhin, J. Glatz, I. Ibragic, A. Kharko, H. Koechlin, B. Korwisi, C. Locher, L. Moll, C. Pawliuk, T. Probst, and D. Sezer. This work was supported by the German Research Foundation (DFG) within the funding programme Open Access Publishing.

**Article history:**
Received 3 June 2021
Received in revised form 8 August 2021
Accepted 11 August 2021

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