# DIAGNOSIS: NOTES AND DEFINITIONS

1. **Chronic Primary Pain (ICD-11)**

   "Pain in one or more anatomical regions that persists or recurs for longer than 3 months and is associated with significant emotional distress or significant functional disability and cannot be better explained by another chronic pain condition".

   This can include:
   Chronic primary musculoskeletal pain
   Chronic widespread Pain
   Chronic primary headache or orofacial Pain
   Chronic primary visceral pain
   Fibromyalgia (RCP Guidelines, 1.1, see below)
   CRPS*

2. **Nociceptive pain**

   Pain caused by harmful stimuli which activates pain receptors (e.g. osteoarthritis).

3. **Neuropathic pain**

   Pain caused by a lesion or disease directly affecting the body's pain-sensing nerves (e.g. discrete nerve injury).

4. **Nociplastic pain**

   Pain caused by a disturbance in peripheral and/or central nervous system pain processing (including fibromyalgia). More precisely, it is pain that arises from 'nociception' (altered activity of the part of the nervous system that senses harmful signals) despite the absence of evidence of actual or threatened tissue damage closing the activation of peripheral nociceptors (peripheral nerves that sense harmful signals) or evidence for disease or lesion of the somatosensory system causing the pain.
   (Royal College of Physicians guidance 2022 on diagnosis of Fibromyalgia)

5. **CRPS - Type I**

"development of CRPS (diagnosed as per Budapest criteria) despite the absence of discrete nerve damage (diagnostic criteria is the same as CRPS Type II)

(Valencia Consensus, in 'Pain', 2021)

6. **CRPS - Type II**

Development of CRPS (diagnosed as per Budapest criteria) associated with discrete peripheral nerve damage which must extend beyond any identified injured nerve territory (the diagnostic criteria is the same as CRPS Type I)

(Valencia Consensus, in 'Pain', 2021)

7. **CRPS-NOS (pre-Valencia)**

"can be considered for patients who have abnormalities in fewer than three Budapest symptom categories, or two sign categories, including those who had more documented signs and symptoms in the past, if current 'signs and symptoms' are still felt to be best explained by CRPS"

(RCP Guidance 2018, introduction)

8. **CRPS-NOS (post Valencia)**

"Has been retained exclusively for application to patients who have *never* been documented to fulfil the new IASP CRPS criteria. That is, they now display some but not all features of CRPS required for formal diagnosis, *and no other diagnosis better explains* the clinical features.

(Valencia Consensus, in 'Pain', 2021)

9. **"CPRS with remission of some features"**

Patients previously documented as having fully met CRPS criteria (either CRPS I or CRPS II) but who currently display CRPS features insufficient to fully meet the diagnostic criteria."

"These patients should not be classified as having CRPS-NOS. Notably, a reduction in the number of CRPS diagnostic signs and symptoms does not necessarily constitute an improvement in the lived experience of CRPS;

these patients may not have improved pain nor are they usually free all CRPS related signs and symptoms."
(Valencia Consensus, in 'Pain', 2021)

10. **Fibromyalgia (FMS) -** (a chronic primary pain)
**"**Persistent and widespread pain associated with intrusive fatigue, sleep disturbance, impaired cognitive and physical function and psychological distress (now considered to be caused by abnormal pain processing within the nervous system) – most common in females 40-60".
(Royal College of Physicians guidance 2022 on diagnosis of Fibromyalgia)

11. **Chronic Widespread Pain (CWP)**
Long-lasting pain in multiple body regions
(Royal College of Physicians guidance 2022 on diagnosis of Fibromyalgia)

12. **Functional Neurological Disorder (FND)**
"Where a person experiences abnormal function in a system that can be demonstrated to be capable of normal function" (Prof Edwards)

"where the nervous system 'software' doesn't function correctly, causing changes to how the brain works, or how the body moves or feels. Its diagnostic classification covers symptoms of:

i) motor dysfunction (weakness, movement disorders such as tremor and dystonia),
ii) sensory loss, episodes that resemble epileptic seizures (eg loss of awareness with limb shaking), and cognitive symptoms.

Pain is <u>not</u> included in current diagnostic criteria. Pain, however, is commonly experienced by people with FND. There is also often overlap between FMS and FND although FM S is not an FND.
(RCP Guidance on Diagnosis of Fibromyalgia, 2022 – Glossary)

Also note:

- Functional Neurological Symptom Disorder (DSM5) and

- Dissociative Disorders in ICD-11 (below)

13. **Myofascial Pain Syndrome**

A chronic condition that arises from inflammation in the muscles and fascia (the thin, connective tissue that surrounds muscles).

14. **Bodily Distress Disorder (BDD) (ICD-11)**

Also known as Bodily Distress Syndrome. Bodily symptoms that are "distressing" to the individual and "excessive attention" is directed toward the symptoms. "Excessive attention" remains despite appropriate clinical investigations and appropriate reassurance.

The symptoms must be persistent and present on most days for at least several months. Usually involves multiple bodily symptoms and may vary over time.

The symptoms and associated distress and preoccupation have at least some impact on the individual's functioning (e.g. strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities).

BDS does not include any additional psychological features associated to the somatic symptoms such as excessive thoughts about the seriousness of symptoms, or health-related anxiety.

Not to be confused with "body dysmorphic disorder" which is essentially persistent preoccupation with one or more perceived defects or flaws in appearance.

15. **Somatic Symptom Disorder (SSD) (DSM-V)**

Excessive focus on physical symptoms, such as pain, weakness or shortness of breath, to a level that results in major distress or problems functioning. The physical symptoms may or may not be associated with a diagnosed medical condition, but the reaction to the symptoms is abnormal.

16. **Conversion Disorder (DSM-V and ICD 11)**

Also known as "Dissociative Neurological Symptoms Disorder", "Functional Neurological Symptom Disorder" or "Functional Neurological Disorder" (see above and below **). It is a psychiatric condition which usually occurs after

psychological trauma, which causes physical symptoms. It is not feigning or attention-seeking - the individual experiences the symptoms, but the brain has converted the effects of the mental health condition into physical symptoms. Common symptoms include disturbance of senses (e.g. blindness), paralysis or seizures.

A distinguishing feature between conversion disorders and SSD is “la belle indifference” where in conversion disorders there is a lack of psychological distress despite significant physical symptoms.

**Whilst the diagnosis is often used interchangeably with FND, they are theoretically different concepts, with a diagnosis of Conversion Disorder typically being founded on suppressed psychological trauma converting to physical symptoms.

17. **Factitious Disorder**

Also known as Munchausen Syndrome. It is a psychiatric disorder where the individual feigns or exaggerates symptoms with the intention of adopting a “sick role”. It is associated with childhood trauma, particularly where the individual required excessive medical intervention as a child. Factitious disorder can be imposed on oneself but can also be imposed on a another (e.g. parent feigning symptoms in their child), this is known as “Factitious Disorder imposed on another” or “Munchausen syndrome by proxy”.

It is important to distinguish Factitious Disorder from malingering. The difference is the intent behind the feigning of symptoms. In FD it is to adopt a sick role and obtain care. In malingering the intent is to obtain some secondary gain e.g. attempt to avoid going to work, to avoid responsibility or for financial gain.

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