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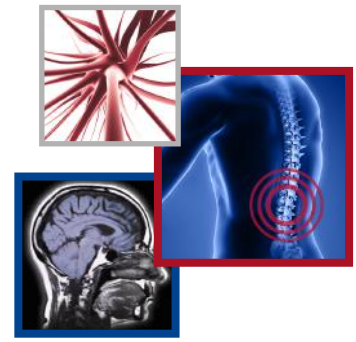

Pain as a disease in the new International Classification of Diseases (ICD-11): Latin American expert consensus

Marco A Narvaez Tamayo*[,1], Carlos Aguayo[2], Elias Atencio[3], Joao Batista Garcia[4], Carmen Cabrera[5], Celina Castañeda[6], Pablo Castroman[7], Graciela Elizeche[8], Patricia Gomez[9], Santiago Guaycochea[10], Marixa Guerrero[11], Rocio Guillen[12], Carla Leal Pereira[13], Guillermo López[14], Jacqueline Macias[15], Bethania Martinez[16], Felipe Mejia[17], Enrique Orrillo[18], José O Oliveira[19], Fabian Piedimonte[20], Francisco Samayoa[21] & Martin Toro[22]

[1]Specialist in Anesthesiology & Pain Medicine, Coordinator of the Pain Unit, Hospital Obrero Nro. 1-Hospital Materno Infantil, Caja Nacional de Salud. La Paz, Bolivia, President of the Latin American Federation of Associations for the Study of Pain (FEDELAT), President of the Bolivian Pain Association

[2]Specialist in Anesthesiology, Head of the Pain Unit, Hospital Clínico FUSAT. Rancagua, Chile. President of the Chilean Association for the Study of Pain & Palliative Care

[3]Specialist in Anesthesiology, Head of the Algiology Service, Complejo Hospitalario 'Dr. Arnulfo Arias Madrid', Panamá. Former President of the Latin American Federation of Associations for the Study of Pain (FEDELAT)

[4]Specialist in Anesthesiology, Pain Medicine & Palliative Care, Universidad Federal de São Luís, Brasil

[5]Specialist in Anesthesiology, Pain Medicine & Interventional Medicine, Pain Therapy & Palliative Care Service.Hospital Alberto Sabogal Sologuren-Essalud, Bellavista, Perú

[6]Specialist in Anesthesiology & Palliative Medicine, Teacher at the Faculty of Medicine of the Universidad Autónoma del Estado de México, Undersecretary of Health, Tlaxcala State, México

[7]Specialist in Anesthesiology, Associate Professor of Anesthesiology, Pain Therapy Service, Department & Chair of Anesthesiology, Hospital de Clínicas, University of Medicine, Universidad de la República, Uruguay, Relevium Co-Founder, Pain Medicine, Montevideo, Uruguay

[8]Specialist in Anesthesiology, Founder & former President of the Paraguayan Association for the Study & Treatment of Pain, Paraguay

[9]Specialist in Anesthesiology, Pain Management & Palliative Care, Associate Professor, Anesthesia Unit, Department of Surgery, Universidad Nacional de Colombia. Bogotá D.C., Colombia

[10]Specialist in Internal Medicine & Medical Clinic, Head of Pain Medicine, Sanatorio Otamendi. Buenos Aires, Argentina, President of the Argentine Association for the Study of Pain

[11]Specialist in Anesthesiology, Epidemiology, Pain Medicine & Palliative Care, General Director of Oncology Clinic Colsubsidio 127, Bogota, Colombia, Member of the Board of Directors of the Colombian Association for the Study of Pain, Coordinator of the Epidemiology Committee of Latin American Federation of Associations for the Study of Pain (FEDELAT)

[12]Specialist in Anesthesiology, Interventional Medicine, Pain Medicine & Palliative Care, Pain Clinic of the Instituto Nacional de Cancerología, México, Director General of Clínica Alive 'Vive sin Dolor', Ciudad de México, México, Former President of the Mexican Association for the Study & Treatment of Pain, Member of the Latin American Federation of Associations for the Study of Pain (FEDELAT)

[13]Specialist in Anesthesiology, Technical supervisor, Pain service. Hospital São Luiz/Rede D'Or. Brasil. Director General of the Pain Service in MedDor – São Paulo/Brasil, Fiscal Council Brazilian Society for the Study of Pain, Brasil, Member of the Latin American Federation of Associations for the Study of Pain (FEDELAT)

[14]Specialist in Anesthesiology & Resuscitation, Adjunct Professor of Anesthesiology Postgraduate, Universidad de Cuenca. Director of the UnitDolor AMETS, Hospital Universitario del Río, Cuenca, Ecuador

[15]Specialist in Anesthesiology & Pain Treatment, RELIF Director 'Centro de Tratamiento del Dolor y Medicina Paliativa', Past President of the Ecuadorian Society for the Study & Treatment of Pain, Ecuador

[16]Specialist in Anesthesiology, Pain Management & Palliative Care, Interventional Pain & Palliative Care Unit (UNIDOLOR SRL), Santo Domingo, Dominican Republic

[17]Specialist in Anesthesiology, Fellow in Interventionism in Pain & Palliative Care. Program Director of Dolor Neurocentro Pereira Colombia, President of Colombian Association for the Study of Pain, Colombia.

[18]Neurology Specialist, Professor & Coordinator of the Diploma in Chronic Pain at the Universidad Nacional Mayor de San Marcos de Lima, Perú, President of the Peruvian Association for the Study of Pain

[19]Neurosurgery Specialist, Neurosurgery Service of Hospital Servidor Público Estadual, President of the Brazilian Society for the Study of Pain, Brasil

[20]Specialist in Neurosurgery, Professor of the Faculty of Medicine, Universidad de Buenos Aires, President of the CENIT Foundation for Research in Neurosciences, Argentina

[21]Specialist in Anesthesiology, Associate Professor, Faculty of Medical Sciences, Universidad Nacional Autónoma de Honduras, Career Coordinator of the Postgraduate Course in Anesthesiology, Resuscitation & Pain, President of the Honduran Society of Anesthesiology, Resuscitation & Pain, Honduras

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[22]Specialist in Anesthesiology, Professor of Pain Medicine & Regional Anesthesia.Universidad Central de Venezuela, President of the Venezuelan Association for the Study of Pain, Venezuela
*Author for correspondence: marcoanarvaezt@gmail.com

Aims: Pain diagnoses in the tenth version of the International Classification of Diseases (ICD-10) did not adequately support the current management of pain. Therefore, we aimed to review the new 11th revision (ICD-11) in order to analyze its usefulness for the management, coding, research and education of chronic pain from a Latin American perspective. **Methods:** The Latin American Federation of Associations for the Study of Pain convened a meeting of pain experts in Lima, Peru. Pain specialists from 14 Latin American countries attended the consensus meeting. **Results:** In ICD-11, chronic pain is defined as pain that persists or recurs longer than 3 months and is subdivided into seven categories: chronic primary pain and six types of chronic secondary pain. Chronic primary pain is now considered a disease in itself, and not a mere symptom of an underlying disease. **Conclusion:** The novel definition and classification of chronic pain in ICD-11 is helpful for better medical care, research and health statistics. ICD-11 will improve chronic pain management in Latin American countries, for both the pain specialist and the primary care physician.

Plain language summary: Chronic pain is one of the most frequent reasons for medical consultation in Latin America. In the tenth revision of the International Classification of Diseases and Related Health Problems (ICD-10), chronic pain was not adequately defined and individual pain diagnoses were poorly defined.

For the first time in Latin America, a meeting of pain experts analyzed and reviewed the 11th version of the International Classification of Diseases (ICD-11), when the Latin America Federation of Associations for the Study of Pain organized a meeting of experts from 14 Latin American countries.

In ICD-11, chronic pain is recognized as a biopsychosocial phenomenon and defined as pain that continues or returns for more than 3 months. It is split into seven types: chronic primary pain and six types of chronic secondary pain. In ICD-11, chronic primary pain is now considered a disease in itself, not a mere manifestation of other disease.

Our article is the first to address the problems, challenges and benefits of using ICD-11 from a Latin American perspective. It will help to facilitate and disseminate the use of this new classification of chronic pain. This will improve chronic pain treatment, statistics, research and development of better health strategies for pain management in Latin America.

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Chronic pain is one of the most frequent reasons for patients to seek medical care in Latin America [1,2]. In the region, as well as in other parts of the world, chronic pain and many diseases associated with chronic pain are major healthcare problems. Although there are no official studies to determine the prevalence of chronic pain in each country in the region, the Latin American Federation of Associations for the Study of Pain (FEDELAT) is currently working on this issue and has estimated that 190 million people suffer from this condition (ranging from 12 to 55% of the Latin American population) from a total population of about 665 million people [2,3].

Chronic pain causes physical and psychological deterioration. It is associated with social isolation that increases problems like depression and anxiety, and has an impact on the functionality and productivity of the patient. The social and economic burden of chronic pain is considerable [1,2,4–6].

Latin America is a huge and heterogeneous region; however, identified challenges show similar difficulties between countries, whether logistical (time and distance to health facilities, treatment abandonment), financial (cost of care, cost of absence from work, lack of health insurance) or cultural (traditional or customary medicine) [2,5–9]. Some of the characteristics, customs and habits of Latin America's population cannot be ignored. The demographics are various and heterogeneous but, in general, in all Latin American countries a lack of recognition of chronic pain as a disease in its own right can be appreciated [7–10]. In addition, the lack of medical education on the proper use of analgesics and other drugs for the management of chronic pain is commonly observed [7–9]. In many Latin American regions, a strong presence of traditional or customary medicine is common. It must be borne in mind

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that 80% of pain patients begin their treatment in primary care, and initiatives for the management of chronic pain must be directed mainly at this level of care [7–10].

Reports of chronic pain prevalence in Latin America are heterogeneous, but it is estimated that the prevalence ranges from 12 to 55% of the population [5]. This variability can be attributed to different definitions of chronic pain, the methodology used in research and the type of population studied [5]. A systematic review of chronic nonspecific low back pain in Latin America, published by Garcia *et al.*, included 28 studies, comprising a total of 20,559 subjects from seven countries in the region [5]. Researchers found that 70 million people (11% of Latin Americans) suffer low back pain, and from these, 10 million people had disability due to low back pain [4]. A study conducted by de Moraes Vieira *et al.* surveyed 1597 people to estimate the prevalence and associated factors of chronic pain in São Luís, Brazil. They reported that the prevalence of chronic pain was 42%, and 10% had chronic pain with neuropathic characteristics [6].

The representation of pain diagnoses in the tenth version of the International Classification of Diseases (ICD-10) did not sufficiently support the current clinical management of pain conditions and did not adequately reflect the state of the art in pain research [11–14]. In ICD-10, many important types of chronic pain had no diagnoses available. For example, chronic neuropathic pain, chronic pain associated with cancer and its treatment, or chronic pain after trauma or surgery were not represented in ICD-10. Another shortcoming of ICD-10 is that one of the most commonly used diagnoses for chronic pain was the vague residual category 'R52.2 other chronic pain', which adds no information for physicians or researchers [11–15].

Organization of chronic pain syndromes in the 11th revision of the International Classification of Diseases (ICD-11), is highly important for planning health management strategies in Latin America. A field test conducted by the International Association for the Study of Pain (IASP) and the WHO recruited 177 healthcare professionals from 35 countries to compare correctness, ambiguity, ease of use, clinical utility and appropriateness of the new ICD-11 codes with those of the ICD-10. The field test showed that ICD-11 was superior to ICD-10 in every respect, offering better accuracy, ease of use and clinical utility in coding chronic pain disorders [11].

Because ICD-10 did not adequately represent pain syndromes, new proposals for the classification of pain syndromes were conducted in subsequent years by international pain societies and committees, including IASP, the WHO and the Pan American Health Organization. In an extraordinary effort, the different proposals were combined and harmonized to be used in the new ICD-11 classification [16–28].

The FEDELAT expert panel consider that there is a need to disseminate the new concept of chronic primary pain and the updated classification and coding system of ICD-11. Thus, within the framework of the XIV Latin American Congress of Pain, held in August 2022 in Lima, Peru; FEDELAT convened a consensus of experts on chronic pain to analyze the Latin American perspective on the ICD-11 classification of chronic pain.

Methods

More than 22 pain specialists from 14 Latin American countries attended the consensus meeting. Presidents, former presidents and prominent national leaders of FEDELAT attended from Argentina, Bolivia, Brazil, Chile, Colombia, Dominican Republic, Ecuador, Honduras, Mexico, Panama, Paraguay, Peru, Uruguay and Venezuela, which made the sample of experts quite representative of Latin America.

At first, an outline of the current state of chronic pain management and the situation of chronic pain research and pain education in Latin America was presented by the president of FEDELAT. The participants then met in seven groups to discuss each of the respective main sections of ICD-11. Next, each group presented a summary of the assigned topic, which was followed by a general discussion of the comments, proposals and recommendations.

The ICD-11 classification was the main focus of the review conducted by the experts of FEDELAT. The main topics agreed upon by the experts appear in the Results section, while comments, opinions and recommendations that enriched the consensus debate are displayed in the Discussion section.

Results

The consensus emphasized supporting initiatives throughout Latin America for the training of a greater number of pain specialists, as well as the development of units or centers of excellence in pain. Given that pain management is multidisciplinary and multimodal, pain education should include not only pain specialists but also other physicians and other health professionals (e.g., nurses, kinesiologists, pharmacists, auditors and health systems administrators).

The consensus highlighted the need to develop strategies with the aim of improving the diagnosis, treatment and resource allocation in Latin American countries. It was unanimously recognized that the use of ICD-11 will improve

Table 1. Classification of chronic pain in ICD-11.

Primary	1. Chronic primary pain
Secondary	2. Chronic cancer-related pain 3. Chronic post-surgical or post-traumatic pain 4. Chronic neuropathic pain 5. Chronic secondary headache or orofacial pain 6. Chronic secondary visceral pain 7. Chronic secondary musculoskeletal pain

Table 2. Different subtypes of chronic primary pain in ICD-11.

1. Chronic widespread pain
2. Complex regional pain syndrome
3. Chronic primary headache orofacial pain
4. Chronic primary visceral pain
5. Chronic primary musculoskeletal pain

research reports on chronic pain through more accurate and adequate coding, as well as the clinical management of patients through better diagnostic classification. The recognition of chronic pain as a disease, and not as a mere symptom, can increase its visibility and help to assign more resources to pain treatment, education and research.

The ICD-11 classification was reviewed and summarized by FEDELAT members. ICD-11 defines chronic pain as persistent or recurrent pain that lasts for more than 3 months [11–26]. This simple definition with a temporality criterion allows chronic pain to be clearly recognizable independently of other descriptors such as pain intensity, impact on functionality and pain-related distress [9,10]. The new ICD-11 classification divides chronic pain into seven groups, in which the first is chronic primary pain and the other six items correspond to chronic secondary pain syndromes (Table 1) [16–26].

In chronic primary pain syndrome, pain is regarded as a disease in itself, whereas in chronic secondary pain syndromes, pain is a symptom or manifestation of an underlying disease. Differential diagnosis between primary and secondary pain conditions may sometimes be difficult, but in both cases the patient needs specialized care when pain, in addition to being chronic, is moderate or severe [16–26].

Secondary chronic pain syndromes are characterized by pain that also persists for more than 3 months, but where pain is the symptom of a underlying condition. Secondary chronic pain is divided into six categories, thus completing the seven types of chronic pain for coding in ICD-11.

Chronic primary pain

Chronic primary pain is a new concept in ICD-11 and represents a first level of diagnosis (etiological). It is characterized by a pain persisting for more than 3 months, associated with significant functional impairment or emotional distress, and that cannot be explained by another cause. Chronic primary pain is recognized as a disease in its own right. Pain-related emotional distress can be manifested in various forms, such as depressed mood, anxiety, demoralization, frustration or anger. Functional disability can be observed as a variety of different interferences in daily life, such as difficulties working, sleeping or participating in social activities [16–26].

Primary chronic pain is multifactorial, as biological, psychological and social factors contribute to the syndrome. ICD-11 recognizes five subtypes of primary chronic pain at a second level of diagnosis (physiopathological and anatomical; Table 2).

In a tree classification scheme, ICD-11 proposes a third level for different diagnoses of chronic primary pain (Table 3).

In the coding system it is interesting to note that, according to the new concept of 'multiple parenting' incorporated in ICD-11, a condition may belong to more than one group of diagnoses, but it always has the same definition and coding. For example, a case of fibromyalgia with tender points on buttocks, hips and knees can also be classified as chronic primary limb pain [27,28].

Chronic cancer-related pain

The prevalence of cancer has increased in recent decades in Latin America and so has the number of patients who survive their condition for many years due to current effective therapies [20,29–34].

Table 3. General structure of the ICD-11 classification for chronic primary pain.

Level 1	Chronic primary pain				
Level 2	Chronic widespread pain	Complex regional pain syndrome	Chronic primary headache or orofacial pain	Chronic primary visceral pain	Chronic primary musculoskeletal pain
Level 3	Fibromyalgia	CRPS Type 1	Chronic migraine	Chronic primary chest pain syndrome	Chronic primary cervical pain
		CRPS Type 2	Chronic tension-type headache	Chronic primary epigastric pain syndrome	Chronic primary thoracic pain
			Trigeminal autonomic cephalalgias	Irritable bowel syndrome	Chronic primary low back pain
			Chronic primary temporomandibular disorder pain	Chronic primary abdominal pain syndrome	Chronic primary limb pain
			Burning mouth syndrome	Chronic primary bladder pain syndrome	
			Chronic primary orofacial pain	Chronic primary pelvic pain syndrome	

CRPS: Complex regional pain syndrome.

Despite its relevance, chronic cancer-related pain was not represented in ICD-10. Pain is one of the most common and disabling symptoms of cancer. In addition to the pain secondary to the malignancy itself, various treatments can also provoke chronic pain. Identifying the nature and cause of pain in a cancer patient or survivor is important to achieve the best pain control [20,29–34].

In ICD-11, chronic cancer-related pain is defined as chronic pain caused by either: the primary cancer itself or metastases (chronic cancer pain); or the treatment of cancer (chronic post-cancer treatment pain). Post-cancer treatment pain can have subtypes according to the different therapies that can be used (i.e., chemotherapy, radiotherapy or surgery). According to the new concept of 'multiple parenting' for coding in ICD-11, cancer pain cases may belong also to other diagnostic groups such as visceral pain or neuropathic pain. The new ICD-11 classification of chronic cancer-related pain is intended to help develop more individualized management strategies for cancer patients and to stimulate research into these pain disorders.

Chronic post-surgical or post-traumatic pain

Chronic post-surgical or post-traumatic pain is defined in ICD-11 as a chronic pain that develops or increases in intensity after a surgical procedure or a tissue injury and persists beyond the healing process, namely, at least 3 months after the surgery or tissue trauma [21]. The risk for the development of chronic pain after surgery or trauma has been underestimated in the past. Chronic pain after tissue trauma was not represented in ICD-10, and therefore was usually under-recognized and undertreated despite its frequency and deleterious impact on the functioning and quality of life of the patient. This lack of diagnostic categories hinders the identification and the treatment of patients with these pain states. Moreover, these cases do not appear in health statistics, with all their consequences for research, access, reimbursement and health strategies [21,35–37].

Although the initiating event for all these pain states is tissue trauma, it is important to separate post-surgical pain, where the trauma is a surgical controlled incision, from post-traumatic pain, where the injury is caused in some accidental or nonintentional, uncontrolled way. Therefore, the subtypes of chronic pain are defined as chronic post-surgical pain and chronic post-traumatic pain.

Pain cases are further subdivided according to the type of surgery and the type of trauma. The pain has to be localized to the surgical field or area of injury, projected to the innervation territory of a nerve situated in this area, or referred to a related dermatome or head zone. For post-surgical pain, the specific subdiagnoses included in ICD-11, considering specific interventions that most commonly lead to this disorder, are chronic pain after amputation, thoracotomy, breast surgery, hernia repair, hysterectomy and arthroplasty. For chronic post-traumatic pain, there are also subcodes representing events that commonly lead to chronic pain, such as multiple trauma, spinal cord injury, whiplash, brain injury, nerve injuries and burns [21,35–37]. It is very important to differentiate chronic post-surgical pain from post-traumatic pain, because the etiology is different (programmed or anticipated in the first case and accidental in the second). This subclassification is essential because very frequently, in daily clinical practice, we see a high number of patients who correspond to this subgroup of the classification [21,35–37].

Table 4. Organization of chronic secondary headache or orofacial pain disorders in ICD-11.

Level 1	Chronic secondary headache or orofacial pain
Level 2	• Chronic headache/orofacial pain attributed to trauma or injury. • Chronic headache/orofacial pain attributed to cranial or cervical vascular disorder. • Chronic headache/orofacial pain attributed to nonvascular intracranial disorder. • Chronic headache attributed to a substance or its withdrawal. • Chronic headache/orofacial pain attributed to infection. • Chronic headache/orofacial pain attributed to disorders of homeostasis or their nonpharmacological treatment. • Chronic headache/orofacial pain attributed to disorder of the cranium, neck, eyes, ears, sinuses, salivary glands and oral mucosa. • Chronic dental pain • Chronic neuropathic orofacial pain • Trigeminal neuralgia • Chronic temporomandibular disorder pain

Chronic neuropathic pain

ICD-11 states that chronic neuropathic pain is a chronic pain caused by a lesion or disease of the somatosensory nervous system [22]. Around 10% of the general population experience neuropathic pain and most of these patients do not receive adequate diagnosis and treatment [22]. Despite their prevalence and clinical importance, conditions of chronic neuropathic pain were either insufficiently defined or missing in ICD-10. Therefore, an updated classification of chronic neuropathic pain was needed to document this public health problem and related therapeutic challenges.

According to the ICD-11, neuropathic pain disorders can be differentiated in accordance with their origin as either chronic peripheral neuropathic pain or chronic central neuropathic pain.

Chronic peripheral neuropathic pain is defined as a chronic pain caused by a lesion or disease of the peripheral somatosensory nervous system. The new classification presents the most frequent conditions of peripheral neuropathic pain as: trigeminal neuralgia, peripheral nerve injury, painful polyneuropathy, postherpetic neuralgia and painful radiculopathy. On the other hand, chronic central neuropathic pain is conceived as chronic pain caused by a lesion or disease of the central somatosensory nervous system. Conditions that provoke central neuropathic pain include spinal cord or brain injury, post-stroke pain and pain associated with multiple sclerosis [22,38–41].

Neuropathic pain is an entity that is difficult to manage in clinical practice. It is underdiagnosed and many times, even with the correct diagnosis, the most studied or indicated drugs are not used. This is a global reality, not only an issue in Latin America, which generates a problem in the management of chronic neuropathic pain. In this particular group of patients, it is extremely important to consider that from one patient to another the response to the same drug may be substantially different. The individual susceptibility to the drug (pharmacological idiosyncrasy) is of vital relevance. This particular aspect should lead us to carry out a strict control and supervision of the treatment to achieve an adequate response and anticipate the adverse effects that may occur and that the patient must be aware of. ICD-11 is a helpful tool for diagnostic code assignment, appropriate allocation of healthcare services and the collection of epidemiological data [22,38–41].

Chronic secondary headache or orofacial pain

In ICD-11, chronic headache or orofacial pain is divided into two main domains: chronic primary headache or orofacial pain, and chronic secondary headache or orofacial pain [9–13,23]. A similar distinction (primary vs secondary) was made for chronic visceral pain and for chronic musculoskeletal pain [15–18,23]. In this item, only secondary (symptomatic) disorders are considered [23].

Chronic secondary headache or orofacial pain disorder is defined as an event that occurs on at least 50% of the days during at least 3 months and lasting at least 2 h per day [23]. Secondary headache or orofacial pain disorders are the consequence of an underlying disorder or dysfunction. Pain is clearly associated with the effects of a disease (regional or systemic), trauma (physical, chemical, radiation), infection or a variety of factors [23,42–45]. Subtypes of secondary headache and orofacial pain disorders are listed in Table 4.

Chronic secondary visceral pain

Chronic secondary visceral pain is chronic pain due to an underlying condition originating from internal organs of the head or neck, or the thoracic, abdominal or pelvic regions [16–18,24]. The pain intensity is not always entirely correlated with the underlying cause, and the chronic visceral pain may persist beyond successful treatment of the

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Table 5. Organization of diagnoses related to chronic secondary visceral pain in ICD-11.

Level 1	Chronic secondary visceral pain
Level 2	• Chronic visceral pain from persistent inflammation • Chronic visceral pain from vascular mechanisms • Chronic visceral pain from mechanical factors

Each diagnosis in level 2 can be further subdivided (level 3) according to the affected anatomical area: head or neck region, thoracic region, abdominal region or pelvic region.

disease. Despite its high prevalence and clinical relevance, chronic secondary visceral pain was not systematically represented in ICD-10 [24].

For ICD-11, chronic secondary visceral pain can be provoked by persistent inflammation, vascular sources or mechanical factors (Level 2; Table 5). In a third level of diagnosis, these subtypes were further divided according to anatomical criteria into four areas: head or neck region; thoracic region; abdominal region; and pelvic region [24]. Common underlying disorders for chronic secondary visceral pain include esophagitis, gastritis, ulcerative colitis, Crohn disease, chronic pancreatitis, recurrent diverticulitis, inflammatory bowel disease, chronic ischemic heart disease, pericarditis, aortic dissection, biliary or urinary stones, endometriosis, salpingitis, recurrent cystitis and urethritis [24,46–48].

The distribution by anatomical area in the classification of secondary chronic visceral pain, in addition to the taxonomy, allows us to order the clinical information in a logical and easy way for a better approach, and if necessary, also acts as a referral criterion to the appropriate level of care and in a timely manner [24,46–48].

Chronic secondary musculoskeletal pain

Chronic musculoskeletal pain is defined as chronic pain arising from musculoskeletal structures such as tendons, muscles, bones or joints [16–19,25,49–52]. Chronic secondary musculoskeletal pain (Level 1) is a symptom that arises from an underlying disease, and it can be further subdivided (Level 2) according to the most frequent causative mechanisms: persisting local or systemic inflammatory diseases (e.g., infections, crystal deposition, autoimmune processes); local structural musculoskeletal changes (e.g., injuries, osteoarthritis, spondylosis); or nervous system illnesses (e.g., muscular hypertonicity in Parkinson's disease).

Chronic musculoskeletal pain syndromes, where the common denominator is chronic pain, provide a clear example of the need for a multidisciplinary approach to pain. The multidisciplinary working group must be formed based on the type of pain suffered by the patient. It is essential that the management team involves the participation of, for example, a neurologist, a physiatrist and an algologist [25,49–52].

Discussion

Our paper presents the results from the first time that a meeting of pain specialists from Latin America gathered to analyze and discuss the implementation of ICD-11 and how this will help regional countries to change clinical practice and to achieve better outcomes in pain management, research, statistics and use of healthcare resources.

In the previous version, ICD-10, chronic pain was not adequately represented and individual diagnoses were scattered and poorly described. It is clear that negative consequences arose from the inadequate representation of chronic pain in ICD-10 for patient management, research, health statistics and health policies. In contrast, ICD-11 includes a specific chapter that defines and improves the representation of primary chronic pain and six types of secondary pain [11–25].

The issues, challenges and benefits associated with the implementation of ICD-11 are not unique to Latin America. Because we are pain specialists from Latin American countries, we limited our analysis to our region. However, the results and discussions of our review can certainly be helpful for other countries and regions as well.

The implementation of ICD-11 can certainly change clinical practice in Latin American countries. The new classification allows better diagnosis and treatment, so its use will be useful for pain specialists, primary-care physicians, researchers, hospital managers, auditors and healthcare policymakers as well. In addition, based on more consistent coding and classification practices, the availability of better data will also be useful to improve the quality of research and the development of health strategies.

The expert panel recommends that the ICD-11 classification should be implemented without delay at all levels, but especially in primary care, because it is at that level where consultation for chronic pain begins in most cases in Latin America. The Latin American reality is different from that of developed countries, and as such, the immediate

use of ICD-11 should be promoted, adapting and integrating its new concepts, especially the concept of primary chronic pain, taking into account the characteristics and possibilities of each region.

The consensus recognized that while the 3-month definition for chronic pain is helpful in distinguishing chronic pain from acute pain, this criterion is not adequate when applied in the context of progressive cancer pain. First, with the progression of the oncological disease, destruction of the tissues can occur, which can generate new sources of pain, and its temporary classification would be complex. Second, many patients with an aggressive tumor may have a survival time of less than 3 months, and therefore their pain syndromes, although prolonged, would not fit within this concept of chronic pain.

Pain is one of the most complex and prevalent symptoms in cancer patients [20,29–34]. Chronic cancer-related pain is a worldwide problem with a prevalence ranging from 40% after curative treatment to 66% in advanced, metastatic or terminal disease [20,29]. Furthermore, in 38% of cases, it is described as moderate to severe [29]. According to Giglio *et al.*, pain-related symptoms such as insomnia, anxiety, depression and fatigue are concomitant and can be seen as symptom clusters in cancer patients [32]. These clusters of symptoms are more important than each symptom on its own and can have a tremendous negative impact on the quality of life of cancer patients [20,29–34].

Pain related to childhood cancer deserves a special mention as each year 29,000 children are diagnosed with cancer in Latin America [33]. Managing chronic pain in these patients is a great challenge because pain is not only common during childhood cancer treatment but can also persist in cancer survivors [33,34]. As stated by the United Nations, childhood cancer is the second leading cause of death in children and adolescents up to 19 years of age in Latin America. The United Nations highlights that unequal access to diagnosis and treatment are the fundamental determinants of this critical reality [50]. Today it is known that childhood cancer can be cured in more than 80% of cases in developed countries. However, there is a huge gap: only 55% of children with cancer survive in Latin America. The main cause of poor survival is the high rate of treatment abandonment, which in the region reaches 30%, and this is often due to lack of resources, lack of economic support and lack of qualified human resources [33,34]. According to the experts, the goal is to reach 60% of survivors by 2030 [20,33,34].

One of the most frequent complications after surgery is chronic post-surgical pain [21,35–37]. It has a significant impact on patients' quality of life and represents a substantial economic and healthcare burden. The median incidence of chronic pain at 6–12 months after surgery is 20–30% [35]. However, there is a wide variability in the reported incidence (5–75%) attributed to variable methods of data collection and different definitions of chronic pain. The inclusion of chronic post-surgical pain in ICD-11 is a key step that will help to report the incidence of chronic post-surgical pain more precisely for clinical, research and statistical purposes [21,35–37].

In ICD-10, there are very few explicit references to conditions of neuropathic pain. They include trigeminal neuralgia, postzoster neuralgia and phantom limb syndrome with pain. The complexity of ICD-10 codes and the incomplete or inaccurate coverage of clinical conditions may be conducive to an under-reporting of chronic pain. The new ICD-11 presents the most common conditions of peripheral neuropathic pain including trigeminal neuralgia, peripheral nerve injury, painful polyneuropathy, postherpetic neuralgia and painful radiculopathy. Conditions of central neuropathic pain include pain caused by spinal cord or brain injury, poststroke pain and pain associated with multiple sclerosis [22,38–41]. The panel of experts put emphasis on localized neuropathic pain conditions because they seem to represent about 60% of cases for neuropathic pain in Latin America [38]. Currently, most of these patients do not receive adequate relief with the treatments they access.

Orofacial pain often involves multiple etiological factors [23,42–45]. Toothache is one of the most prevalent types of orofacial pain, especially in Latin America, where access to dental treatment is limited [37–39]. In Latin America, a higher prevalence of untreated cavities, periodontal disease and tooth loss has been reported compared with developed countries [43]. In some cases, the diagnosis of orofacial pain can be challenging. In addition to common chronic orofacial pain conditions such as headaches, temporomandibular disorders and trigeminal neuralgia, pain may be derived from an odontogenic source [42–45]. Therefore, it is key to understand that a multidisciplinary team becomes essential for assessment, diagnosis and management of chronic orofacial pain.

Chronic visceral pain is a major challenge for both patients and physicians [24,46–48]. The IASP classification of chronic visceral pain used in the ICD-11 considered already established taxonomies for the chronic visceral pain syndromes such as the Rome criteria [45–48]. Visceral pain syndromes are often associated with emotional or psychological conditions as well as functional disorders. They can overlap and may occur in the context of other conditions, forming clusters of pain disorders. Most patients with chronic visceral pain need the assistance of multidisciplinary teams composed of pain physicians, other specialists according to the underlying disease (e.g., rheumatologist,

cardiologist, gastroenterologist, gynecologist, urologist) and other health professionals (psychologists, nurses, rehabilitation therapists, physiotherapists) [24,46–48].

Chronic pain and loss of muscle functioning are the primary mechanisms through which musculoskeletal disorders lead to disability and work loss. Musculoskeletal pain is highly prevalent and is among the most disabling and costly conditions in Latin America. ICD-11 integrates the biomedical approach with functional, psychological and social factors that play a role in the experience of chronic musculoskeletal pain. Patients with chronic musculoskeletal pain may receive care from multidisciplinary teams that include pain physicians, collaborating with psychologists, rehabilitation therapists and other health professionals [5,25,49,51,52].

There are some obstacles for the implementation of ICD-11, such as the lack of awareness of its necessity, the limitation of resources, the lack of government financing in most countries and the lack of physicians and healthcare personnel who are well trained on the use of the new classification. Regarding research and health statistics, another challenge may arise from the difficulties in transferring information from ICD-10 or previous versions to the new categories that appear in ICD-11 [11–13,50–52]. Our article is the first to point out the existence of these problems in Latin American countries and is intended to facilitate the improvement of medical awareness and education in the region.

The present article also contributes to the dissemination of this new classification, and we are confident that it will change clinical practice for the better. It will facilitate patient-centered multimodal pain management and encourage research through more accurate epidemiological analyses. Therefore, we recommend that the use of ICD-11 should begin without delay in Latin American countries.

The notion that access to pain relief is a human right has gained acceptance in recent years. However, in Latin America the right to pain relief is drastically hampered by inadequate access to pain treatment [53,54]. ICD-11 will help to reduce the global burden of pain, which is significant in Latin America. The management of pain, recognized as a biopsychosocial disorder, requires a multidisciplinary approach that addresses its physical, psychosocial and spiritual dimensions. Therapeutic approaches certainly will be different depending on the type and nature of pain. In this scenario, opioids have a central role in the management of moderate-to-severe acute and chronic pain. Despite advances in palliative care and access to opioids in Latin America, there are still several barriers that hinder effective pain management [53,54].

The burden of chronic pain is critical because companies, institutions, governments and health insurance systems either minimize the problem or do not recognize its real importance until they know the social and economic repercussions. Therefore, it is important to achieve greater support from governments and health systems in the countries of the region. Awareness of the importance of chronic pain as a public health problem in Latin America must be promoted not only among physicians but also among all health agents such as nurses, auxiliary technical personnel, pharmacists and the authorities, administrators and auditors of regulatory agencies, institutions, health systems and governments. The use of ICD-11 will certainly be helpful to approach these challenges.

Taking into account the scope of the legal limits of their competence and authority, it would be the obligation of governments: first, to guarantee patients access to the best available treatment; second, to implement programs to sensitize and educate the population about chronic pain and its treatment; third, to provide resources to adequately finance research on chronic pain as a public health problem; and fourth, to establish norms and regulations that promote educational programs for health professionals on pain management, at the levels of both primary care physicians and pain specialists.

Also, considering the scope of the legal limits of their competence and authority, it would be the obligation of scientific societies and health professionals to ensure that their congresses and/or conferences include specific content on chronic pain. Likewise, pain education should be widely promoted in the training of health professionals, at both the undergraduate and postgraduate levels.

All patients with chronic pain in Latin America have the right to access the best possible treatment implemented by experts in the management of pain. The lack of access to adequate pain therapy causes unnecessary, avoidable and ethically reprehensible additional suffering to these patients.

Conclusion

This is the first time that a panel of pain experts analyze and discuss the features of ICD-11 from a Latin American perspective. FEDELAT expert panel recognizes the huge impact of chronic pain in Latin American population. The limitation of resources in Latin America is a critical factor and it is necessary to enhance the recognition and visualization of chronic pain in the countries of the region. Our article contributes to the dissemination of the

ICD-11 trusting that it will allow for better diagnosis and treatment. Therefore, the use of the new classification should be implemented in all Latin American countries without delay at all levels of care. The ICD-11 should also be used to improve clinical research, increasing the statistical data on the epidemiology and therapeutic results of chronic pain management in Latin America.

Summary points

The following are some key messages and recommendations proposed by the FEDELAT Consensus to improve the current situation of chronic pain in Latin America:

- The 11th version of the International Classification of Diseases (ICD-11) allows for better diagnosis and treatment, so its use should be implemented without delay at all levels of care, and especially in primary care, because in Latin America consultation for chronic pain begins at this level in most cases.
- The recognition of chronic pain as a disease by itself, and not only as a symptom of an underlying disease, will increase its visibility and will improve the assignment of resources to pain treatment, education and research.
- ICD-11 should also be used to improve clinical research, increasing the statistical data on the epidemiology and therapeutic results of chronic pain management in all Latin American countries.
- The Latin American reality is different from that of other countries, and as such, the immediate use of ICD-11 should be promoted, adapting and integrating its new concepts, especially the concept of primary chronic pain, taking into account the characteristics and possibilities of each region.
- It is necessary to disseminate the novel concept of chronic primary pain to primary care physicians and other healthcare providers.
- It is vital to train primary care physicians in the appropriate management of pain, including assessment, diagnosis, treatment options and timely referral to pain specialists.
- Strategies are needed to sensitize health and regulatory authorities in the region, promote multidisciplinary and multimodal treatment of chronic pain, reinforce pain education at undergraduate and postgraduate levels and generate resources for pain research in each country of Latin America.
- All patients suffering chronic pain in Latin America have the right to access the best possible treatment implemented by experienced professionals.

Author contributions

All authors contributed extensively to the work presented in this paper. All authors have contributed significantly to the conception, design, or acquisition of data, or analysis and interpretation of data. All authors have participated in in drafting, reviewing and/or revising the manuscript and have approved its submission.

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Competing interests disclosure

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