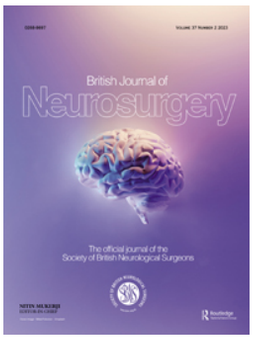

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LETTER TO THE EDITOR

Persistent spinal pain syndrome: a proposed replacement for failed back surgery syndrome

Sir,

Flawed nomenclature and classification inevitably hamper diagnosis, clinical communication and research, and may impede access to appropriate treatment. This is clearly illustrated by the term 'failed back surgery syndrome' (FBSS), which is particularly misleading and inadequate, and carries unintended negative connotations.

We represent an independent international group of 25 experts in the clinical and scientific aspects of chronic pain of spinal origin who seek support for the aim of discontinuing use of the term FBSS, and for its replacement.

FBSS (and FNSS: 'failed neck surgery syndrome') fails to indicate whether surgery caused or exacerbated the pain directly, or indirectly, or simply failed to relieve the pain, and it is unclear about recurrent pain. It identifies neither inappropriately-performed surgery, for example insufficient decompression and unjustified intervention, nor the effects of complications of surgery, such as neurological damage. There is no reference to pathophysiological mechanisms nor, even, to the particular operation(s) performed. Psychological and social factors are ignored, despite their frequent relevance, but the juxtaposition of 'failed' and 'syndrome' can imply that the patient is to blame. The therapeutic nihilism infers a poor prognosis. Finally, *successful* back surgery is not clearly defined, so there is no point of reference.

Following a three-year process of literature review, extensive discussion and a structured Delphi selection procedure, we propose that the term 'persistent spinal pain syndrome' (PSPS) be adopted.[1] This term is based on the principle of a persistent spinal syndrome and includes, but is not restricted to, post-surgical pain. Its logical basis should facilitate the diagnosis and therapy of individual patients in a manner that is physiologically orientated and not emotionally laden, ambiguous or stigmatising.

The latest version of the International Classification of Diseases, ICD-11, was adopted by the WHO in 2019 and is due for international implementation in January, 2022. Within this, chronic pain is recognised as a disease entity for the first time.[2] ICD-11 proposes the term 'chronic pain after spinal surgery' (CPSS) and, to avoid ambiguity, defines it narrowly as 'pain caused by, or probably caused by, surgery'.[3] Thus, cases where the pain persisted after surgery but was not caused by it, i.e. the majority, are excluded from CPSS. Furthermore, cases where surgery was not performed may be otherwise indistinguishable from cases where it was.

PSPS takes a different approach, by starting from the broad concept that the upright posture predisposes humans both to the development of pain of spinal origin, and related symptoms, and to their persistence. This predisposition may militate against favourable surgical outcomes. It refers to persistent pain of spinal origin, with or without associated neurological symptoms, axial, radicular or mixed, and does not apply exclusively to the lumbar spine. In PSPS type 2, spinal surgery occurred which may be directly causative, indirectly causative, not causative, or unclear. It incorporates CPSS as a subgroup but is not restricted to it. Type 1 is where no spinal surgery was performed and symptoms persist despite optimal nonsurgical management. Chronic primary pain is excluded from PSPS as it is not specifically of spinal origin.

Under ICD-11, cases currently labelled FBSS will be distributed between four first-level diagnostic categories. The integration of PSPS into ICD-11 would rationalise this, partly by making use of the novel ICD-11 tool 'shared parents'. Ambiguity regarding causation would be avoided, and the commonality of cases where surgery was causally irrelevant, *or did not even occur*, would be recognised. The terms FBSS and FNSS need no longer be used if PSPS is adopted; we urge authors and editors to help drive this process.

Author contributions

All authors have discussed and agreed the contents of the manuscript.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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