Editorial

Issues with chronic musculoskeletal pain

Of all the happiness mankind can gain, is not in pleasure but in rest from pain.

John Dryden (1631–1700), The Indian Explorer (1665), Act 1, Scene 1

Pain is the most common symptom of which the human kind complains. Pain has been recognized by the World Health Organization as a problem of global proportions [1] and the focus on musculoskeletal pain and the burden it produces has been one of the driving forces in the creation of the International Bone and Joint Decade (2000–2010) [2]. Musculoskeletal diseases are the most common cause of pain in the UK [3] and internationally [4]. It is often said that although on the majority of measures the health of communities (at least in the developed world) has been improving over the last few decades, we are, as individuals, feeling ‘sicker’ than ever before! In this issue of Rheumatology, Harkness et al. [5] present compelling evidence that this is so—at least in the northwest region of England. Their study demonstrates an increased prevalence of musculoskeletal pain of between 2- and 4-fold over the last 50 yr. Although there were some differences in study design, the authors argue strongly that this is unlikely to have a significant effect on the results and that there is a genuine increase in the ‘pain’ of the community.

The high prevalence of musculoskeletal pain observed in UK communities is also mirrored in other populations around the world. In Sweden approximately 30% of patients treated in a primary care setting had a medically defined pain problem—the majority of which was in the musculoskeletal system [6]. In The Netherlands a self-reported postal questionnaire identified 26% of the population with low back pain, over 20% with shoulder pain and 20% with neck pain. In nearly one-third of these cases the pain was accompanied by a limitation in daily activity but, interestingly, fewer than 50% had actually consulted their general practitioner [7]. It is of concern that musculoskeletal pain is also reported in over 30% of children aged 14—a significant increase over those aged 3 [8]. Whether these children go on to become adults with pain is unclear. This high prevalence of musculoskeletal pain has also been reported in over 35% of females and 20% of males in Kuwait using a validated WHO/ILAR/COPCORD questionnaire [9]. A high prevalence of musculoskeletal pain is also seen in India [10], the Philippines [11] and Indonesia [12] using similar methodology. The Community Oriented Program for Control of Rheumatic Diseases (COPCORD), which was launched by the WHO/International League of Associations for Rheumatology (ILAR) in 1981, has provided some very interesting information on the burden of musculoskeletal disease and particularly the impact of pain in communities around the world [13].

The 2003 report Pain in Europe [14] reported a prevalence of chronic pain varying from 30% in Norway, 21% in Austria, 18% in the Netherlands to 15% in France, 13% in the UK and 11% in Spain. Just under one in five adults in Europe suffer from chronic pain and the most common site for this pain is the back. Over one-quarter of respondents in this study reported that the chronic pain they suffered had affected their job, while nearly 20% said they had lost their job due to pain.

Although chronic musculoskeletal pain significantly affects populations of working age [15] there is clear evidence that musculoskeletal pain, in particular, increases with age [16, 17]. With an ageing population it is therefore likely that musculoskeletal pain in the community will increase. But there are also other factors that may lead to an increasing burden of musculoskeletal pain. These include the association of musculoskeletal pain with obesity—an epidemic of which is occurring around the world. In both sexes, self-reported work-restricting pain in the neck and back area and in hip, knee and ankle joints was more common in obese subjects than in a general Swedish population ranging from odds ratios of 1.7 to 9.9 [18]. Interestingly, in this study surgical treatment of the obesity resulted in a reduction in pain (including the neck and back in those patients responding). The association of obesity with osteoarthritis of the knee and knee pain is well described and reduction in weight both decreases pain and the progression of arthritis [19].

Pain is a very complex process influenced by genetic, environmental and cultural factors as well as socio-economic status and psychological factors. This has been added to the neurophysiological response of the body to the ‘injury’ that has produced/is producing the pain. One factor that Harkness et al. did not discuss was that of ethnicity. The Manchester group have already reported that musculoskeletal pain is more widespread among ethnic minority communities in the UK and suggested that this may reflect social and cultural differences. In their study [20] the prevalence of musculoskeletal pain varied from 29% in Bangladesh women to 36% in White men and women to 53% in African/Caribbean men. This emphasizes the importance of reviewing the ethnic make-up of a population when studying pain, and may well contribute to changes in the prevalence of pain in a population as immigration alters that ethnic mix.

So, what might be the reasons for this increase in musculoskeletal pain? Like the authors I believe that factors such as the increasing number of lawyers and psychosocial issues are very important. I note, for example, that the percentage of married or cohabiting had reduced from 86% in Study 1 to 71% in Study 2 and that 7% of Study 2 participants were divorced or separated as opposed to zero in Study 1. It has been reported in other studies that those living alone or those who are divorced have a higher prevalence of musculoskeletal pain [21, 22] and that this may be related to depression and psychological stress [23].

The risk factors for chronic pain in the community have been well described by the Manchester Group [24] who have demonstrated a clear association between pain and a variety of symptoms indicative of the process of ‘somatization’ [25]—illness behaviour where patients convert psychological distress into physical symptoms (in this case, pain).

I am not sure whether the increase in lawyers is a result of or the cause of our more litigious society (I suspect the latter). It is interesting to note that there has been a trebling of the number of lawyers in the UK since the 1950s and roughly a trebling of chronic pain in the community. In America and Australia, where lawyers can advertise for clients who think they might be involved...
in personal injury, this is a major issue and has been discussed broadly by Hadler in a number of contexts [26, 27]. One should perhaps question a society that allows the number of lawyers to increase significantly over a period of time while the numbers of doctors is held relatively stable. This has also occurred in Australia, where there is one barrister or solicitor for every 550 Australians—I am certainly encouraging my Vice Chancellor to take on some community ‘responsibility’ and close down the Law School! As a profession we are probably unlikely to win this argument since, certainly in the USA, UK and Australia, a significant number of politicians in parliament have a legal background.

Individuals certainly seem to accept less responsibility for their own actions now, and the litigious nature of society may well provide a fertile soil in which ‘pain’ can grow.

Given this approaching pain ‘epidemic’ the important issue is how we can influence it. The focus of the Bone and Joint Decade [28] and the various educational activities it is promoting, particularly for the community, may well help. However, we do need to focus more broadly on the problem of pain in the community. This includes stimulating a much greater emphasis on research and education into the area of pain. The establishment of organizations such as the International Association for the Study of Pain have certainly assisted in raising the profile. There is a need to develop curricula at both the undergraduate and postgraduate level which will, by their nature, be multidisciplinary [29] and will ensure an understanding of the nature of musculoskeletal pain by all health professionals.

Pain research, particularly musculoskeletal pain, also needs to be encouraged and this also needs to be interdisciplinary in nature. Of critical importance in reducing pain would seem to be strategies for the management of acute musculoskeletal pain conditions which might lead to a reduction in the percentage which go on to become chronic. A number of evidence-based guidelines have been produced recently which might address this issue [30–32]. We also need to be more aware of the risk factors that may lead to the persistence of pain in an individual, particularly those psychological features that lead to somatization. A fundamental question that has always intrigued me is what is it that converts a person with pain into a patient with pain—what is it that causes that person with an ache to seek a health practitioner often without any change in the pain per se?

Some of these important issues have been raised in a recent editorial in this journal [33] and they should be taken up forthwith.

As practitioners of musculoskeletal medicine we are at the forefront of pain management—if we are going to treat acute and chronic musculoskeletal pain appropriately it seems to me that we need to know a little bit more about it. Harkness and colleagues have identified a major issue in relation to pain and rheumatology (rheumatologists) now needs to rise to that challenge.

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**References**