Resume of the 1. Meeting in the Rome Consensus Group (ESSOMM) 7/7/2024

Participants of the group today

Herman Locher – Germany
Michaela Habring - Austria
Stephan Vinzelberg - Germany
Bernard Terrier – Schwizerland
Frederico Di Segni – Itali
Marietta Karadjova – Bulgaria
Karen Goss – Denmark
Henk Bultmann – Holland
Alexander Lechner – Austria
Stefan Dreher – Germany
Victoria Sotos – Spain
Nicolas Straiton – UK
Gerhard Schmid – Austria
Robert Satran – Israel
Tina Simenova - Bulgaria

Introduction by Herman Locher, what has inspired the idea for a classification of the 80% LBP now known as "unspecific".

Michaela was at the Interdisciplinary world conference of low back pain in Australia, she gave an account of that in Lech and made contact with Paul Hodges.

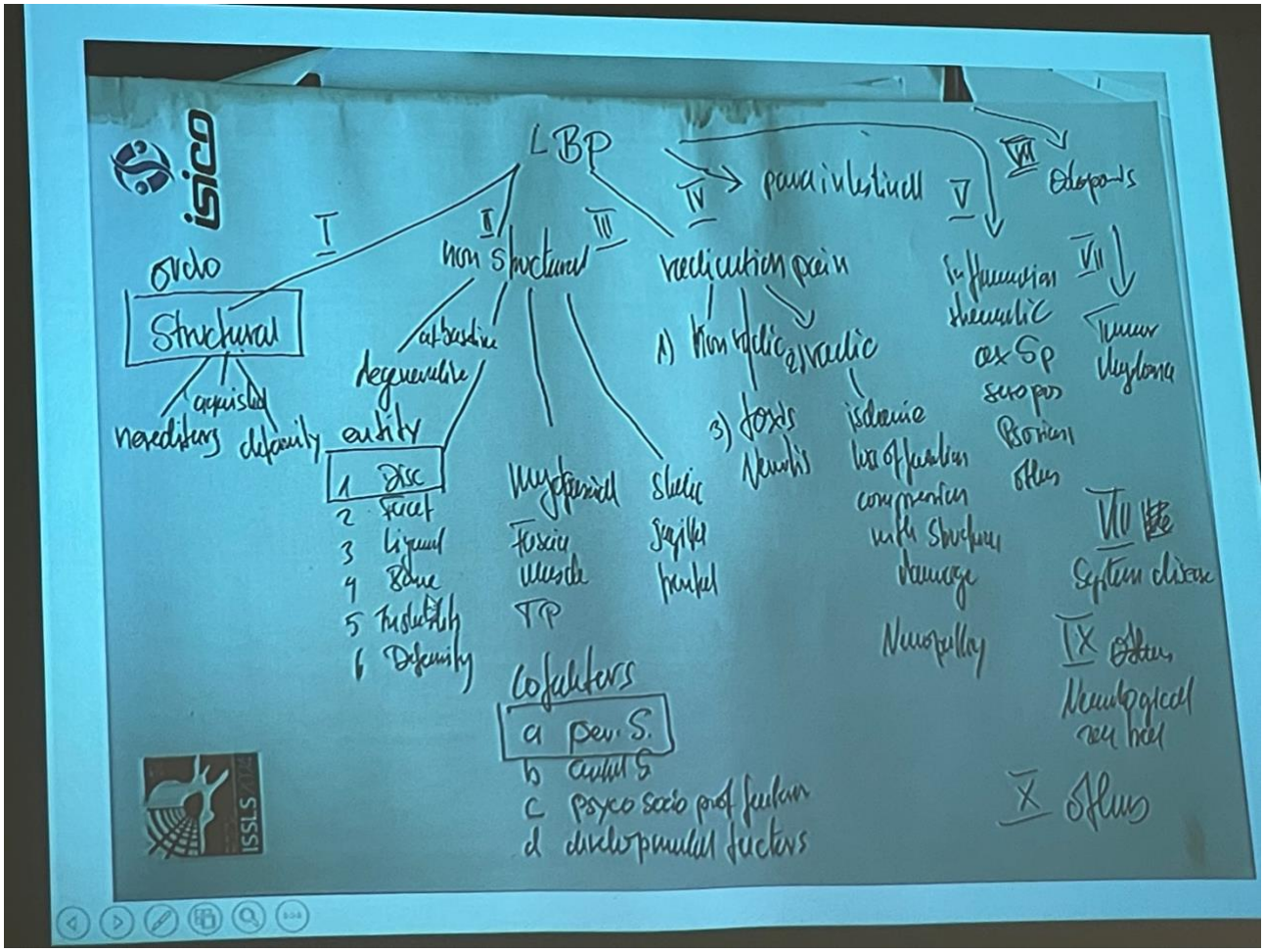
Herman and Michaela were in Milano for the ISSLS meeting this spring, very scientific, very high level
On their homepage you can see the program and all the abstracts (250 speakers 80 posters)
Lots of focus on structure, but noting on pain.

Poul Hoges is in charge of terminology in IASP and he is interested in our project.

We have to somehow fathom the complexity of the task we are about to think about.
Many aspects
Nociplastisity, sensitization, psychosocial situations, all things that could explain how a set condition can have many presentations to the physician.

SO …. **ICLDP** **I**nternational **C**lassification og **L**ow **B**ack **P**ain

Next we had a discussion about Herman's 1. Attempt to make a classification



3 step Diagnosis

A Symptoms / time
B Structure, imaging, biochemistry
C Psychosocial surroundings.

Essential Questions

Do we want to do this ??
Why do we want to do it ?
What do we need it for ?
Will it be good or bad for the patients / insurance aspect.
We must be addressing pain AND function
We will have several levels of classification (could be difficult to stay on focus)
Additional chapters : Convergens , Sensitization, non-expected occurrences.

Bernard 1.
A presentation of the
ICD-10 , https://www.cdc.gov/nchs/icd/icd10.htm
ICF
https://en.wikipedia.org/wiki/International_Classification_of_Functioning,_Disability_and_Health
and **ICHD** **https://ichd-3.org/**

To use as inspiration and examples.

LUNCH

Karen gave a short presentation on the diagnostics of Axial Spondylarthritis and showed a couple of examples of flowcharts and other tools for diagnostics and classification.

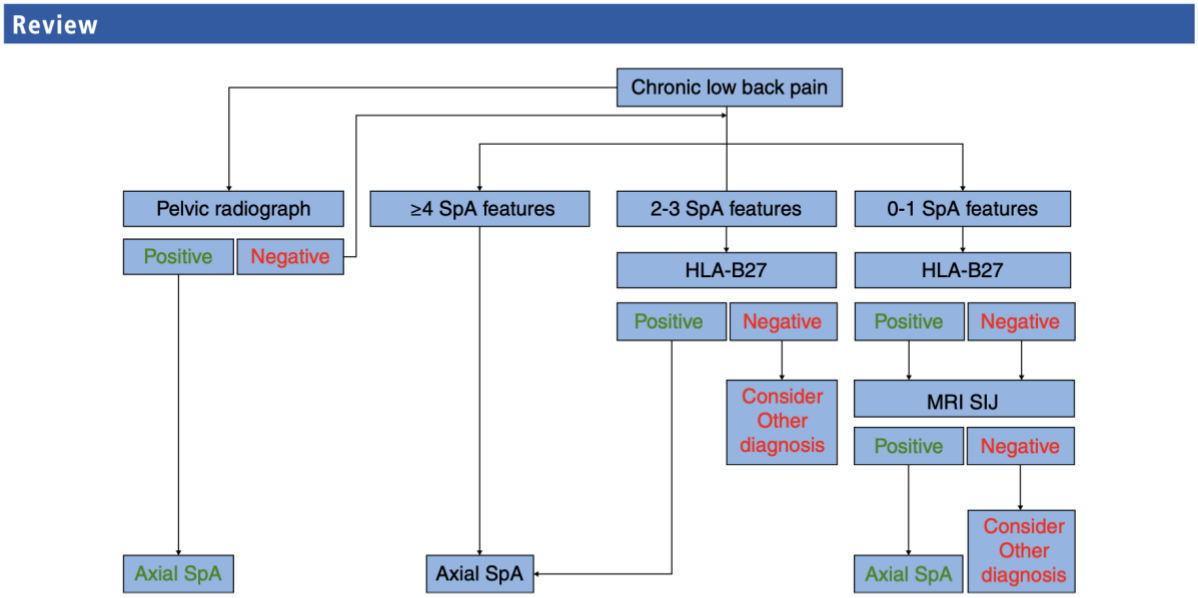


Figure 3 ASAS adaptation of the Berlin algorithm. ASAS, Assessment in SpondyloArthritis international Society; HLA, human leucocyte antigen; SIJ, sacroiliac joints; SpA, spondyloarthritis. SpA features: inflammatory back pain, alternating buttock pain, good response to non-steroidal anti-inflammatory drugs, peripheral arthritis, enthesis, dactylitis, psoriasis, inflammatory bowel disease, uveitis, elevated acute phase reactants, preceding infection, family history. Adapted from van den Berg *et al*.[42]

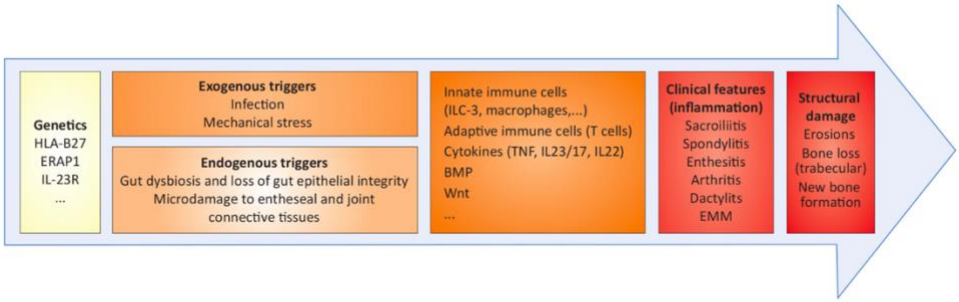


Figure 2 Pathogenesis scheme for axial spondyloarthritis. A schematic presentation of the various aspects that play a role in the pathogenesis of axial SpA. BMP, bone morphogenetic protein; EMM, extra-musculoskeletal manifestation; ERAP, endoplasmic reticulum aminopetidase; HLA, human leucocyte antigen; IL, interleukin; ILC, innate lymphoid cell; SpA, spondyloarthritis; TNF, tumour necrosis factor.

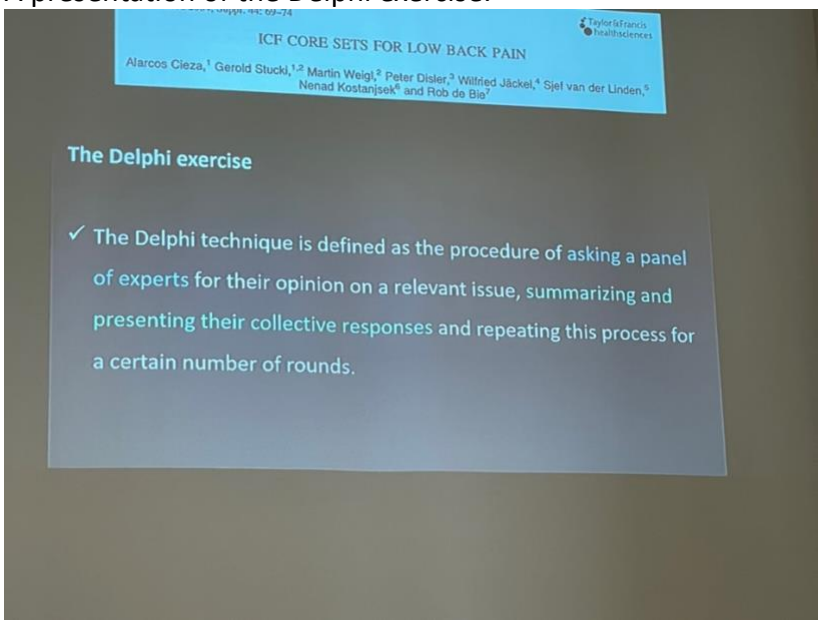
We must have a definition of LBP
This brought us to the already made long list and categorization of pian and also LBP made by IASP . International Classification of Pain chapter 26

WE ALL NOW HAVE THE TASK OF READING THIS AND MAKING KOMENTS, OVERVUE OF THIS PAPER. Victoria will send us the link.

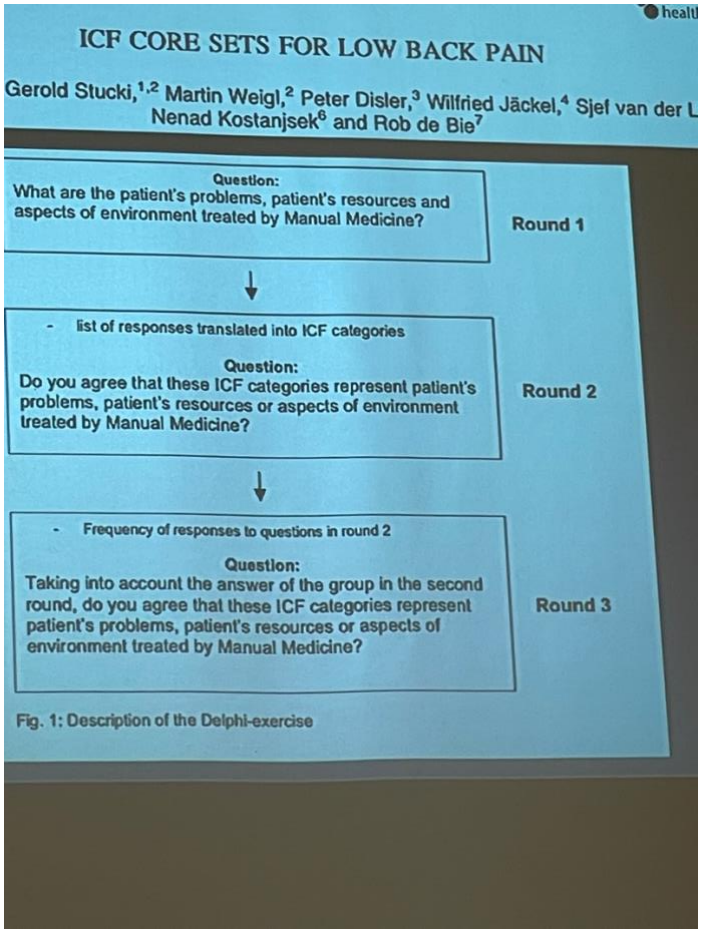
Bernard 2

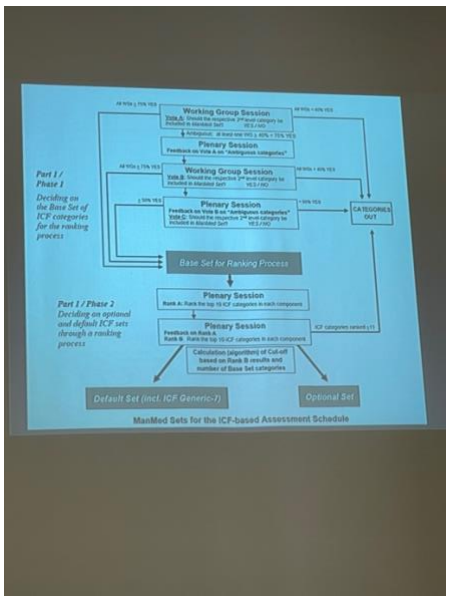
Deeper analysis of the differences between ICD-10 and ICD-11 (more open structure)
And also ICF , how it is built up with core sets , that are a good example and correlate nicely with Hermans first idea . (Roman letters I – X)

A presentation of the Delphi exercise.



Something we could use. And thereby heighten the level of evidence from D to C ??





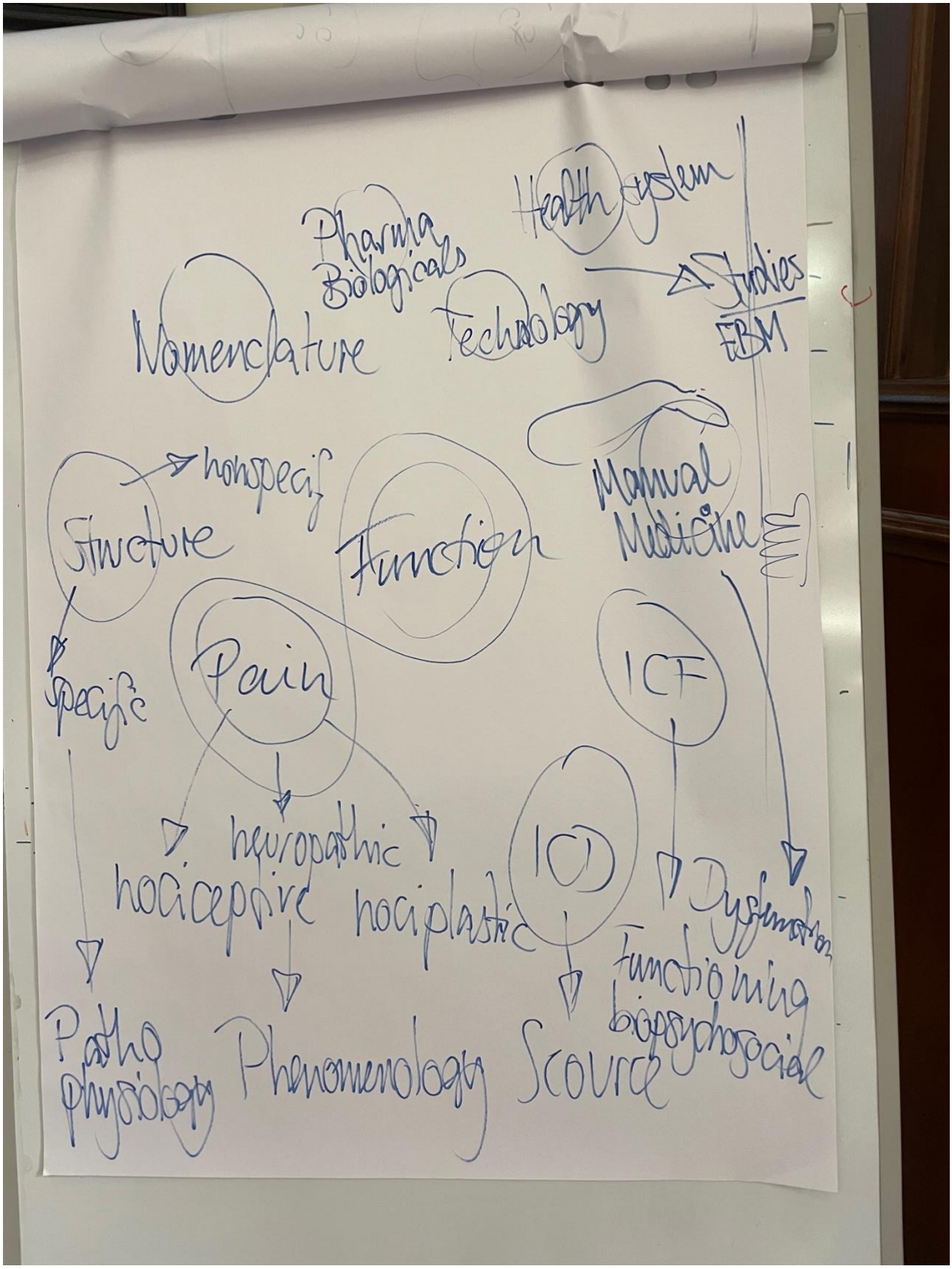
Examples of Delphi sessions and rounds.

So the plan generally accepted was :

1) Study the literature and make a revue, publish a paper on this.
2) Establish the Core sets including details
3) Create another volume : Therapeutic consequences.

THEN STEPHAN BROUGHT THE DAY TOGETHER WITH THE PAINTING IN THE SALA OF THE BABY JESUS , HIS MOTHER AND ALL THE “PEOPLE “ARROUND HIM.

Jesus and Mary are Pain and function together… a unity that must be considered together.
The Father is the Structure and the supportive people around them are ICD, ICF, Nomenclature, Pharma industry, Health system, technology .. and looking at it all is Manual Medicine.


Health system
Pharma
Biologicals
Studies
EBM
Nomenclature
Technology
Manual
Medicine
Structure
nonspecific
Function
specific
Pain
ICF
ICD
neuropathic
nociceptive
nociplastic
Dysfunction
Functioning
biopsychosocial
Patho
physiology
Phenomenology
Source

DAY 2

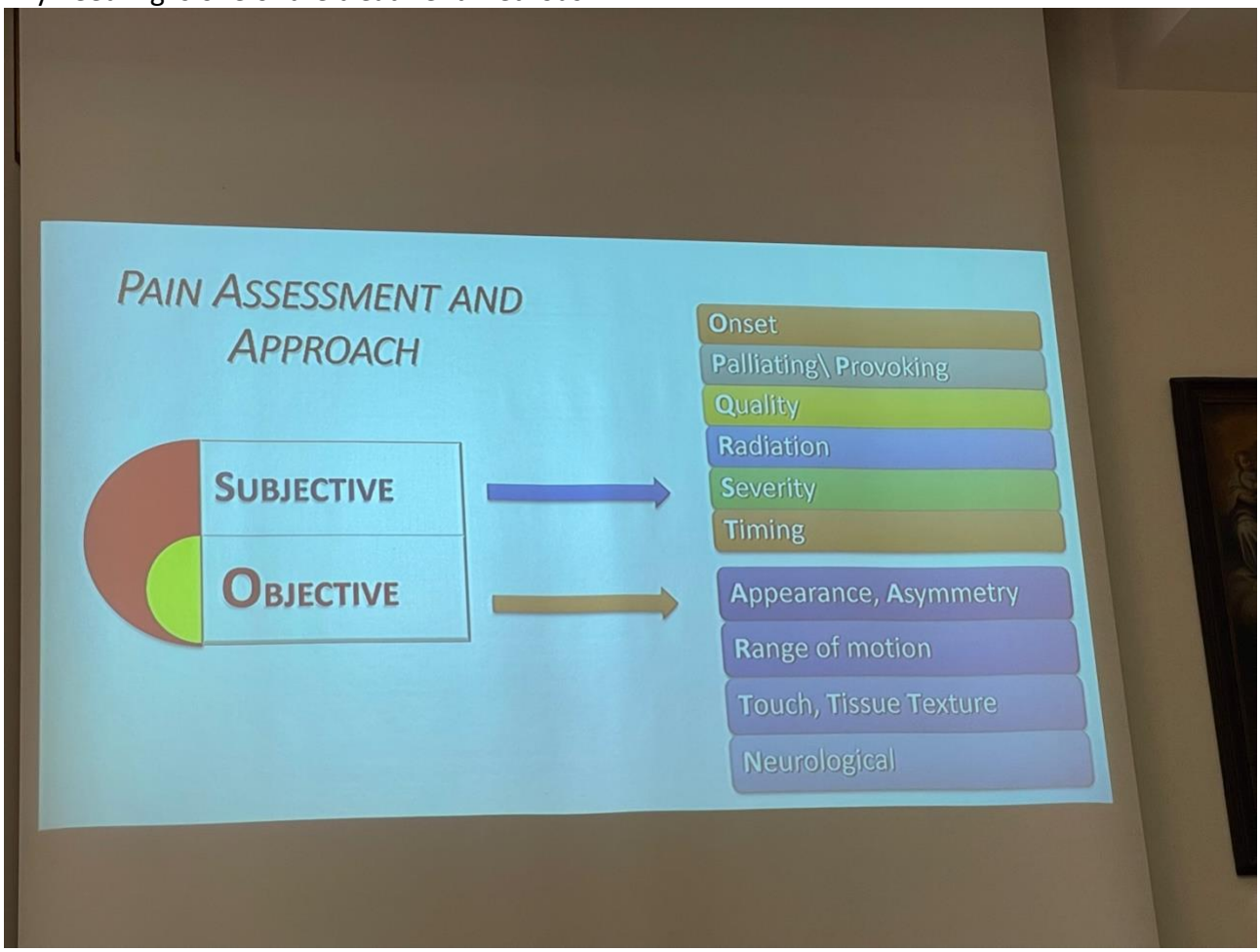
GA, se other paper.

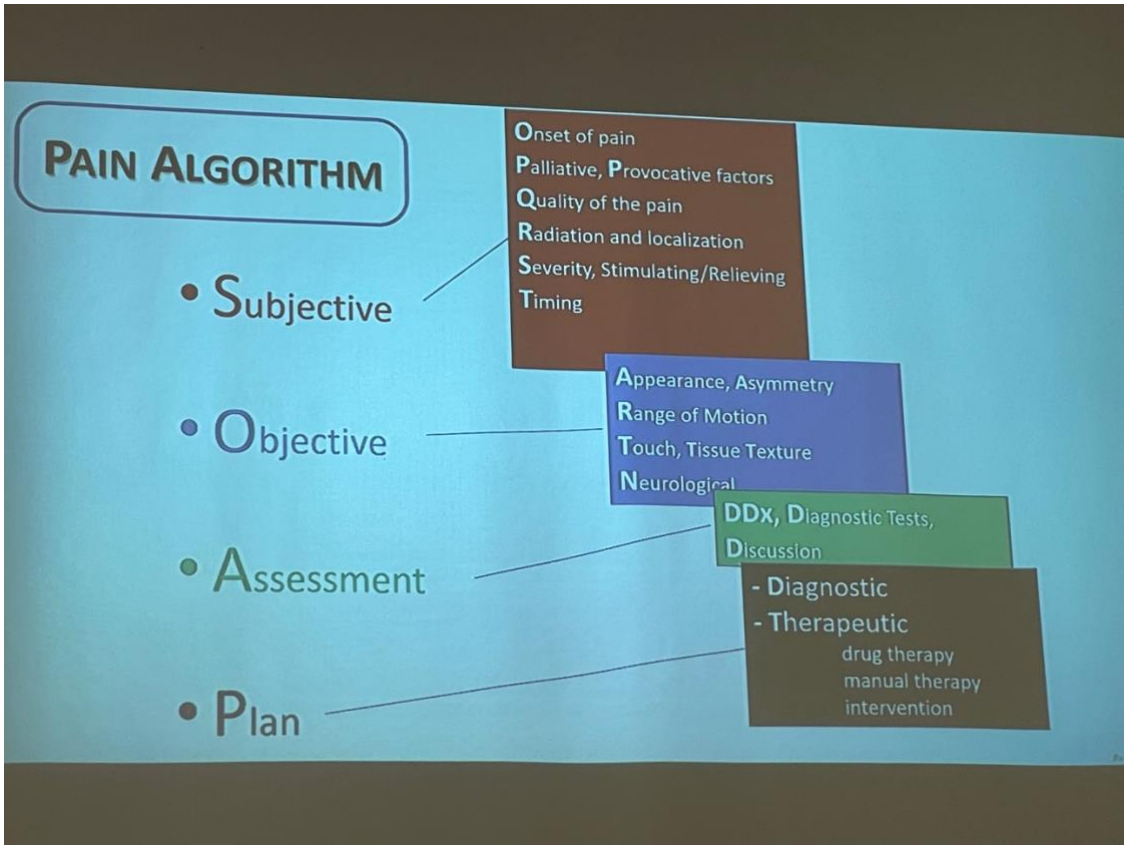
We went through the summery of day 1.

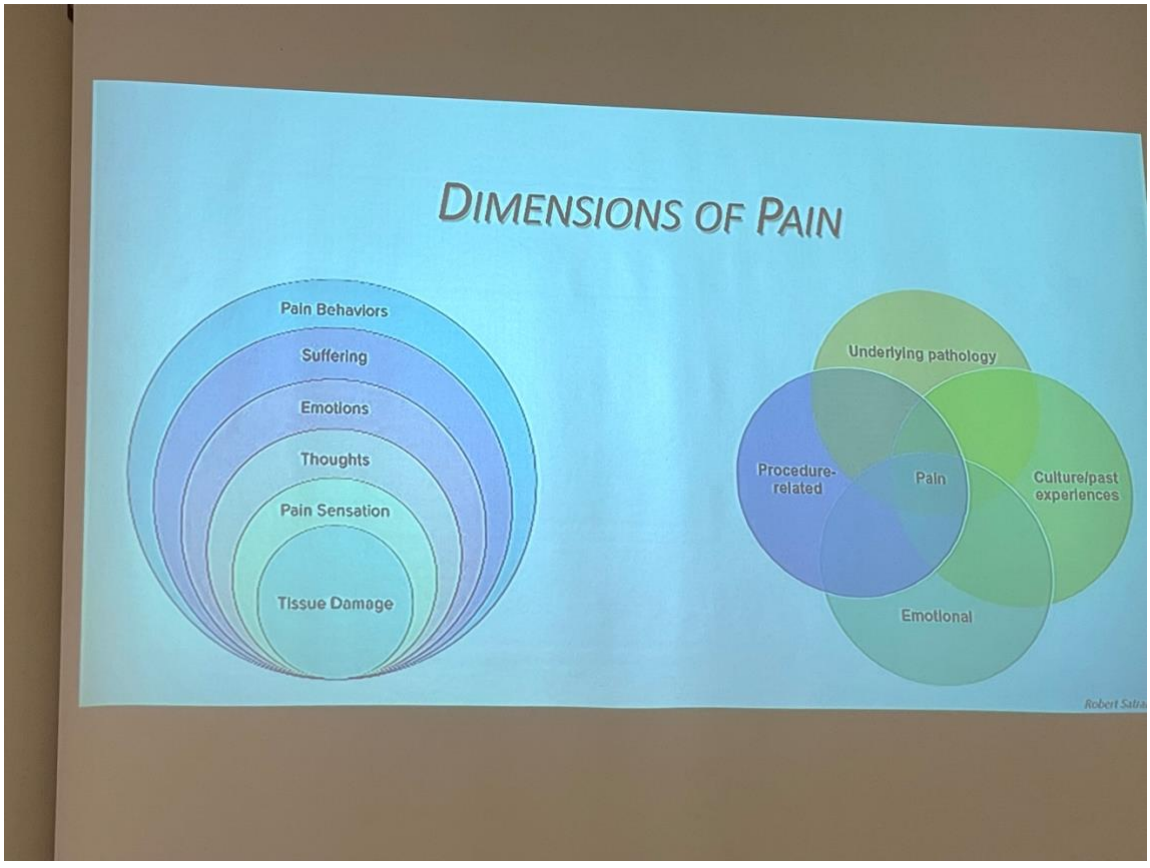
PLANS to continue in ESSOMM :

1) Furter work on the ICLBP
2) Meeting with content , workshops, presentations, discussions about our challenges as MM societies.
3) Enjoy the good company and Rome feeling.

Robert from Israel told us about how they try to teach diagnosis of Musculoskeletal conditions. Dry needling is one of the treatment methods.




PAIN ALGORITHM
• Subjective
• Objective
• Assessment
• Plan
Onset of pain
Palliative, Provocative factors
Quality of the pain
Radiation and localization
Severity, Stimulating/Relieving
Timing
Appearance, Asymmetry
Range of Motion
Touch, Tissue Texture
Neurological
DDx, Diagnostic Tests,
Discussion
- Diagnostic
- Therapeutic
drug therapy
manual therapy
intervention


DIMENSIONS OF PAIN
Pain Behaviors
Suffering
Emotions
Thoughts
Pain Sensation
Tissue Damage
Underlying pathology
Procedure-related
Pain
Culture/past experiences
Emotional

Tina gave us a review of the literature
Ultrasound diagnosis and therapeutic intervention in the spine.

Henk made a presentation still asking the question.. Should we do it ?

On what purpose ?
On which conditions ?
Pain, function ?

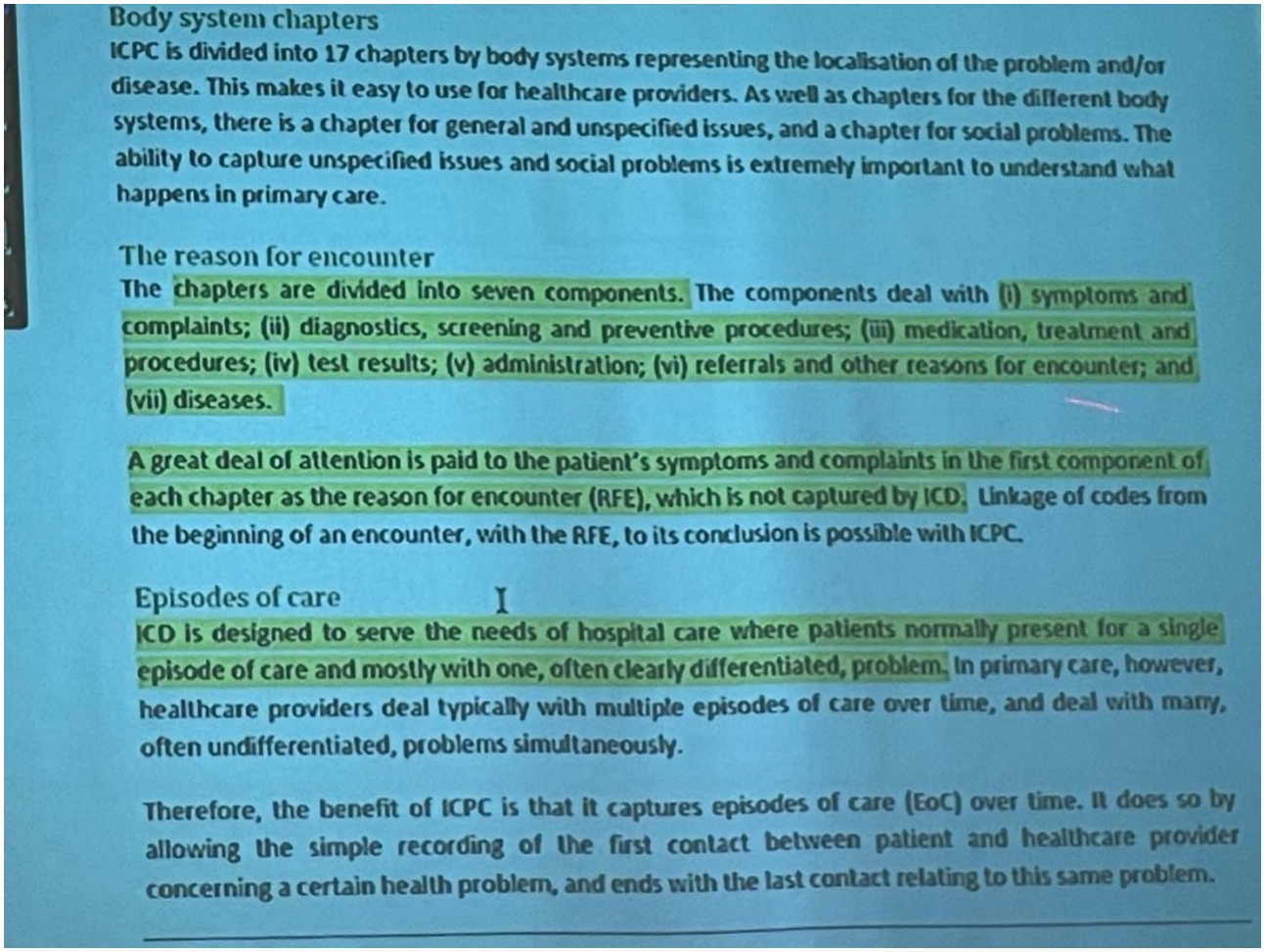
Focus on daily use in the clinical practice
MM system for our use. Our core values.

- History taking
- Examination
- MM diagnosis
- Treatment/therapy plan

Additional to other calcification

ICPC (for GP's) allows communication between ICPC and ICD.

Steps se photo



Body system chapters

ICPC is divided into 17 chapters by body systems representing the localisation of the problem and/or disease. This makes it easy to use for healthcare providers. As well as chapters for the different body systems, there is a chapter for general and unspecified issues, and a chapter for social problems. The ability to capture unspecified issues and social problems is extremely important to understand what happens in primary care.

The reason for encounter

The chapters are divided into seven components. The components deal with (i) symptoms and complaints; (ii) diagnostics, screening and preventive procedures; (iii) medication, treatment and procedures; (iv) test results; (v) administration; (vi) referrals and other reasons for encounter; and (vii) diseases.

A great deal of attention is paid to the patient's symptoms and complaints in the first component of each chapter as the reason for encounter (RFE), which is not captured by ICD. Linkage of codes from the beginning of an encounter, with the RFE, to its conclusion is possible with ICPC.

Episodes of care

ICD is designed to serve the needs of hospital care where patients normally present for a single episode of care and mostly with one, often clearly differentiated, problem. In primary care, however, healthcare providers deal typically with multiple episodes of care over time, and deal with many, often undifferentiated, problems simultaneously.

Therefore, the benefit of ICPC is that it captures episodes of care (EoC) over time. It does so by allowing the simple recording of the first contact between patient and healthcare provider concerning a certain health problem, and ends with the last contact relating to this same problem.

Could be a way to approach it
A LBP calcifications for MM

Advantages of making this classification :

It will strengthen MM, visibility of MM,
Not threatening for other specialties.
Could be a cooperation between ESSOMM, FIMM and IAMMM

Global
Blueprint for other areas
Guidelines derived on it
Focus on prevention, first we need classification.

CLBP in MM

How to move forward with the IClBP (working title)

TASKS … ?
Looking at the literature we need help form eksperts that can do this much better than us.

Looking at the classifications that are there already (Herman)
Lack of information that are relevant for us concerning assessment.
Look at the title .. put in comprehensive classification of LBP ?

Bernard proposes that the EX board makes a plan for how to move forward.

We each make a flow chart about something we work with on a daily basis

We now end the 12'th instructor course.

Thank you all for a good couple of days!

Karen Goss