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EDITORIAL

Differential diagnosis of patients with chronic pain: heuristics and biases

Diagnóstico diferencial de pacientes com dor crônica: heurística e vieses

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Assessing a healthy patient with acute abdominal pain and concluding their diagnosis after anamnesis, clinical examination and perhaps laboratory tests is commonplace in a hospital emergency environment. However, biases negatively influence this decision-making in outpatient consultation environments in cases of patients with chronic pain. A real case: a 54-year-old married woman, off work due to diffuse pain, diagnosed with fibromyalgia, irritable bowel syndrome, body mass index of 18 kg/cm^2, consults a doctor complaining of persistent pain and changing pain patterns in the right iliac fossa, confirms that she has always had episodes of pain in this area but that the pain has become more intolerable in the last three or four months. She also reported pain in the medial, anterior and lateral areas of the right hip, as well as in the lumbar, sacroiliac, cervical, left upper limb and plantar regions. The doctor decided to order an imaging test and *eureka*! A diagnosis of appendicitis was confirmed.

The satisfaction of the clinical diagnosis established in a "clouded" clinical case is undeniable, but situations like this are not commonplace. Beyond heuristic thinking and bias control, diagnosing an acute illness with signs and symptoms similar to those of the patient with diffuse chronic pain is almost like an outlier, an exception.

Patients with chronic pain have complex clinical manifestations, and their clinical examination is rarely described by a specific and limited scenario. The diseases associated with chronic pain have a significant psychosocial impact that influences the interpretation of signs and symptoms. The need to include the multi-dimensionality of pain in the assessment is supported by the inclusion of complementary codes from the International Classification of Diseases (ICD-11)[1].

Anamnesis and clinical assessment expose the variability of the pain characteristics, descriptors, indexes, intensity and location, usually with mood disorders, sleep disorders, concentration and memory difficulties, food intolerance or digestive problems, as well as other associated symptoms and diseases[2]. Despite the similarity in the persistence of pain, it is essential to remember that patients diagnosed with chronic pain are heterogeneous.

In Brazil, the highest prevalence of chronic pain is in the lumbar region and joint pain (rheumatoid arthritis or osteoarthritis), followed by musculoskeletal pain, headaches, neuropathic pain and fibromyalgia[2]. According to data from before the COVID-19 pandemic, 15% of Brazilians had described the location of their pain as diffuse. These may represent the group of patients with the greatest difficulty in making a differential diagnosis in situations of acute pain, or "new complaint of pain". The history of chronic pain could be classified as a confounding variable in the patient's clinical assessment. Although chronic pain does not represent a risk factor for acute conditions such as appendicitis[3], cholecystitis and renal lithiasis, it is possible to recognize some obstacles in the heuristic evaluation of a patient with comorbidities of irritable bowel syndrome, fibromyalgia or even chronic low back pain. Age, gender, lifestyle habits and genetic factors are among the risk factors for these acute conditions[3].

The long path in search of treatment and diagnosis with long periods of doctor appointments, tests and assessments can corroborate low expectations about health services, avoiding consultations, as well as aggravating psychosocial aspects associated with pain/illness[4]. Despite alarming data on costs, in Brazil, approximately 8% of patients with chronic pain interviewed before the pandemic[2] no longer sought consultation due to pain.

Dissociating the complaint of new pain from a patient with chronic pain involves several stages in the care process: (1) the patient realizing that they need to consult, (2) health professionals who follow the patient regularly should encourage or reassure them about seeking a different diagnosis, (3) the attending physician and/or (4) the emergency physician.

In the process of looking for help, pain is one of the main reasons for making a doctor appointment, but when the pain is persistent, the reason for the consultation is more associated with the intensity or a change in the pain characteristics. It is estimated that patients with chronic pain who usually or not at all seek consultations with physicians are motivated by the perception of good symptom management[5] or by fear of judgment, making their complain of pain an impossibility[6].

International guidelines for the treatment of chronic pain recommend an emphasis on pain education (for example: understanding that chronic pain is not associated with an injury or acute illness), patient comfort and safety in treatment with a multidisciplinary team[7]. It is estimated that being welcoming, guiding and making explanations about chronic pain will encourage the necessary lifestyle changes to improve the patients' quality of life. Unfortunately, having a diagnosis of chronic pain is not a protective factor against oth-

er diagnoses, or other diseases or situations that require medical evaluation and intervention. There is a gray area between "understanding chronic pain" and "noticing a change in the pain pattern", as well as between negligence and hypervigilance. Patients with chronic pain can - and should - have regular assessments for early diagnosis of other health conditions, as they can also be affected by acute situations. The patient's chronic pain should not mask the anamnesis and clinical assessment.

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