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Persistent Spinal Pain Syndrome

Last month's editorial highlighted concerns about nominating "nonsurgical refractory back pain" as a specific indication for spinal cord stimulation (SCS). These concerns include the heterogeneous nature of the populations treated in studies to date, the innate bias within each study design, the limited follow-up, and the potential implications of poor outcomes for future access to SCS and other costly treatments.

The recognition that patients who had and those who had not undergone spinal surgery could be clinically identical led Simpson to propose a "persistent spinal syndrome," a product of incomplete adaptation to the upright posture. The consensus was that this term should include "pain"; thus, "persistent spinal pain syndrome" (PSPS) was introduced five years ago (Christelis et al., 2021) to replace "failed back surgery syndrome" with PSPS-type 2. PSPS-type 1 represents those with chronic pain of spinal origin who have not undergone spinal surgery to relieve pain (excluding neuromodulation procedures); a vast and heterogeneous group. The patients treated with SCS in recent studies are drawn from this group.

A recent consensus article,"The Implementation of Persistent Spinal Pain Syndrome (PSPS): Mechanism-Based Recommendations," (Thomson et al., 2026) proposes an alternative method of clustering PSPS patient phenotypes based upon the innovative PAMC scale (i.e., PSPS type; Anatomy; Mechanism; Certainty). The mechanism of the pain, rather than anatomical pathology, has primacy. The three mechanisms of pain (nociceptive, nociplastic, and neuropathic) may exist independently, sequentially, or simultaneously. The grades of certainty of the diagnosis are "possible, probable, and

certain." PSPS can affect all levels of the spine and include patterns of referred and radicular pain to head, limb, and coccyx.

We support a collective effort to rationalise our diagnostic and therapeutic selection in an area of healthcare that is served by many differing medical and non-medical specialties. We should not accept a blanket term of non-specific low back pain nor assume that anatomical-pathological categories continue to dominate. If we can develop a more accurate and common language of patient phenotypes, identifying diagnostic and prognostic factors, there is a possibility that we will achieve better clinical evidence, informing more effective treatment guidance, and, in turn, resulting in better clinical and more cost-effective treatment outcomes. For example, identifying multifidus dysfunction in back pain-only PSPS might lead to more specific treatment than in the recent SCS studies for a subpopulation of PSPS-type 1 patients.

This month's editorial is a collaborative effort by Dr. Simon Thomson, MBBS Consultant in Pain Medicine and Neuromodulation, Mid & South Essex University Hospitals NHSFT, UK; Dr. Brian Simpson, Department of Neurosurgery, University Hospital of Wales, Cardiff, UK (retired); and Dr. Richard North, WIKISTIM's Editor-in-Chief.

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Dorsal Root Ganglion Stimulation (still 315 citations)

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