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PELVICON 2026

SAME SYMPTOMS, DIFFERENT PAIN: PHENOTYPING PELVIC PAIN IN CLINICAL PRACTICE

DR. PAUL HODGES

POST-CON 2026



PAUL HODGES

Paul Hodges is one of the foremost physiotherapy researchers of his generation.

An internationally recognized researcher in pain, movement, rehabilitation, and pelvic health, Paul has authored 600+ peer-reviewed scientific papers and 30+ book chapters, with his work influencing clinicians and researchers around the world. His groundbreaking research has transformed our understanding of how the nervous system, muscles, pain, and movement interact.

Few people have shaped the science behind how we practice as profoundly as Paul.

@paulwhodges

PHENOTYPING PELVIC PAIN IN CLINICAL PRACTICE

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Same Symptoms, Different Pain: Phenotyping Pelvic Pain in Clinical Practice

Paul W. Hodges



About Me

- Physiotherapist, Neuroscientist & Pain Scientist
- PhD MedDr DSc Drhc BPhty(Hons) FACP FAA FAHMS FISEK FQA
- Director, Centre for Innovation in Pain and Health Research (CIPHeR), The University of Queensland, Brisbane, Australia
- Director, DISCERN NHMRC Synergy Grant

Pain Descriptors

- What are they and how do they apply to pelvic conditions - revision
- How can they guide treatment matching?
- How do we discriminate between them?
- Clinical application

Pain Descriptors

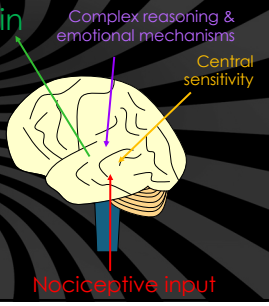
- What are they and how do they apply to pelvic conditions - revision
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- How do we discriminate between them?
- Implications for practice?

Pain descriptors: Revision

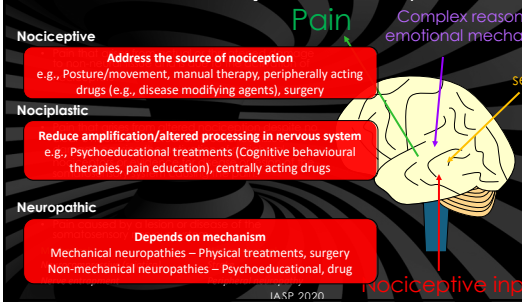
Pain mechanistic descriptors;

- Nociceptive pain
- Nociplastic pain
- Neuropathic pain

IASP 2020



Neuroscience of pain: Not all pain is the same



Nociceptive
Address the source of nociception
e.g., Posture/movement, manual therapy, peripherally acting drugs (e.g., disease modifying agents), surgery

Nociplastic
Reduce amplification/altered processing in nervous system
e.g., Psychoeducational treatments (Cognitive behavioural therapies, pain education), centrally acting drugs

Neuropathic
Depends on mechanism
Mechanical neuropathies – Physical treatments, surgery
Non-mechanical neuropathies – Psychoeducational, drug

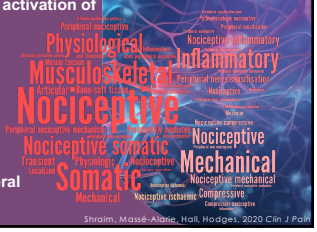
IASP 2020

Nociceptive pain

Mechanisms

Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors

- **Mechanical**
- **Chemical**
  - Inflammatory, Ischaemic
- **Thermal**
- **Primary hyperalgesia, local peripheral sensitisation**



Shraim, Massé-Alarie, Hall, Hodges, 2020 *Clin J Pain*

Nociceptive pain

- Inflammatory
  - CAUSE: long-lasting inflammation of internal organs → due to infectious or noninfectious agents or autoimmune causes.
  - EXAMPLES: Recurrent cystitis and urethritis, Crohn disease, ulcerative colitis, chronic salpingitis and oophoritis, chronic pelvic inflammatory disease, and chronic prostatitis.

Nociceptive pain

- Vascular
  - CAUSE: Alterations of arterial or venous blood vessels supplying the viscera
  - EXAMPLES: Ischemic colitis and iliac artery aneurysms;

Nociceptive pain

- Mechanical
  - CAUSE
    1. Obstruction of hollow viscera as a consequence of internal migrating obstacles (eg, stones) or stenosis
    2. Traction of ligaments and vessels of internal organs
    3. External compression of internal organs
  - EXAMPLE
    - Recurrent urinary colic because of obstructions such as lithiasis of lower urinary tract, ureteric kinking or stenosis of the anus/rectum; compression of the male or the female reproductive organs

Neuropathic pain

Mechanisms

Pain caused by a lesion or disease of the somatosensory nervous system.

- **Central nervous system**
- **Peripheral nervous system**
  - Mechanical
  - Non-mechanical



Shraim, Massé-Alarie, Hall, Hodges, 2020 *Clin J Pain*

Neuropathic pain

- Neuropathic causes of pain
  - CAUSES: Nerve entrapment (e.g., pudendal), herniated intervertebral disc, spinal pathology, Tarlov cyst, sacral chordoma, multiple sclerosis
  - Polyneuropathy

Nociplastic pain

Mechanisms

Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage causing the activation of peripheral nociceptors or evidence for disease or lesion of the somatosensory system causing the pain.

- **Any mechanisms that "amplifies" pain**
- **Central sensitisation is assumed to be the major mechanism**
- **Cells to networks**
- **including neuro-immune interactions**



Shraim, Massé-Alarie, Hall, Hodges, 2020 *Clin J Pain*

Nociplastic pain

- Chronic primary pelvic pain syndrome
  - Symptoms are not better accounted for by one of the other possible chronic secondary visceral pelvic pain diagnoses: chronic visceral pelvic pain from persistent inflammation, vascular mechanisms, and

Nociplastic pain

- Chronic primary bladder pain syndrome
  - Perceived in the region of the urinary bladder - when not better accounted for by any diagnosis of chronic secondary visceral pain
  - Associated with at least one other symptom
    - Worsening of the pain upon bladder filling and urinary frequency
    - Sexual dysfunction
    - Dysfunction of the lower urinary tract
  - Other names - "interstitial cystitis," "painful bladder syndrome," and "PBS/IC" or "BPS/IC"

Chronic pelvic pain

- Primary and secondary pain are both often associated emotional, cognitive and behavioural features
- A condition/disease process might be present, but it might not explain the pain
  - i.e., transition from nociceptive/neuropathic to nociplastic pain
- Primary pain vs. Nociplastic pain
  - Not equivalent, but overlapping
  - Primary pain does not require presence of additional features including generalised sensitivity

Pain Descriptors

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What are they and how do they apply to pelvic conditions - revision

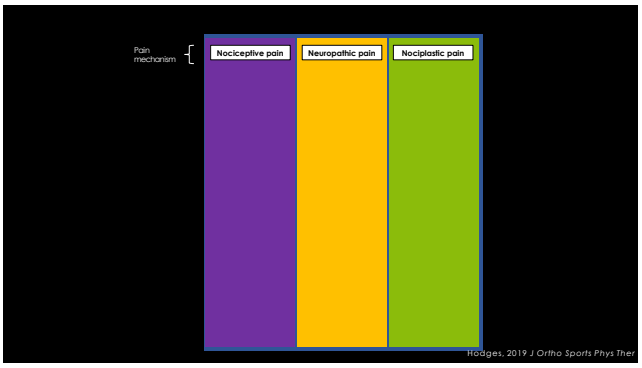
- How do pain descriptors relate to pelvic health conditions?
- Not yet well defined
- Major controversies
  - Endometriosis – when are "lesions" relevant?

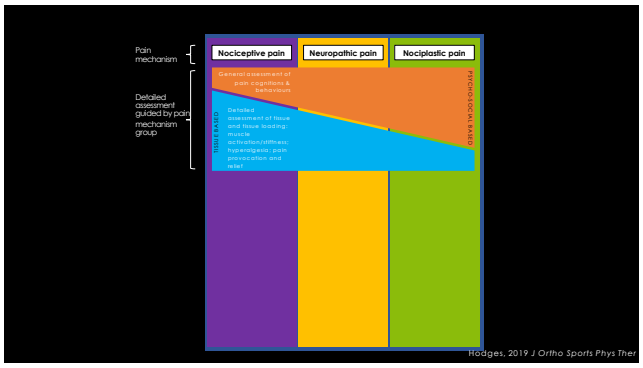
Pain Descriptors

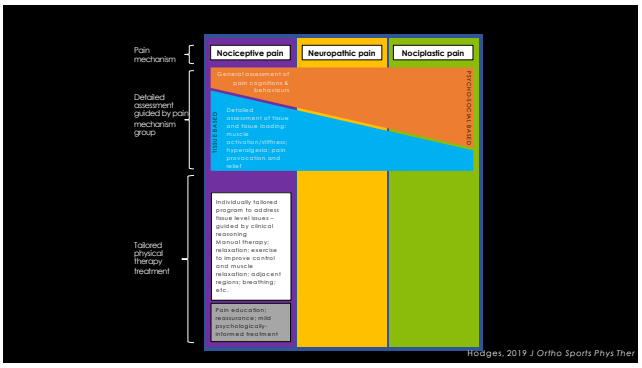
DISRUPT PELVICON 2026

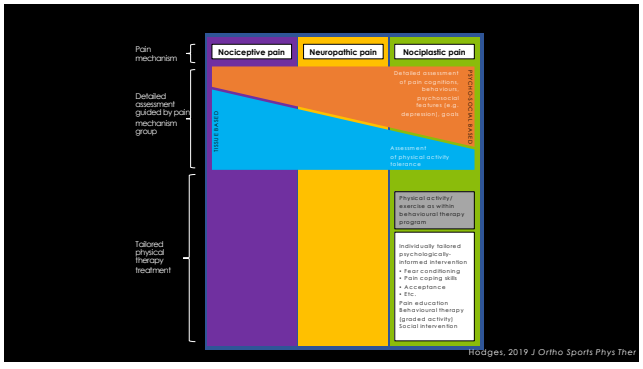
- **What are they and how do they apply to pelvic conditions - revision**
- **How can they guide treatment matching?**
- **How do we discriminate between them?**
- **Implications for practice?**

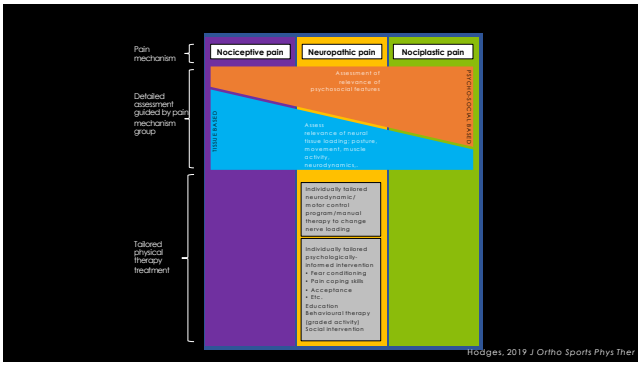

How can can pain mechanistic descriptors guide assessment and treatment?

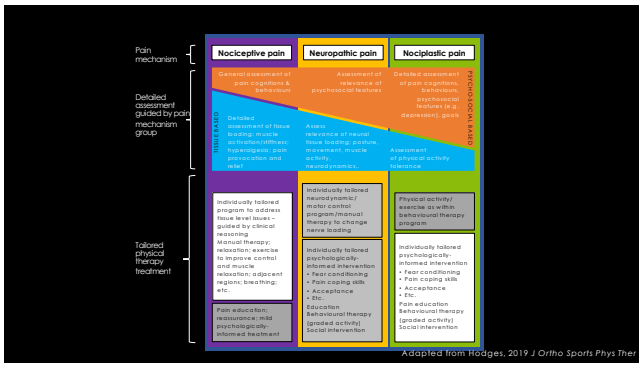

Pain mechanism
Nociceptive pain
Neuropathic pain
Nociplastic pain
Hodges, 2019 J Ortho Sports Phys Ther


Pain mechanism
Nociceptive pain
Neuropathic pain
Nociplastic pain
Detailed assesment guided by pain mechanism group
General assessment of pain cognitions & behaviours
Detailed assesment of tissue and tissue loading; muscle activation/stiffness; hyperalgesia; pain provocation and relief
TISSUE BASED
PSYCHOSOCIAL BASED
Hodges, 2019 J Ortho Sports Phys Ther


Pain mechanism
Nociceptive pain
Neuropathic pain
Nociplastic pain
Detailed assesment guided by pain mechanism group
General assessment of pain cognitions & behaviours
Detailed assesment of tissue and tissue loading; muscle activation/stiffness; hyperalgesia; pain provocation and relief
TISSUE BASED
PSYCHOSOCIAL BASED
Tailored physical therapy treatment
Individually tailored program to address tissue level issues - guided by clinical reasoning Manual therapy; relaxation; exercise to improve control and muscle relaxation; adjacent regions; breathing; etc.
Pain education; reassurance; mild psychologically-informed treatment
Hodges, 2019 J Ortho Sports Phys Ther


Pain mechanism
Nociceptive pain
Neuropathic pain
Nociplastic pain
Detailed assesment guided by pain mechanism group
Detailed assessment of pain cognitions, behaviours, psychosocial features (e.g., depression), goals
Assessment of physical activity tolerance
PSYCHOSOCIAL BASED
TISSUE BASED
Tailored physical therapy treatment
Physical activity/ exercise as within behavioural therapy program
Individually tailored psychologically-informed intervention
• Fear conditioning
• Pain coping skills
• Acceptance
• Etc.
Pain education
Behavioural therapy (graded activity)
Social intervention
Hodges, 2019 J Ortho Sports Phys Ther


Pain mechanism
Nociceptive pain
Neuropathic pain
Nociplastic pain
Detailed assesment guided by pain mechanism group
Assessment of relevance of psychosocial features
Assess relevance of neural tissue loading: posture, movement, muscle activity, neurodynamics.
PSYCHOSOCIAL BASED
TISSUE BASED
Tailored physical therapy treatment
Individually tailored neurodynamic/ motor control program/manual therapy to change nerve loading
Individually tailored psychologically-informed intervention
• Fear conditioning
• Pain coping skills
• Acceptance
• Etc.
Education
Behavioural therapy (graded activity)
Social intervention
Hodges, 2019 J Ortho Sports Phys Ther



Pain Descriptors

- What are they and how do they apply to pelvic conditions - revision
- How can they guide treatment matching?
- **How do we discriminate between them?**
- Clinical application

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How can we identify pain mechanisms in clinical practice?

Systematic Review and Meta-Analysis

PAIN

Methods to discriminate between mechanism-based categories of pain experienced in the musculoskeletal system: a systematic review

Muath A. Shraim[a], Hugo Massé-Alarie[a,b], Paul W. Hodges[a,*]

How can we identify the predominant pain mechanism in clinical practice?

- 184 papers; 200 unique methods; 5 themes
  - Clinical examination
  - Quantitative sensory testing
  - Imaging
  - Diagnostic and laboratory testing
  - Pain-type questionnaires

Build on this information to build a consensus based tool

Consensus on candidate measures

Research Paper

PAIN

Features and methods to discriminate between mechanism-based categories of pain experienced in the musculoskeletal system: a Delphi expert consensus study

Muath A. Shraim[a], Kathleen A. Sluka[b], Michele Sterling[c], Lars Arendt-Nielsen[d], Charles Argoff[e], Karl S. Bagraith[f], Ralf Baron[g], Helena Brisby[h], Daniel B. Carr[i], Ruth L. Chimenti[j], Carol A. Courtney[k], Michele Curatolo[l], Beth D. Darnall[m], Jon J. Ford[n], Thomas Graven-Nielsen[o], Melissa C. Kosek[p], Eva Kosek[q,r], Richard E. Liebano[s], Shannon L. Merkle[t], Romy Parker[u], Felipe J. J. Reis[v,w], Keith Smart[x], Rob J. E. M. Smeets[y,z], Peter Svensson[ab], Bronwyn L. Thompson[ab], Rolf-Detlef Treede[ac], Takahiro Ushida[ad], Owen D. Williamson[ae], Paul W. Hodges[a,*]

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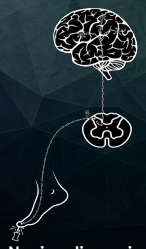
What features do you think are typical for Nociceptive pain?

The Slido app must be installed on every computer you're presenting from

slido

Pain characteristics

	Nociceptive pain
Pain features	Predictable Inc/dec with movement/posture Proportional Localised
QST	Normal sensitivity or local hyperalgesia
Questionnaire	Generally low psychosocial features – multiple questionnaires available to assess specific features
History	Relevant injury



Nociceptive pain
Arises from **activation of nociceptors**

Shraim, Massé-Alarie & Hodges 2021 Pain.



What features do you think are typical for Nociplastic pain?

Do not edit

The Slido app must be installed on every computer you're presenting from

slido

Pain characteristics

	Nociplastic pain
Pain features	Unpredictable Inconsistent inc/dec Disproportionate Broad area/multiple area/changing area
QST	Hyperalgesia - ↓ pressure/ temp threshold – local & distant areas
Questionnaire	Central Sensitization Inventory Various Psychological Qs – Pain Catastrophizing Scale; Fear Avoidance, Pain Self Efficacy, etc
History	Mismatch between pain & history/mechanism



Nociplastic pain
Arises from **altered nociceptive/pain processing** (i.e. *central sensitisation*)

Shraim, Massé-Alarie & Hodges 2021 Pain.



What features do you think are typical for Neuropathic pain?

Do not edit

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slido

Pain characteristics

	Neuropathic pain
Pain features	"Electric" Dermatomal distribution/ribbon Pins & needles Numbness +/- positive neurodynamic signs
QST	Can be sensitized – Hyperalgesia - ↓ pressure/ temp threshold
Questionnaire	PainDETECT, LANSS (not specific to neuropathic)
History	History of nerve damage/ dysfunction



Neuropathic pain
Caused by a **lesion** or **disease** of the **nervous system**

Shraim, Massé-Alarie & Hodges 2021 Pain.

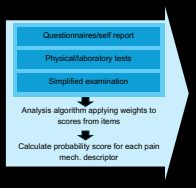
How can we identify pain mechanisms in clinical practice?

	Nociceptive pain	Neuropathic pain	Nociplastic pain
Pain features	Predictable Inc/dec with movement/posture Proportional Localised	"Electric" Dermatomal distribution/ribbon Pins & needles Numbness +/- positive neurodynamic signs	Unpredictable Inconsistent inc/dec Disproportionate Broad area/multiple area/changing area
QST	Normal sensitivity or local hyperalgesia	Can be sensitized – Hyperalgesia - ↓ pressure/ temp threshold	Hyperalgesia - ↓ pressure/ temp threshold – local & distant areas
Questionnaire	Generally low psychosocial features – multiple questionnaires available to assess specific features	PainDETECT, LANSS (not specific to neuropathic)	Central Sensitization Inventory Various Psychological Qs – Pain Catastrophizing Scale; Fear Avoidance, Pain Self Efficacy, etc
History	Relevant injury	History of nerve damage/ dysfunction	Mismatch between pain & history/mechanism

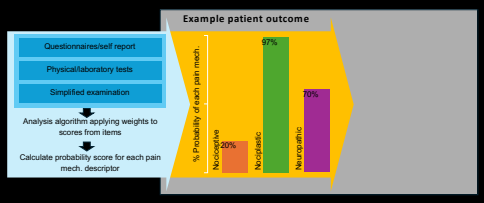
Smart2012a, b, c Man Ther; Nijs et al. 2015 Pain Physician; Chimenti et al 2018 PhysTher; Shraim, Massé-Alarie & Hodges 2021 Pain.

Development of a tool to discriminate between pain mechanism descriptors

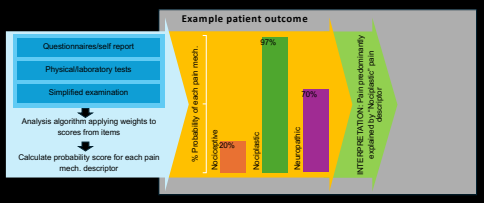
Pain mechanism discrimination tool



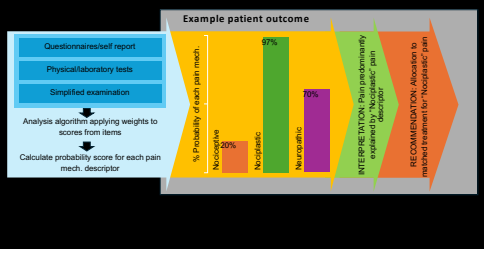
Pain mechanism discrimination tool



Pain mechanism discrimination tool



Pain mechanism discrimination tool



Tool development

- Collaboration with IASP Terminology Task Force
- 23 members + Expert panel of 50 members
- Diverse disciplines, geography, gender…

IASP Terminology Task Force

- Paul Hodges (Chair)
- Michele Sterling
- Kathleen Sluka
- Andrew Rice
- Daniel Clauw
- Eva Kosek
- Jo Nijs
- Lars Arendt-Nielsen
- Milton Cohen
- Ralf Baron
- Muath A Shraim
- Ian Gilron
- Matthias Ringkamp
- Miroslav Backonja
- Richard Harris
- Eleni Kaprelli
- Fusao Kato
- Sigrid Elesenbruch
- Felipe Reis
- Lester Jones
- Vivian Blechschmidt
- Chris Veasley
- Anina Schmid
- Victoria Tory Madden
- Anushka Soni

Next steps

- Ranking and prioritisation of candidate measures → COMPLETE
- Operationalise test items → COMPLETE
- Define preliminary algorithm based on scores, rank and weighting → COMPLETE
- Patient vignettes → COMPLETE

- Validation → UNDERWAY
- Detailed translation to pelvic health conditions → UNDERWAY
- Psychometric properties → UNDERWAY

Pain Descriptors

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- What are they and how do they apply to pelvic conditions - revision
- How can they guide treatment matching?
- How do we discriminate between them?
- **Clinical application**

Identification of **Neuropathic** pain



Neuropathic pain
Caused by a **lesion** or **disease** of the **nervous system**

Neuropathic pain

Descriptor	Domain	Item
Neuropathic	History	Patient history suggests pain is associated with a relevant lesion or disease of the somatosensory nervous system
Neuropathic	Diagnostic tests	Diagnostic tests suggest pain is consistent with a relevant lesion or disease of the somatosensory nervous system
Neuropathic	Sensory signs and symptoms	Pain is associated with sensory symptoms or signs consistent with a relevant lesion or disease of the somatosensory nervous system
Neuropathic	Body chart	Pain is present in a neuroanatomically plausible distribution
Neuropathic	Symptoms	Pain is associated with electric-like sensations
Neuropathic	Symptoms	Pain is associated with heat-related sensations
Neuropathic	Symptoms	Pain is associated with cold-related sensations
Neuropathic	Physical examination	Abnormal reflexes consistent with a relevant lesion or disease of the somatosensory nervous system
Neuropathic	Physical examination	Examination suggests symptoms are provoked by movements that load, compress or tension neural tissue consistent with a relevant lesion or disease of the somatosensory nervous system
Neuropathic	Questionnaire	Scores on 'Douleur Neuropathique 4' above cut off
Neuropathic	Questionnaire	Scores on 'Neuropathic Pain Questionnaire' above cut off

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
History	Patient history suggests pain is associated with a relevant lesion or disease of the somatosensory nervous system	Question[1]: To determine whether they have been advised by a health practitioner that their pain is caused by a lesion or disease of their nervous system	Question: As per self-report	Interview: Clarification of history of relevant lesion or disease of somatosensory nervous system that plausibly explains their pain

- Subjective Ax: Based the history of (onset of pain, onset of neural damage/disease, associated symptoms/signs), is patient's pain likely to be explained by damage or disease of the somatosensory nervous system?

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Diagnostic tests	Diagnostic tests suggest pain is consistent with a relevant lesion or disease of the somatosensory nervous system	Question: To determine whether they have had any tests or investigations that confirm a lesion or disease of the nervous system	Question: As per self-report	Interview: Clarification of diagnostic tests that verify presence of relevant lesion or disease of somatosensory nervous system that plausibly explains their pain

- Subjective Ax: Have you been told by a medical practitioner that you have damage or a disease of your nervous system (nerve, spinal cord or brain) based on the results of nerve conduction tests, skin biopsy, imaging or other relevant test?

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Sensory signs and symptoms	Pain is associated with sensory symptoms or signs consistent with a relevant lesion or disease of the somatosensory nervous system	Question: To determine whether they have symptoms consistent with positive or negative sensory signs of lesion or disease of the nervous system	Test: Selected simple "bedside"[2] Sensory Tests to test for evidence of positive and negative sensory signs of lesion or disease of the nervous system in the area of pain	Test: Quantitative Sensory Tests to test for evidence for positive and negative sensory signs of lesion or disease of the nervous system in the neuroanatomically plausible distribution of pain

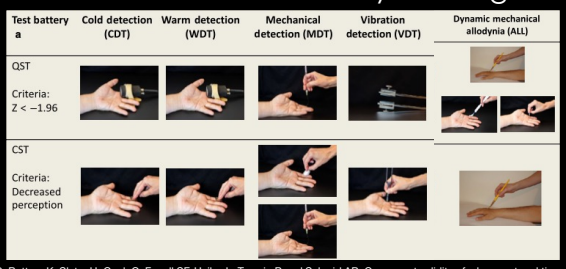
NEUROPATHIC PAIN

- Symptoms
  - Sensory loss – numbness
  - Sensory gain – pins and needles, crawling, prickling, tingling, itchy
- Same neuroanatomically plausible distribution of the pain.

NEUROPATHIC PAIN

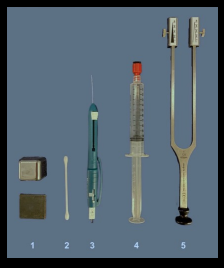
- Signs
  - Sensory loss - hypoaesthesia, hypoalgesia
  - Sensory gain - hyperaesthesia
- Same neuroanatomically plausible distribution of the pain

Assessment of sensory loss or gain



Zhu GC, Bottger K, Slater H, Cook C, Farrell SF, Hailey L, Tampin B and Schmid AB. Concurrent validity of a low-cost and time-efficient clinical sensory test battery to evaluate somatosensory dysfunction. *Eur J Pain* 2019;23:1826-1838.

"Bedside" sensory testing (QST)



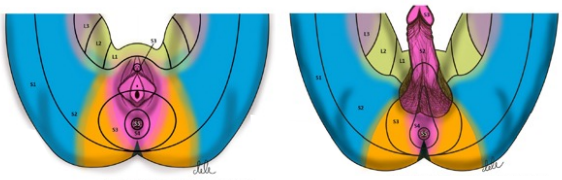
Test–retest reliability of a simple bedside-quantitative sensory testing battery for chronic neuropathic pain

Sachau et al. *Pain Reports* 8 (2023) e1049

Assessment of sensory loss or gain

- SITES
  - Area of pain
  - Control site – adjacent/opposite area of similar tissue
- APPLY STIMULUS
  - To both sites
- MEASURE
  - Rate perception of sensation
    - Same sensation in both areas
    - Less sensation in the painful area
    - More sensation in the painful area
    - Painful sensation in the painful area
    - If painful – report pain on scale 0-10
- POSITIVE
  - More or less in area of pain; any pain reported (allodynia)

Pelvic dermatomes/peripheral nerves



- Posterior femorocutaneous n.
- Inferior cluneal n.
- Pudendal n.
- Genitofemoral n.
- Obturator n.
- Coccygeal n.

Small group activity

- Propose method that could be used to assess sensory loss or gain relevant for pelvic pain
- Form groups of 4-5 people
- Select a sensory domain – thermal, mechanical, pressure
- 10 minutes: Discuss how this might be assessed in clinical practice
  - Feasible, accurate, acceptable
- 2 minutes: Report back – proposal, pros and cons
- 2-5 minutes: Whole group feedback

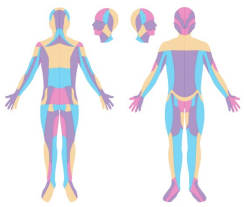
Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Body chart	Pain is present in a neuroanatomically plausible distribution	Body chart: Determine whether the pain has a neuroanatomically plausible distribution	Body Chart: As per self-report	Interpretation: Clarification that pain drawing shows a neuroanatomically plausible distribution of pain

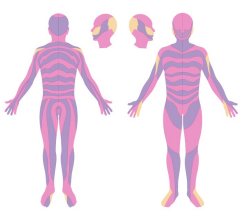
- Dermatomal distribution
- Peripheral nerve distribution

Neuroanatomically plausible distributions

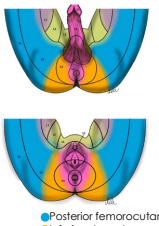
Peripheral nerve



Dermatomes



Ilaka

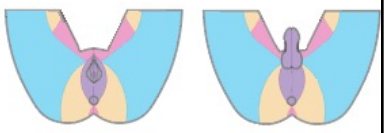


- Posterior femorocutaneous n.
- Inferior cluneal n.
- Pudendal n.
- Genitofemoral n.
- Obturator n.
- Coccygeal n.

Dermatomes



Peripheral nerve



Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	Pain is associated with electric-like sensations	Question: To determine whether their pain is associated with an electric sensation	Question: As per self-report + draw on Body chart	Body Chart: Confirm distribution of electric-like sensation is relevant for the pain experience

- Electric shock-like, lightning, stinging, shooting, jumping, flashing pain
- in the same neuroanatomically plausible distribution of the pain.

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	Pain is associated with heat-related sensations	Question: To determine whether their pain is associated with an burning sensation	Question: As per self-report + draw on Body chart	Body Chart: Confirm distribution of burning sensation is relevant for the pain experience

- Fire-like, hot, burning, scalding, searing sensations
- Same neuroanatomically plausible distribution of the pain.

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	Pain is associated with cold-related sensations	Question: To determine whether their pain is associated with a cold or freezing sensation?	Question: As per self-report + draw on Body chart	Body Chart: Confirm distribution of freezing-like sensation is relevant for the pain experience

- Cool, cold, freezing sensations
- Same neuroanatomically plausible distribution of the pain.

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Physical examination	Abnormal reflexes consistent with a relevant lesion or disease of the somatosensory nervous system	No item	No Item	Test: Perform clinically relevant test of reflexes as evidence of neurological lesion or disease

- Test reflexes relevant to neuropathy to suspected neuropathy
- Patellar tendon Reflex: L2, L3, L4 nerve roots
- Ankle Reflex: S1 nerve root

Reflexes to assess pelvic nerves

Reflex	How it is elicited	Normal response	Main pathways assessed
Bulbocavernosus or bulbospongiosus reflex (BCR); often called the **clitoro-anal reflex** in women	Gently compress/tap the glans penis or clitoris; catheter traction is sometimes used	Contraction of bulbospongiosus and/or external anal sphincter, observed or palpated	Afferent dorsal penile/clitoral branch of pudendal nerve → S2–S4 → pudendal motor efferents
Superficial anal reflex—"anal wink"	Lightly stroke or prick the perianal skin on each side	Ipsilateral, usually followed by bilateral, external anal sphincter contraction	Inferior rectal branch of pudendal nerve and sacral segments, principally S2–S4; some descriptions emphasise S3–S5
Cremasteric reflex, males only	Stroke the upper medial thigh	Ipsilateral testicular elevation	Ilioinguinal afferent and genital branch of genitofemoral nerve, L1–L2—not a test of the sacral pelvic-floor nerves
Rectoanal contractile reflex	Rapid rectal balloon distension	External anal sphincter contraction	Rectal afferents, sacral integration and pudendal motor output
Rectoanal inhibitory reflex	Gradual rectal balloon distension during anorectal manometry	Transient relaxation of the internal anal sphincter	Predominantly enteric and autonomic pathways; useful for anorectal disease but poorly localising for pelvic nerve lesions
Urethroanal or guarding reflex	Urethral stimulation or bladder filling, generally during urodynamics	Increased urethral/external sphincter activity	Pelvic/urethral afferents with pudendal motor output; mainly a specialist or research test

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Physical examination	Examination suggests symptoms are provoked by movements that load, compress or tension neural tissue consistent with a relevant lesion or disease of the somatosensory nervous system	No item	No Item	Test: Perform clinically relevant nerve provocation tests

- e.g., pelvic peripheral nerves - pudendal nerve palpation

What constitutes a positive finding?

Local landmark tenderness

- Pain only beneath the examining finger.
- Weak and nonspecific evidence because the nerve, muscle, fascia, ligament and periosteum are compressed together.

Concordant pain reproduction

- Examination reproduces the patient's recognisable clinical pain in the appropriate nerve territory.
- More informative but does not establish a nerve lesion.

Tinel-like response

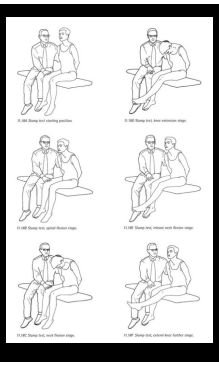
- Palpation or percussion produces distal electric, tingling or shooting symptoms along the nerve.
- Provides strongest palpation-based evidence of neural mechanosensitivity, although sensitivity and specificity remain uncertain.

Nerve palpation in pelvic pain

Nerve/pathway	Palpation technique and landmark	Findings considered supportive
Pudendal nerve at the ischial spine	Single-digit vaginal or rectal examination. Identify the ischial spine and apply gentle pressure immediately medial/posterior to it, where the nerve crosses near the sacrospinous ligament	Familiar perineal, genital or anorectal pain; stronger evidence if pressure produces distal tingling or shooting pain in a pudendal distribution
Pudendal nerve in Alcock's canal	Palpate the posterolateral vaginal or rectal wall along the medial surface of obturator internus, anterior to the ischial spine	Concordant pain or paraesthesia radiating toward the perineum, anus or genitalia
Dorsal clitoral/penile nerve	Gentle external palpation or percussion beneath the inferior pubic ramus, near the root of the clitoris or penis	Distal clitoral/penile tingling, burning or electric pain—a more conventional Tinel-like response
Perineal branches of the pudendal nerve	Gentle palpation along the medial ischiopubic ramus and superficial perineal tissues	Radiating pain into the posterior labium/scrotum or perineum rather than purely local tenderness
Ilioinguinal nerve	Palpate around a lower abdominal scar, medial to the ASIS, along the inguinal canal and near the superficial inguinal ring	Familiar pain radiating to the mons pubis, anterior labium/scrotum or upper medial thigh

Nerve palpation in pelvic pain

Nerve/pathway	Palpation technique and landmark	Findings considered supportive
Iliohypogastric nerve	Palpate the lower abdominal wall superior and medial to the ASIS and along transverse/Pfannenstiel scars	Suprapubic or lower-abdominal burning pain, sensory change or radiation
Genitofemoral nerve	Palpate near the pubic tubercle/external ring for the genital branch and below the inguinal ligament for the femoral branch	Radiation to the upper anterior thigh, anterior scrotum/labium or genital region
Obturator nerve	Palpation around the medial pubic ramus, obturator foramen and proximal adductor origin; some clinicians assess the lateral vaginal wall	Familiar deep groin or medial-thigh pain, ideally with sensory change or adductor weakness
Posterior femoral cutaneous/inferior cluneal branches	Palpate around the ischial tuberosity, sacrotuberous ligament and intragluteal fold	Buttock or posterior-thigh pain, with possible radiation into the lateral perineum
Sciatic nerve/deep gluteal region	External palpation at the greater sciatic notch, piriformis region and midway between the ischial tuberosity and greater trochanter	Radiating posterior-leg symptoms; usually combined with straight-leg raise or slump testing
Superior/middle cluneal nerves	Palpate where the nerves cross the posterior iliac crest or near the PSIS	Focal Tinel-like pain radiating across the upper or medial buttock



Neurodynamic tests

Butler DS, The Sensitive Nervous System, Unley, DC, Australia: NOIgroup Publications, 2000

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Questionnaire	Scores on 'Douleur Neuropathique 4' above cut off	Questionnaire: Neuropathic Pain Questionnaire (Douleur Neuropathique 4). Self-report items only.	Questionnaire: Neuropathic Pain Questionnaire (Douleur Neuropathique 4). Including items assessed by examiner.	Questionnaire: As per simple clinical

- Scores on 'Douleur Neuropathique 4' above cut off (≥ 4).

DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1:
Does the pain have one or more of the following characteristics?

	YES	NO
Burning	❑	❑
Painful cold	❑	❑
Electric shocks	❑	❑

QUESTION 2:
Is the pain associated with one or more of the following symptoms in the same area?

	YES	NO
Tingling	❑	❑
Pins and needles	❑	❑
Numbness	❑	❑
Itching	❑	❑

EXAMINATION OF THE PATIENT

QUESTION 3:
Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?

	YES	NO
Hypoesthesia to touch	❑	❑
Hypoesthesia to pinprick	❑	❑

QUESTION 4:
In the painful area, can the pain be caused or increased by:

	YES	NO
Brushing?	❑	❑

YES = 1 point
NO = 0 points

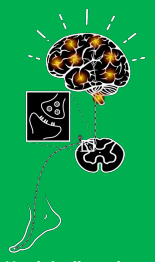
Patient's Score: /10

Neuropathic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Questionnaire	Scores on 'Neuropathic Pain Questionnaire' above cut off	Questionnaire: Neuropathic Pain Questionnaire (NPQ) above threshold	Questionnaire: As per self-report	Questionnaire: As per self-report

- Rate your usual level of numbness
  - 0= No numbness
  - 100 Worst numbness imaginable
- Rate your usual level of tingling pain
  - 0= No tingling pain
  - 100 Worst tingling pain imaginable
- To what degree does your pain increase due to touch:
  - 0= No increase at all
  - 100 Greatest increase imaginable

Identification of **Nociplastic** pain



Nociplastic pain
Arises from **altered nociceptive/pain processing** (i.e. *central sensitisation*)

Nociplastic pain

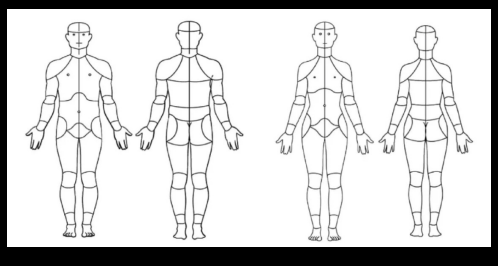
Descriptor	Domain	Item
Nociplastic	Body chart	Pain is present in a diffuse, widespread or regional distribution
Nociplastic	Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is evoked in adjacent or remote areas
Nociplastic	Symptoms	Multiple symptoms of fatigue, sleep disturbances or cognitive problems
Nociplastic	Examination	Pain is NOT provoked or relieved by specific movements, postures or physical activities in a consistent, predictable or proportional manner
Nociplastic	Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is evoked in an area of pain
Nociplastic	Symptoms	History suggests hypersensitivity to multiple of light, sound, odours
Nociplastic	Questionnaire	Scores on CSI* questionnaire above cut off
Nociplastic	Questionnaire	High scores on Fibromyalgia Criteria and Severity Scales (FCSS) (Note: This does not infer that fibromyalgia is synonymous with Nociplastic pain, but that presence of features evaluated in the test increase the likelihood that an individual has nociplastic pain)
Nociplastic	History	Patient history suggests pain is NOT explained a relevant injury or disease of the somatosensory nervous system or other musculoskeletal or visceral tissues
Nociplastic	Diagnostic tests	Diagnostic tests suggest pain is NOT consistent with a relevant lesion or disease of the somatosensory nervous system or other musculoskeletal or visceral tissues

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Body chart	Pain is present in a diffuse, widespread or regional distribution	Body chart: Determine whether the pain has a diffuse, widespread or regional distribution according to prespecified criteria	Body chart: As per self-report	Interpretation: Clarification that pain drawing shows widespread, regional or diffuse distribution of pain

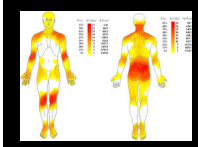
- Multi-site pain (3 or more regions; not in the same body part) or spread of pain over time to new body sites/areas.
- Pain experienced in a non-neuroanatomically plausible distribution.
- Varying pain distribution or spread of pain over time to new body sites/areas.

Segment/region body chart



Self-report

	Neuropathic	Nociceptive	Nociplastic
Pain location	Neurologically plausible distribution	Localised	Widespread distribution



Shade/draw all areas in which you experienced pain in the past month.
Calculate the number of segments and distribution of segments shaded by the patient.

Presence of:
- Widespread pain (axial pain AND pain on both sides)
OR
- Regional limb pain (3 contiguous pain sites)
OR
- Multisite pain (8 or more pain sites

Varying or spreading pain

- Varying
  - Does your area of pain vary in size from day to day?
  - Does the precise location of your pain vary from day to day?
- Pain spread
  - Has your pain spread to new areas since it first began?
  - Has your pain stayed in the same location but become larger in area (more diffuse)?
  - Has your pain spread to a similar location on the other side of your body?
  - Was the spread of pain associated with a separate event causing tissue damage?

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is evoked in adjacent or remote areas	Question: To determine whether sensory sensitivity is present to evoke a pain response in areas that are adjacent or remote to their area of pain	Test: Selected simple "bedside" Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response in areas that are adjacent or remote to their area of pain	Test: Quantitative Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response in areas that are adjacent or remote to their area of pain

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is evoked in an area of pain	Question: To determine whether sensory sensitivity to evoke a pain response is present in an area of pain (e.g., area of main^3 pain)	Test: Selected "bedside" Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response in an area of pain e.g., area of main^3 pain)	Test: Quantitative Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response an area of pain e.g., area of main^3 pain)

Signs of hyperalgesia

Assessment of hyperalgesia



Zhu GC, Bottger K, Slater H, Cook C, Farrell SF, Hailey L, Tampin B and Schmid AB. Concurrent validity of a low-cost and time-efficient clinical sensory test battery to evaluate somatosensory dysfunction. *Eur J Pain* 2019;23:1826-1838.

Assessment of hyperalgesia

- SITES
  - Area of pain
  - Control site – adjacent/opposite area of similar tissue
  - Remote site – foot/hand
- APPLY STIMULUS
  - To each sites
- MEASURE
  - Rate perception of sensation
    - Is it cold or painful?
    - Is it warm or painful?
    - Is it pricking or painful?
    - Is it pressure or painful?
- POSITIVE
  - Any pain reported (allodynia)

Small group activity

- Propose method that could be used to assess local and remote hyperalgesia for pelvic pain
- Form groups of 4-5 people
- Select a sensory domain – thermal, mechanical, pressure
- 10 minutes: Discuss how this might be assessed in clinical practice
  - Feasible, accurate, acceptable
- 2 minutes: Report back – proposal, pros and cons
- 2-5 minutes: Whole group feedback

Assessment of sensory loss or gain

- Sites
  - External
  - Vestibular/vulvar
  - Intra-vaginal
  - Visceral

Possible Advanced QST battery

Purpose	Recommended method
Regional superficial pelvic sensitivity	Standardised lower-abdominal/perineal pinprick or monofilament testing
Regional deep-tissue sensitivity	Digital pressure algometer over a reproducibly defined abdominal, perineal or gluteal muscle
Vestibular sensitivity in women	Electronic vulvalgesiometer at posterior vestibular sites
Pelvic-floor muscle sensitivity	Finger-mounted intravaginal algometer over bilateral levator ani and obturator internus
Regional thermal sensitivity	Small vestibular thermode if available; otherwise conventional thermode over lower-abdominal referred-pain region
Generalised sensitivity	Identical pressure and thermal modalities at a remote standard site—preferably tibialis anterior/foot or forearm/hand
Visceral hypersensitivity	Optional bladder filling or rectal barostat module, kept separate from somatic QST

NOCIPLASTIC

- Criterion 2: Generalised hypersensitivity/tenderness outside region of pain
- Physical Ax: Manual tender point examination
  - PERFORM IN AREAS WITHOUT PAIN.
  - Thumb pressure applied for 4s with roughly enough force to blanch the examiner's nail bed (4kg).
  - NRS-11: 0=no pain - 10=worst imaginable pain
  - Abnormal if Pain intensity ≥2

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	Multiple symptoms of fatigue, sleep disturbances or cognitive problems	Question: To determine whether that have symptoms of fatigue, sleep disturbances or cognitive problems	Question: As per self-report	Question: As per self-report

- Have you noticed any of the following problems for at least 3 months? Select all that apply.
  - Repeated waking at night
  - Feeling unrefreshed on waking up
  - Feeling fatigued or lacking energy
  - Trouble with memory or concentration (e.g., brain fog)
  - None of these have been present for 3 months

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Examination	Pain is NOT provoked or relieved by specific movements, postures or physical activities in a consistent, predictable or proportional manner	Question: To determine whether their pain is provoked or relieved by specific stimuli in a consistent, predictable or proportional manner	Test: Evaluation of response to specific stimuli that are identified to increase and decrease their pain or a stimulus relevant to tissues in painful area if no provocative stimuli are identified	Test: Detailed interpretation of response to specific stimuli that are identified to increase and decrease their pain or a stimulus relevant to tissues in painful area if no provocative stimuli are identified

- Negative score of Nociceptive test item

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	History suggests hypersensitivity to multiple of light, sound, odours	Question: To determine whether they have hypersensitivity to light, sound, odours	Question: As per self-report	Question: As per self-report

- Do you have hypersensitivity to stimuli
  - sound,
  - light,
  - odor,
  - Taste
  - None of the above

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Questionnaire	Scores on CSI[4] questionnaire above cut off	Questionnaire: Central Sensitisation Inventory above cut off	Questionnaire: As per self-report	Questionnaire: As per self-report

Scores on Central Sensitisation Inventory (CSI) ≥40

Please circle the best response to the right of each statement.

1. I feel tired and unrefreshed when I wake from sleeping.	Never	Rarely	Sometimes	Often	Always
2. My muscles feel stiff and achy.	Never	Rarely	Sometimes	Often	Always
3. I have anxiety attacks.	Never	Rarely	Sometimes	Often	Always
4. I grind or clench my teeth.	Never	Rarely	Sometimes	Often	Always
5. I have problems with diarrhea and/or constipation.	Never	Rarely	Sometimes	Often	Always
6. I need help in performing my daily activities.	Never	Rarely	Sometimes	Often	Always
7. I am sensitive to bright lights.	Never	Rarely	Sometimes	Often	Always
8. I get tired very easily when I am physically active.	Never	Rarely	Sometimes	Often	Always
9. I feel pain all over my body.	Never	Rarely	Sometimes	Often	Always
10. I have headaches.	Never	Rarely	Sometimes	Often	Always
11. I feel discomfort in my bladder and/or burning when I urinate.	Never	Rarely	Sometimes	Often	Always
12. I do not sleep well.	Never	Rarely	Sometimes	Often	Always

13. I have difficulty concentrating.	Never	Rarely	Sometimes	Often	Always
14. I have skin problems such as dryness, itchiness, or rashes.	Never	Rarely	Sometimes	Often	Always
15. Stress makes my physical symptoms get worse.	Never	Rarely	Sometimes	Often	Always
16. I feel sad or depressed.	Never	Rarely	Sometimes	Often	Always
17. I have low energy.	Never	Rarely	Sometimes	Often	Always
18. I have muscle tension in my neck and shoulders.	Never	Rarely	Sometimes	Often	Always
19. I have pain in my jaw.	Never	Rarely	Sometimes	Often	Always
20. Certain smells, such as perfumes, make me feel dizzy and nauseated.	Never	Rarely	Sometimes	Often	Always
21. I have to urinate frequently.	Never	Rarely	Sometimes	Often	Always
22. My legs feel uncomfortable and restless when I am trying to go to sleep at night.	Never	Rarely	Sometimes	Often	Always
23. I have difficulty remembering things.	Never	Rarely	Sometimes	Often	Always
24. I suffered trauma as a child.	Never	Rarely	Sometimes	Often	Always
25. I have pain in my pelvic area.	Never	Rarely	Sometimes	Often	Always

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Questionnaire	High scores on Fibromyalgia Criteria and Severity Scales (FCSS)	Questionnaire: Fibromyalgia Criteria and Severity Scales (FCSS) high score	Questionnaire: As per self-report	Questionnaire: As per self-report

Note: This does not infer that fibromyalgia is synonymous with Nociplastic pain, but that presence of features evaluated in the test increase the likelihood that an individual has nociplastic pain)

NOCIPLASTIC

- Fibromyalgia Criteria and Severity Scales (FCSS)
- Shoulder girdle left, Shoulder girdle right, Upper arm left, Upper arm right, Lower arm left, Lower arm right, Hip or buttock left, Hip or buttock right, Upper leg left, Upper leg right, Lower leg left, Lower leg right, Jaw left, Jaw right, Chest, Abdomen, Upper back, Lower back, Neck, I did not have pain in any of these areas in the last week
- Rate how severe you found the following symptoms in the last week?
- Scale:No problem (0), Mild or occasional problems (1), Moderate problems, often present (2) Severe, continuous problems (3)
  - Fatigue
  - Waking up tired and unrefreshed
  - Trouble thinking or remembering
- Which of the following symptoms have you experienced in the last 6 months? (Check all that apply)
  - Headache
  - Pain or cramps in the lower abdomen
  - Depression
  - I have none of these symptoms
- Item met if WPI = ≥ 7 AND SSS ≥ 5 OR WPI 3-6 AND SSS ≥ 9

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
History	Patient history suggests pain is NOT explained a relevant injury or disease of the somatosensory nervous system or other musculoskeletal or visceral tissues	Question: To determine whether they have been advised by a health practitioner that their pain is NOT explained by an injury or disease of tissues including somatosensory nervous system	Question: As per self-report	Interview: Clarification of history of no relevant lesion, disease or inflammation of neural or non-neural tissue that plausibly explains their pain?

Nociplastic pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Diagnostic tests	Diagnostic tests suggest pain is NOT consistent with a relevant lesion or disease of the somatosensory nervous system or other musculoskeletal or visceral tissues	Question: To determine whether they have had any tests or investigations that confirm that their pain is NOT explained by injury or disease of tissue including the somatosensory nervous system	Question: As per self-report	Interview: Clarification of diagnostic tests that verify presence of no relevant lesion, disease or inflammation of neural or non-neural tissue that plausibly explains their pain?

Identification of **Nociceptive** pain



Nociceptive pain
Arises from **activation of nociceptors**

Nociceptive pain

Descriptor	Domain	Item
Nociceptive	History	Patient history suggests pain is associated with a relevant injury or disease of musculoskeletal or visceral tissues
Nociceptive	Diagnostic tests	Diagnostic tests suggest pain is consistent with a relevant injury or disease of musculoskeletal or visceral tissues
Nociceptive	Examination	Pain is provoked or relieved by specific stimuli in a consistent, predictable or proportional manner (e.g., for musculoskeletal pain this might be movements, postures or physical activities)
Nociceptive	Body chart	Pain is present in a discrete or localised distribution
Nociceptive	Inflammation	Pain is associated with signs and symptoms suggesting local inflammation
Nociceptive	Symptoms	Pain is NOT associated with skin, hair or nail changes suggesting autonomic dysfunction
Nociceptive	Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is NOT evoked in adjacent or remote areas
Nociceptive	Questionnaire	Scores on modified PainDETECT questionnaire below cut off

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
History	Patient history suggests pain is associated with a relevant injury or disease of musculoskeletal or visceral tissues	Question: To determine whether they have been advised by a health practitioner that their pain is caused by an injury or disease of tissue other than somatosensory nervous system	Question: As per self-report	Interview: Clarification of history of relevant lesion, disease or inflammation of non-neural tissue that plausibly explains their pain

- Have you experienced an injury or condition of tissues explains your pain?

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Diagnostic tests	Diagnostic tests suggest pain is consistent with a relevant injury or disease of musculoskeletal or visceral tissues	Question: To determine whether they have had any tests or investigations that confirm an injury or disease of tissue other than somatosensory nervous system	Question: As per self-report	Interview: Clarification of diagnostic tests that verify presence of relevant lesion, disease or inflammation of non-neural tissue that plausibly explains their pain

- Has tissue damage been verified by diagnostic tests or investigations?
  - Examples of tests include (but are not limited to) MRI or CT scan, Ultrasound or surgical report.

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Examination	Pain is provoked or relieved by specific stimuli in a consistent, predictable or proportional manner (e.g., for musculoskeletal pain this might be movements, postures or physical activities)	Question: To determine whether their pain is provoked and/or relieved by specific stimuli in a consistent, predictable or proportional manner	Test: Evaluation whether pain is increased and decreased in response to specific stimuli that they identified	Test: Detailed interpretation of response to specific stimuli that are identified to increase and decrease pain

NOCICEPTIVE

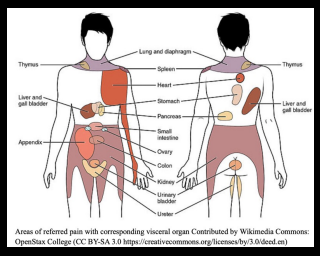
- Increase
  - There is something I can do that will increase my pain, every time. This might be a movement, a posture, an activity, something you ...
  - When I do this my pain increases in a predictable manner (e.g., how easily the pain comes on, how much the pain worsens, how long the pain lasts)
- Decease
  - There is something I can do that will reduce my pain, every time. This might be a movement, a posture, an activity, something you ...
  - When I do this my pain reduces in a predictable manner (e.g., how much the pain settles, how long it takes for the pain to reduce)

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Body chart	Pain is present in a discrete or localised distribution	Body chart: To determine whether their pain has a localised or discrete distribution according to prespecified criteria	Body Chart: As per self-report	Interpretation: Clarification that pain drawing shows a localised or discrete distribution of pain

- Consider visceral referral patterns

NOCICEPTIVE



Areas of referred pain with corresponding visceral organ Contributed by Wikimedia Commons: OpenStax College (CC BY-SA 3.0 https://creativecommons.org/licenses/by/3.0/deed.en)

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Inflammation	Pain is associated with signs and symptoms suggesting local inflammation	Question: To determine whether their pain is associated with signs and symptoms suggesting local inflammation	Test: Observation for signs of inflammation in addition to symptoms suggesting local inflammation	Test: As per simple clinical

- Do you notice any of the following features in the same area as your main pain? Select all that apply.
  - Swelling of specific tissues (e.g. a joint or muscle)
  - Redness or warmth of specific tissues (e.g. a joint or muscle)
- Do you notice any of the following patterns associated with your main pain?
  - Stiffness after periods of rest (e.g., in the morning)
  - Night pain that improves with movement (e.g. walking around at night)
  - Dull ache that can be eased with anti-inflammatory medication (e.g., Aspirin, Advil, Naprosyn, Voltaren, Meloxicam)

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Symptoms	Pain is NOT associated with skin, hair or nail changes suggesting autonomic dysfunction	Question: To determine whether their pain is associated with autonomic dysfunction	Test: Observation for signs of autonomic dysfunction	Test: As per simple clinical

- Do you notice any of these features in the same area as your pain?
  - Select all that apply.
    - Changes in skin colour (e.g, it looks mottled, red or pale)
    - Changes in skin temperature (e.g, it feels warmer or cooler than other parts of your body)
    - Changes in sweat patterns (dry or sweaty)
    - Changes in hair or nail growth
    - Changes in size (e.g., the whole limb looks swollen)

Nociceptive pain

Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Sensory sensitivity tests	Pressure, heat or cold hyperalgesia or allodynia is NOT evoked in adjacent or remote areas	Questions: To determine whether sensory sensitivity is present in areas that are adjacent or remote to their area of pain	Test: Selected simple "bedside" Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response in areas that are adjacent or remote to their area of pain	Test: Quantitative Sensory Tests to test for evidence of sensory sensitivity to evoke a pain response in areas that are adjacent or remote to their area of pain

- NO generalised hypersensitivity
- NO Allodynia and/or hyperalgesia in adjacent to primary area of pain

Nociceptive pain

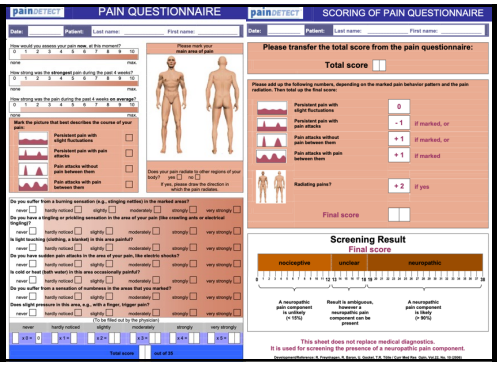
Domain	Item	Self-report	Simple clinical	Advanced/laboratory
Questionnaire	Scores on modified PainDETECT questionnaire below cut off	Questionnaire: PainDETECT below cut off	Questionnaire: As per self-report	Questionnaire: As per self-report

- Scores on modified PainDETECT ≤12

PainDETECT

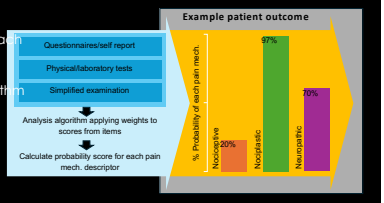
1. Do you suffer from a burning sensation (e.g. stinging nettles in your area of pain)?
2. Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?
3. Is light touching (clothing, a blanket) in this area painful?
4. Do you have sudden pain attacks in the area of your pain, like electric shocks?
5. Is cold or heat (bath water) in this area occasionally painful?
6. Do you suffer from a sensation of numbness in the area of your pain?
7. Does slight pressure in the area of your pain e.g. with a finger, trigger pain?

- Scoring
  - 5 point Likert scale
    - 0-Never; 1-Hardly noticed; 2-Slightly; 3-ModeratelY; 4-Strongly
  - Total score range 0-35: Below the cut off score ≤12



DECISION

- What is the predominant pain descriptor?
  - Expect some evidence for each
  - Expect dominance of one descriptor
  - Future – application of algorithm with weights to scoring





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