JMcBeth, GJMacfarlane, SBenjamin and ASilman. Arthritis and Rheumatism, April (2001) Vol.44 #4 p 940.

A prospective study to identify risk factors for chronic widespread pain CWP. A close link between Diffuse RSI and CWP has been argued in the LPC reviews of this subject.

1685 people identified as free from CWP entered a one year study. Age range 18 to 65. Upon entry, each subject completed a battery of questionnaires including a pain questionnaire, GHQ (12), Somatic Symptom Checklist, Fatigue Questionnaire, Illness attitude scales. The same battery of questionnaires was applied 12 months after entry. 93% successful follow-up. GP notes upon entry were inspected and analysed.

Outcomes were defined as chronic if greater than or equal to 3 months continuous pain and widespread if pain is present in 2 or more quadrants.

Illness behaviour was measured by visits to GP with symptoms that disrupt normal activities, and, reporting more somatic symptoms.

At baseline; 825 subjects were pain-free and 833 had pain, but not CWP. At 12 months 18 and 63 had CWP respectively. Out of 1953 people who were considered for the study 295 (15%) were excluded because they already had CWP.

Prevalence of <u>new</u> CWP (at 12 months after enrollment) ranged from 5.3% (95% CI = 3.1,7.5) to 7.4%(95% CI = 4.8,10.0) ages 18-34 and 50-64 respectively.

<u>Predictive factors</u> were identified as follows:

<u>Illness behaviour</u> (measured by the use of medical intervention…)

Rating	Odds ratio (95% CI)
0 – 4	OR = 1.0
5 – 7	OR = 4.3 (1.8, 10.7)
8 – 24	OR = 9.0 (3.7,22.2)

<u>Somatic Symptoms</u> at entry to study

Rating	Odds ratio (95% CI)
0 – 2	OR = 1.0
3 – 5	OR = 3.3 (1.5,7.4)

GHQ (12), not significant

Fatigue, not significant

Health anxiety, not significant.

<u>Comment</u>
The prevalence of CWP at baseline (15%) indicates that this is among the most common health-related concerns in the working age population. Claims of alleged event related outcomes should be investigated for a history of similar problems.

On the face of it, an employer would have to find a 30% prevalence of CWP in his workforce if he were to believe there was an occupational link. However, the study did not report changes of employment status during the study period. This factor must be accurately known if any link between work and CWP is to be properly assessed.

GHQ (12) is widely used to indicate mental health. It has often been proposed that poor mental health is a predictive factor for CWP. No evidence of this was found (by this measure) in this study. However, complaints about pain and adoption of illness behavior were predictive of CWP. Other studies of correlations between GHQ (12) and illness behaviour would be of interest.

The success of behavioral variables is significant, as it tends to indicate a pivotal role for beliefs and interpretation of pain in the pathogenesis of CWP. This being the case would indicate the prophylactic value of addressing beliefs and illness behaviour. It is questionable whether employers can be expected

to do this [except perhaps by making work such a pleasure that people don't take time off to go to their GP!].

This report made no mention of work-related variables such as job satisfaction or employment involving repetitive tasks. It is known (to us) that these variables were addressed in the course of the study and it is anticipated that further publications will explore the relevant findings.