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Original Article

Clinical science

In clinical hand osteoarthritis research, self-reported pain questionnaires do not reflect the patient experience

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Abstract

Objective: Pain in hand osteoarthritis (OA) is evaluated with repeated pain questionnaires. It is unclear whether these questionnaires adequately capture changes in pain recalled by patients. This study investigated whether changes on pain questionnaires (real-time evaluation) correspond to recalled pain.

Methods: Data from hand OA patients from the HOSTAS cohort (four one-yearly) and HOPE trial (one six-week interval) were used. Pain was measured with the Australian/Canadian hand Osteoarthritis Index (AUSCAN, range 0–20) and a recall question (how is the pain compared with your last visit). Changes in AUSCAN pain were categorized into improved (≤−1), stable or worsened pain (≥1) and compared with the recall question using Cohen's kappa and percentage agreement. We determined concordance between measurement methods, and investigated associations of mental well-being and illness perceptions with concordance using generalized estimating equations (GEE).

Results: Of 708 intervals from HOSTAS (307 patients, 82% women, mean age 61.0 years, mean AUSCAN 9.1), AUSCAN changes and recall were concordant in 42% (Cohen's kappa 0.13). There was concordance in 47% of 86 intervals (Cohen's kappa 0.14) from the HOPE trial (86 patients, 80% women, mean age 63.5, mean AUSCAN 10.7). The most frequent recall answer was worsened pain in the HOSTAS (60%), improved pain in the HOPE trial (76%). In both studies, AUSCAN pain most frequently improved. Depression and anxiety showed no association with concordance.

Conclusion: Changes in repeatedly measured AUSCAN pain often differ from the recalled course of pain over the same period. This has profound implications for evaluating patient-reported pain in clinical trials.

Keywords: hand, osteoarthritis, pain assessment and management, clinical trials and methods, epidemiology.

Rheumatology key messages

- Changes in patient-reported pain scores on questionnaire and patient's recalled pain are often discordant.
- This discordance is seen in both cohort and trial settings.
- No associations between this discordance and mental well-being were seen.

Introduction

Hand osteoarthritis (OA) is a common subtype of OA with pain as its primary symptom. As no curative treatment currently exists, guidelines advocate symptomatic treatment and patient education [1]. Pain is recognized as one of the core domains for hand OA studies by the Outcome Measures in Rheumatology (OMERACT) hand OA working group [2]. Furthermore, the OMERACT pain working group has described the need for standardized measures to assess pain in trials across rheumatic musculoskeletal diseases, to correctly assess the multidimensionality of pain [3].

Pain in hand OA is commonly investigated with validated questionnaires such as the Australian/Canadian Hand Osteoarthritis Index (AUSCAN) [4] and using pain scales such as the visual analogue scale (VAS) or numeric rating scale (NRS). Changes in pain over time are often evaluated by the differences between measurements at different time points. These changes can be presented with absolute values (e.g. the difference between two measurements) or a cut-off [e.g. the minimal clinical important improvement (MCII)] [5, 6]. However, various factors may influence the differences over time captured in this way, not just changes in pain.

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Methodological issues such as response shift, including changes in the way patients answer a questionnaire following changes in their internal standard of pain, their perception of what constitutes their pain or what consequences their pain has, as well as the context in which they evaluate their pain, including intercurrent positive or negative life events, can also play a role [7]. Similarly, patient expectations and perceptions have been described to affect patients' experience from medical treatment, and thus how they answer pain questionnaires [8].

In clinical practice, changes in pain are usually assessed by asking the patient how they recall the change in their pain compared with the last visit. Treatment decisions are based on the changes in pain and current pain reported by the patient. This clinical approach can be approximated in studies with a recall question asking the patient whether their pain has worsened, improved or remained stable. Again, however, factors other than changes in pain may influence the reported changes (e.g. bias due to recall) [9].

It is unclear how changes on validated questionnaires correspond to changes recalled by patients. If these do not correspond, the outcomes of trials in hand OA may not adequately reflect the course of hand pain we wish to investigate. Thus, in this study we aimed to compare changes on a validated pain questionnaire with a recall question regarding the pain course, and whether influencing factors could be identified.

Methods

Study design

Data from two previously published studies were used. The first data set involves data from the HOSTAS (Hand Osteoarthritis in Secondary Care) cohort study. HOSTAS is an observational cohort consisting of 538 consecutively included patients with primary hand OA diagnosed by a rheumatologist, collected from the Leiden University Medical Centre (LUMC) rheumatology outpatient clinic between June 2009 and October 2015. Data from baseline to year four were used. Additionally, data from the Hand Osteoarthritis Prednisolone Efficacy (HOPE) trial, a randomized clinical trial (RCT) in which patients were treated for 6 weeks with prednisolone or placebo, were analysed. The HOPE trial included 92 patients with primary hand OA fulfilling the American College of Rheumatology criteria [10], with at least 30 mm finger pain on a 100 mm VAS with a flare of 20 mm on NSAID washout, and signs of inflammation on ultrasound. The trial was conducted between December 2015 and October 2018. Full details about inclusion and exclusion criteria for both studies have been published previously [11, 12].

Both studies were approved by the medical ethics committee at the LUMC (P09.004 and P15.096) and conducted in accordance with Good Clinical Practice guidelines, and with the Helsinki Declaration of 1975, as revised in 2000. All patients provided written informed consent.

Outcomes

Pain was measured with the AUSCAN pain subscale (range 0–20) at baseline and annually thereafter in the HOSTAS study, and at baseline and after six weeks in the HOPE trial [4]. The AUSCAN pain subscale consists of five questions (how much pain did you have in the hands in rest, when gripping items, when lifting items, when turning items over and when squeezing items during the previous 48 h), each scored 0–4, summed to reach a total score with a range of 0–20, where higher scores represent more pain [4]. Patients were unaware of previously submitted scores on the questionnaire at each study visit. AUSCAN pain scores were regarded as missing if two or more questions were missing.

From 2014 onwards, an annual recall question was added to the HOSTAS study: 'Think only of the pain you experienced in your hands during the past 48 hours due to your hand osteoarthritis. How was the pain during the last 48 hours, compared with the last study visit?', with the answer options 'Worsened – more pain', 'No change', 'Improved – less pain' and 'I have never had this symptom'. The HOPE trial collected the recall question at week 6. Patients were included in the current analysis when both change in AUSCAN pain (calculated from AUSCAN at the beginning and end of the interval) and the recall question (collected at the end of the interval) were available for at least one time interval.

In both studies, age and sex were collected at baseline. Further baseline measurements included patient recalled symptom duration, hand examination including tender joint count, and hand radiographs. Radiographs were scored by trained readers blinded for clinical data using the Kellgren–Lawrence system and the Verbruggen–Veys method to assess erosive disease [13, 14]. Reliability of scoring was good in both studies [11, 12].

In HOSTAS, the hospital anxiety and depression scale (HADS), consisting of separate 0–21 scales for anxiety and depression was collected annually [15]. Higher scores indicate more symptoms of anxiety or depression. No missing values were allowed for the calculation of the HADS scores. The illness perception questionnaire (IPQ) was collected at baseline, year 2 and year 4 [16]. For all domains measured, higher scores indicate a stronger belief in the investigated construct. For details on the scales and calculation thereof, see Supplementary Data S1, available at *Rheumatology* online. For the IPQ scales, 1 or 2 missing values were accepted and treated with mean imputation, based on the scale, as per the IPQ instruction.

Statistical analysis

Change in pain measured with AUSCAN between visits was categorized according to two methods. Firstly, any change in pain was categorized as worsening, improvement or stable (i.e. change scores ≤ -1 were categorized as improvement, scores of 0 as stable, and scores ≥ 1 as worsening). Secondly, the minimal clinical important improvement (MCII) of 1.6 (according to work by Bellamy *et al.*) was used as a cutoff [5]. As no minimal clinical important deterioration or similar value is available, this cutoff was used in both directions. As the AUSCAN only allows for changes in discrete numbers, a cut-off of 1.6 functions as a cut-off for ≥ 2. (i.e. change scores ≤ -2 were categorized as improvement, scores between -2 and 2 as stable, and scores ≥ 2 as worsening).

Unweighted Cohen's kappa indicated the overall agreement between the recall question and AUSCAN pain change. As in the HOSTAS, data from multiple years were available; these were first calculated separately for each year and afterwards with data from all years pooled. The analysis was repeated after splitting the cohort into low pain at start of interval and high pain at start of interval, based on median pain at start of the interval, being 9 for the HOSTAS and 11

for the HOPE. This yielded the best balanced groups in terms of size. Kappa values <0 were regarded as poor, 0–0.20 as slight, 0.21–0.40 as fair, 0.41–0.60 as moderate, 0.61–0.80 as substantial and 0.81–1.00 as almost perfect [17]. To address potential effects of the unbalanced groups, we also calculated the Prevalence Adjusted Bias Adjusted Kappa (PABAK) [18]. Percentage agreement between the AUSCAN change and the recall question were calculated overall and stratified by the AUSCAN change categories (stable, improvement and deterioration).

Variables hypothesized to influence the concordance between AUSCAN changes and the recall question were assessed in the HOSTAS population. To this end, the change in AUSCAN pain was used as the index parameter compared with which patients overestimated or underestimated the recall question. Patients were categorized as being concordant, overestimating (recall question answered as improved pain when the change in AUSCAN reflects equal or worsened pain, or recall question answered as stable pain when the change in AUSCAN reflects worsened pain) or underestimating (recall question answered as worsened pain when the change in AUSCAN reflects equal or improved pain, or recall question answered as stable pain when the change in AUSCAN reflects improved pain).

Variables investigated consisted of age, sex, body mass index (BMI) measured at baseline, the HADS scales and the IPQ scales. The factors were chosen based on previous literature describing effects of illness and treatment perceptions and mental well-being on answers provided to pain questionnaires [19–21]. HADS domain scores were dichotomized into presence of depression or anxiety using a cutoff of 8 or higher [22]. As no cutoffs were available for the IPQ, the scales were divided into tertiles to investigate trends between patients scoring low, middle or high on the scales, as the continuous scores violated the assumption of a linear association with the log odds of being concordant in the two questionnaires. The HADS and IPQ scores collected at the end of the interval investigated were used; for example, if the recall question at the second visit was used, the HADS of the second visit was used.

Associations between being concordant *vs* overestimating or underestimating and variables of interest were assessed using logistic generalized estimating equations (GEE) to adjust for clustering within a patient, with robust standard errors and the correlation matrix specified as exchangeable. All analyses were performed with R version 4.1.3 and STATA version 16 (for the GEE analyses).

Results

Of the patients in the HOSTAS study, 307 had both an AUSCAN change score and recall question for at least one year. The mean age amongst these patients was 61.0 years, with 82% women. The mean BMI was 27.3 kg/m^2, and the mean AUSCAN pain at baseline 9.1 [standard deviation (SD) 4.2)] (Table 1).

In the data from the HOSTAS study, 708 annual intervals with both change in AUSCAN and recall questions were available. Of the 307 patients, 95 provided one interval, 74 provided two intervals, 87 provided three and 51 provided four intervals. Results are described in Table 2. The most frequent answer on the recall question was a worsening of pain (422/708 intervals, 60%), whereas AUSCAN pain worsened in only 279 (39%) of intervals. The mean (SD, 95% confidence interval, range) change in AUSCAN pain score in patients stating their pain had worsened was +0.43 (3.04, 0.14–0.72, −12–8). For no change and less pain, the AUSCAN change scores were −0.68 (2.93, −1.07 to −0.28, −12–5) and −2.36 (3.71, −3.23 to −1.49, −8–10), respectively (Table 3, Supplementary Fig. S1, available at *Rheumatology* online). Yearly kappa's were all low (year 1: 0.12, year 2: 0.06, year 3: 0.18, year 4: 0.12). When pooling the years, the recall question was in accordance with the AUSCAN pain in 295 out of 704 (42%) of the intervals, with a Cohen's kappa of 0.13 and a PABAK of −0.16 (Table 2). Of the discordant intervals, patients answered the recall more negatively than the change in AUSCAN reflected in 322 intervals (underestimate group) and more positively in 86 intervals (overestimate group). Stratifying for high or low baseline pain did not yield different results (Kappa 0.19 for low baseline pain, 0.08 for high baseline pain) (data not shown). Expressed in percentage agreement, improvement was recalled in 16% of intervals with improvement scored on the AUSCAN, a stable level of pain was recalled in 35% of intervals with a stable AUSCAN score and a worsening of pain was recalled in 72% of intervals with a worsening indicated by AUSCAN change score.

Table 1. Patient characteristics

	HOSTAS N=307	HOPE N=86
Patient characteristics		
Female sex; N (%)	252 (82)	69 (80)
Age, years	61.0 (8.2)	63.5 (8.7)
BMI, kg/m^2	27.3 (4.8)	27.3 (4.7)
Disease characteristics		
ACR criteria fulfilled; N(%)	276 (90)	86 (100)
KL sum score (range 0–120); median (IQR)	16 (8–28.5)	37.5 (27.3–45)
Symptom duration, years; median (IQR)	5.9 (2.3–13.5)	10.1 (4.1–16.3)
Tender joint count (range 0–30); median (IQR)	3 (1–6)	4 (2–7)
Patient-reported outcome measures		
AUSCAN		
Pain (range 0–20)	9.1 (4.2)	10.7 (3.2)
Function (range 0–36)	15.0 (8.3)	18.7 (7.1)

Patient characteristics. Data are mean (SD) unless indicated otherwise. BMI = Body mass index. HADS = Hospital Anxiety and Depression scale. ACR = American college of Rheumatology criteria for hand OA. KL = Kellgren-Lawrence. AUSCAN = Australian/Canadian osteoarthritis hand index. VAS = Visual analog scale. Percentage of missing data was lower than 5%, unless indicated otherwise. Currently working n = 326.

Table 2. Change in AUSCAN pain over one year compared with recalled pain over the last year in the HOSTAS

		Change in AUSCAN pain (any)			
		Improved (≤−1)	Stable (=0)	Worsened (≥1)	Total
Recall question	Worsened – more pain	143 (20)	78 (11)	**201 (28)**	422 (60)
	No change	101 (14)	**47 (7)**	63 (9)	211 (30)
	Better – less pain	**47 (7)**	8 (1)	15 (2)	70 (10)
	Never had this symptom	3 (0)	2 (0)	0 (0)	5 (1)
	Total	294 (41)	135 (19)	279 (39)	708 (100)

Change in AUSCAN pain vs recall questions in the HOSTAS. The number and % of concordant answers in bold. In the HOSTAS study, the answer "I have never had this symptom" was given in 5 intervals.

Table 3. AUSCAN baseline, follow-up and change scores per recall answer in the HOSTAS data

		N	Baseline AUSCAN pain	Follow-up AUSCAN pain	Change in AUSCAN pain
Recall question	Worsened – more pain	422	9.7 (3.9)	10.1 (3.9)	0.4 (3.0)
	No change	211	7.7 (4.1)	7.1 (3.7)	−0.7 (2.9)
	Better – less pain	70	8.1 (4.5)	5.7 (4.3)	−2.4 (3.7)
	Never had this symptom	5	1.8 (1.8)	1.0 (1.0)	−0.8 (0.8)

Data are mean (SD).

As some patients provided multiple intervals, stability of concordance over time within patients was assessed visually. Nearly all patients varied between overestimating on the recall question, underestimating on the recall question and answering the recall question concordantly during four years of follow-up in the HOSTAS (Fig. 1).

Comparing age, sex and BMI between the three groups with the concordant group as index, no differences were found (Table 4). The subdomains anxiety and depression of the HADS and the IPQ domains similarly showed no associations with concordance (Table 4 and Supplementary Table S1, available at *Rheumatology* online).

The concordance results from the observational HOSTAS cohort were compared with data from the HOPE trial. Of patients in the HOPE trial, 86 had AUSCAN change scores and recall questions available [mean age 63.5 years, 80% female, mean BMI 27.3 kg/m^2, mean AUSCAN pain at baseline 10.7 (SD 3.2)]. For details see Table 1. In the HOPE trial, improvement of pain was the most frequent answer on the recall question after six weeks (43%). The mean (SD, 95% confidence interval) change in AUSCAN pain score in the group stating their pain had worsened was −1.38 (3.73, −3.41 to +0.64). For no change and improvement of pain the AUSCAN change scores were −1.53 (2.30, −2.28 to −0.78) and −4.89 (4.20, −6.24 to −3.54), respectively (Supplementary Fig. S2, available at *Rheumatology* online). Of 86 intervals, 40 (47%) were in accordance, with a Cohen's kappa of 0.14 and a PABAK of −0.06 (Table 5). Splitting the trial into the intervention and placebo arms yielded values of 0.23 and −0.06 for Cohen's kappa, respectively. Stratifying for high or low baseline pain did not yield different results (Kappa 0.10 for low baseline pain, 0.17 for high baseline pain) (data not shown). Expressed in percentage agreement, improvement was recalled in 51% of intervals with improvement scored on the AUSCAN, a stable level of pain was recalled in 33% of intervals with a stable AUSCAN score and a worsening of pain was recalled in 33% of intervals with a worsening indicated by AUSCAN change score.

For both the cohort and the trial data, comparing the recall questions with categories of AUSCAN responses classified based on the MCII yielded even lower concordance than comparing the recall questions' answers to any change in AUSCAN pain, and lower Cohen's kappa's (Supplementary Tables S2 and S3, available at *Rheumatology* online).

Conclusion

In this study, annual changes on the AUSCAN pain scale and a recall question asking patients how they recalled the course of their pain between two study visits were compared. Patients in the HOSTAS cohort most frequently recalled the course of their pain as worsening, which was not reflected by changes in AUSCAN pain scores. On average the AUSCAN pain score improved more in the group of patients indicating pain had improved than in the group of patients indicating pain had worsened. There was little concordance between changes in AUSCAN pain scores and the recall question when comparing to absolute change in AUSCAN pain or changes in AUSCAN pain categorized based on the MCII. Similarly, little concordance was found in the HOPE trial data, although in this trial patients most frequently regarded the course of their pain as improving. These data are of great importance for evaluating patient-reported pain in trials, which is nearly always the primary outcome measure in hand OA research.

The AUSCAN was previously described to be responsive to change [23], and the recall question used in this study closely mirrored the anchor question used by the investigator that developed the AUSCAN and the associated MCII [5]. When looking at average change scores per group of the recall question answers, the improve group showed an average decrease, and the deterioration group showed an average increase in pain scores. The largest difference was seen in the group that indicated their pain had improved, with an average decrease of 2.4 points on the AUSCAN. However, categorical changes on the AUSCAN were frequently incongruent with the recall question, both for any change or the MCII as a cutoff. HOSTAS patients most frequently answered that their pain had worsened over the past year, in 422 out of 708 (60%) of the intervals whereas the changes between yearly AUSCAN

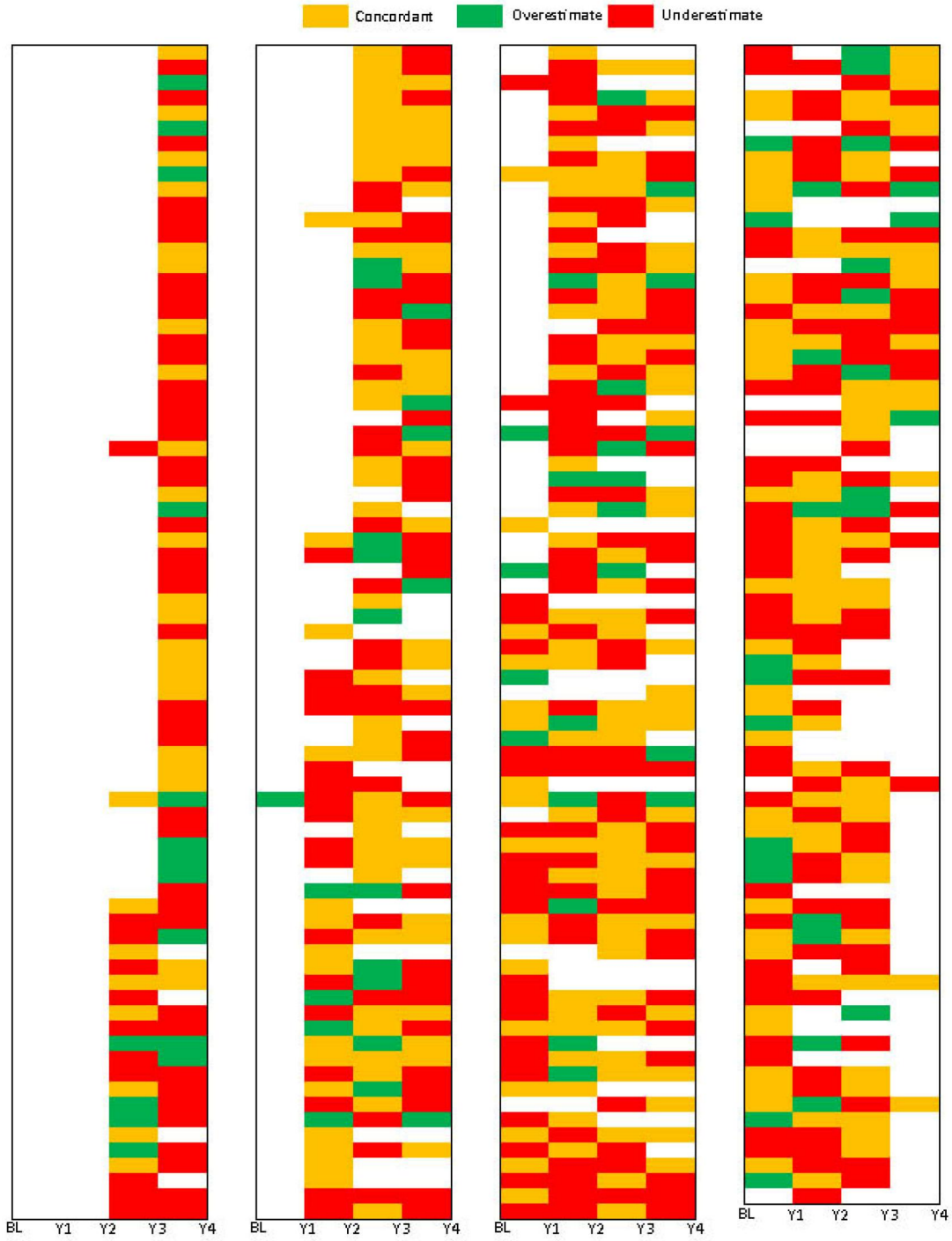

Figure 1. Overview of concordance between recall questions and AUSCAN changes. Every row of four blocks represents a single patient. White blocks represent years for which no information is available. Orange blocks (left colour in the legend) represent years in which measurements were concordant ($n = 295$), red blocks (right colour in the legend) represent years in which the measurement was an underestimation (recall question more negative than the AUSCAN change, $n = 322$) and green blocks (middle colour in the legend) represent overestimated years (recall question more positive than the AUSCAN change, $n = 86$)

pain questionnaires indicated worsened pain in 39% of intervals. The other answer categories, stable and decreasing pain, were similarly incongruent. Patients almost always differed in being concordant, overestimating or underestimating the answer to the recall questions compared with the change in AUSCAN pain between measured intervals. Although data from the HOPE trial showed improved pain more often on both the recall question and the change in AUSCAN scores, concordance was still low. In line with the overall concordance data, the percentage agreement between changes in the AUSCAN with the recall question were low and had a wide range.

This discordance could be caused by the different structures of the questions used, with the AUSCAN questions centered around specific ways of using the hands, whereas the recall question only concerns pain, leaving interpretation to

Table 4. Association between concordance and age, sex, BMI and HADS scores

	Concordant *n*=295	Underestimate *n*=322		Overestimate *n*=86	
			Odds ratio (95% CI)		Odds ratio (95% CI)
Age at baseline visit; mean (SD)	60.8 (7.9)	61.2 (8.0)	1.00 (0.99–1.02)	60.8 (7.4)	1.00 (0.97–1.03)
BMI at baseline visit; mean (SD)	27.6 (4.9)	27.2 (4.8)	0.99 (0.96–1.02)	27.8 (5.2)	1.01 (0.96–1.06)
Sex; N(%)					
Female	241 (81.7%)	262 (81.4%)	1.05 (0.74–1.49)	67 (77.9%)	0.76 (0.40–1.44)
Male	54 (18.3%)	60 (18.6%)		19 (22.1%)	
Depression; N (%)					
Yes	34 (11.8%)	29 (9.2%)	0.74 (0.48–1.16)	5 (5.8%)	0.48 (0.19–1.21)
No	255 (88.2%)	288 (90.9%)		81 (94.2%)	
Anxiety; N (%)					
Yes	47 (16.4%)	45 (14.2%)	0.83 (0.55–1.23)	7 (8.2%)	0.47 (0.21–1.02)
No	240 (83.6%)	271 (85.8%)		78 (91.8%)	

Associations with overestimation or underestimation of change in pain. Overestimate = recall question answered more positively than the change in AUSCAN. Underestimate = recall question answered more negatively than the change in AUSCAN. CI = Confidence Interval. HADS = Hospital Anxiety and Depression Scale, scale 0–21, using cutoffs at 8 or higher.

Table 5. Change in AUSCAN pain over six weeks compared with change in pain on recall question over the last six weeks in the HOPE study

		Change in AUSCAN pain (any)			
		Improved (≤−1)	Stable (=0)	Worsened (≥1)	Total
Recall question	Worsened – more pain	5 (6)	3 (3)	**5 (6)**	13 (15)
	No change	27 (31)	**2 (2)**	7 (8)	36 (42)
	Better – less pain	**33 (38)**	1 (1)	3 (3)	37 (43)
	Never had this symptom	0	0	0	0
	Total	65 (76)	6 (7)	15 (17)	86 (100)

Change in AUSCAN pain vs recall questions in the HOPE trial. The number and % of concordant answers in bold.

the patient. The question can be interpreted as maximal pain level, average pain level, or even as the frequency with which patients are forced to alter behavior due to pain. However, because both the HOSTAS and HOPE studies focus on hand pain, this area of the body will be the most important determinant of the recalled pain. Another important difference between the questionnaires is that the AUSCAN has a maximal score, whereas the recall question does not. Reaching this ceiling, the worst possible score, precludes increasing pain scores on the AUSCAN, but patients can still experience increasing pain and state so on the recall question. Imprecise recall may also play a role, as recalling the level of pain experienced a year ago is very difficult. As the recall question is explicitly based on a recalled experience and the AUSCAN is not, this could further drive the discordance. The comparison between the recall question and the categorized MCII change in AUSCAN could also be distorted by the fact that the cutoff was determined solely for improvement. Patients may regard deterioration differently, necessitating a different cutoff for deterioration compared with improvement. Similar differences have been found for fatigue [24]. To properly study pain development, either increases or decreases, it may thus be valuable to establish a minimal clinical difference for deterioration as well. Finally, pain in hand OA may fluctuate on a narrow scale within a patient. This may potentially further drive the discordance, as the AUSCAN is more likely to respond to small fluctuations than the recall question, due to the difference in time scales. This difference in responsiveness to these fluctuations could hypothetically drive the discordance further. However, repeating the analysis with the MCII as a cutoff rather than any change yielded similar results. This makes it unlikely that the small fluctuations had an effect in our analysis.

There also are several known methodological drawbacks of questionnaires that may have caused discordance. It has been described for global perceived effect scales that patients base their answers on a current state when asked how a symptom has developed over a period of time, rather than on the change [25]. Should a patient experience the condition as equally negative at two consecutive visits, this could lead to stable AUSCAN scores but worsened pain on the recall question. Both questionnaires may also be affected by response shift and changes in behavior, which affects the pain answer that patients provide [7].

Previous work has described that treatment perceptions can also be influenced to change outcomes in pain relief, emphasizing the clinical importance of these perceptions [19]. Prior to the analyses, we thus hypothesized that more negative illness perceptions, such as attributing more consequences to the hand OA, would be associated with more negative recall compared with the measured change in pain. However, we did not find any associations between the various IPQ domains and the concordance between the recall question and change in AUSCAN pain when measuring the IPQ at the moment the recall question was collected. Mental well-being, measured with the HADS subscales for anxiety and depression, was similarly expected to be associated with more negative recall. This association was not found either. It should be noted that the low number of patients per stratum and thus the low power of this analysis necessitates confirmation in future studies. Stratification on high or low baseline pain did not affect the found agreement between the recall question and change in AUSCAN.

The setting in which a study is conducted may also influence the concordance between pain measurement by subsequent questionnaires or a recall question. As such, we compared trial data with cohort data in this study. Most patients in the HOPE stated improved pain on both questions, causing most concordant patients to also be in this group, as opposed to the HOSTAS data. However, there was still low overall concordance in the clinical trial. This might be explained in various ways. First, previous literature described the effects of patient expectations on treatment outcomes and the placebo effect, supporting this [8, 26, 27]. If we take the recall question to be true, this would mean that the decreases in pain seen in trials are potentially overstated (as seen with the placebo effect, and accounted for by using control groups) and that in cohorts it may be the increases in pain that are overstated. Second, there was a large difference in the interval time between the studies (1 year *vs* 6 weeks). This could have affected pain recall. More importantly, one might expect the concordance between pain questionnaires and recall to be better over a shorter period of time. However, the Cohen's kappa values obtained were similar. It may thus be that the discrepancy between pain recall and repeated questionnaires is already present after a shorter time period than 6 weeks. Based on this, future studies should investigate the optimal amount of time to study pain recall, because many questionnaires include an inherent recall component (e.g. the AUSCAN measures pain over the past 48 h). This knowledge could also aid in establishing cutoffs for questionnaires using anchoring methods, which is often done, and recommended in rheumatology by the Outcome Measures in Rheumatology (OMERACT) [5, 6, 28–30]. Third, the AUSCAN and recall question may capture different elements of the pain experience, as described earlier in the discussion. Differences between the AUSCAN and the recall can become more visible depending on the setting, in case these elements differ between the study settings.

Our study has various strengths. The large cohort allowed for the investigations of numerous intervals, illustrating the performance of both a pain questionnaire and a recall question in a natural setting over multiple years. The trial on the other hand allowed us to study the influence the placebo effect has on these pain measurements and their concordance. Using both allowed us to compare between the different settings, contrasting long follow-up with short follow-up and a cohort setting with a trial setting. There are also some weaknesses. As stated, the study was not powered to investigate the associations between mental well-being and concordance of pain measurements. We also did not have the data to further investigate the optimal recall interval for pain, which would be of great additional value.

To conclude, these findings indicate that research on pain development may not reliably estimate changes in pain recalled by the patient, and that recalled changes in pain and changes in pain need not be the same. This discordance has important consequences for the chance of finding successful interventions to alleviate patient-reported symptoms, as it highlights the difficulty in accurately measuring pain. These mechanisms may contribute to the large amount of negative trial results in the OA field. A new pain assessment tool, specifically aimed at assessing long-term pain changes, may be required. Alternatively, a recall question and a change score may both be needed to more properly assess changes in pain.

Supplementary material

Supplementary material is available at *Rheumatology* online.

Data availability

For requests for the study data underlying this article, please contact the corresponding author.

Contribution statement

C.v.d.M., L.A.v.d.S. and M.K. designed the study. F.P.B.K. and M.K. collected the data. C.v.d.M., L.A.v.d.S. and M.K. analysed the data. C.v.d.M., L.A.v.d.S., F.P.B.K., M.N., F.R.R. and M.K. interpreted the data and wrote and reviewed the report. All authors approved the final version of the manuscript.

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