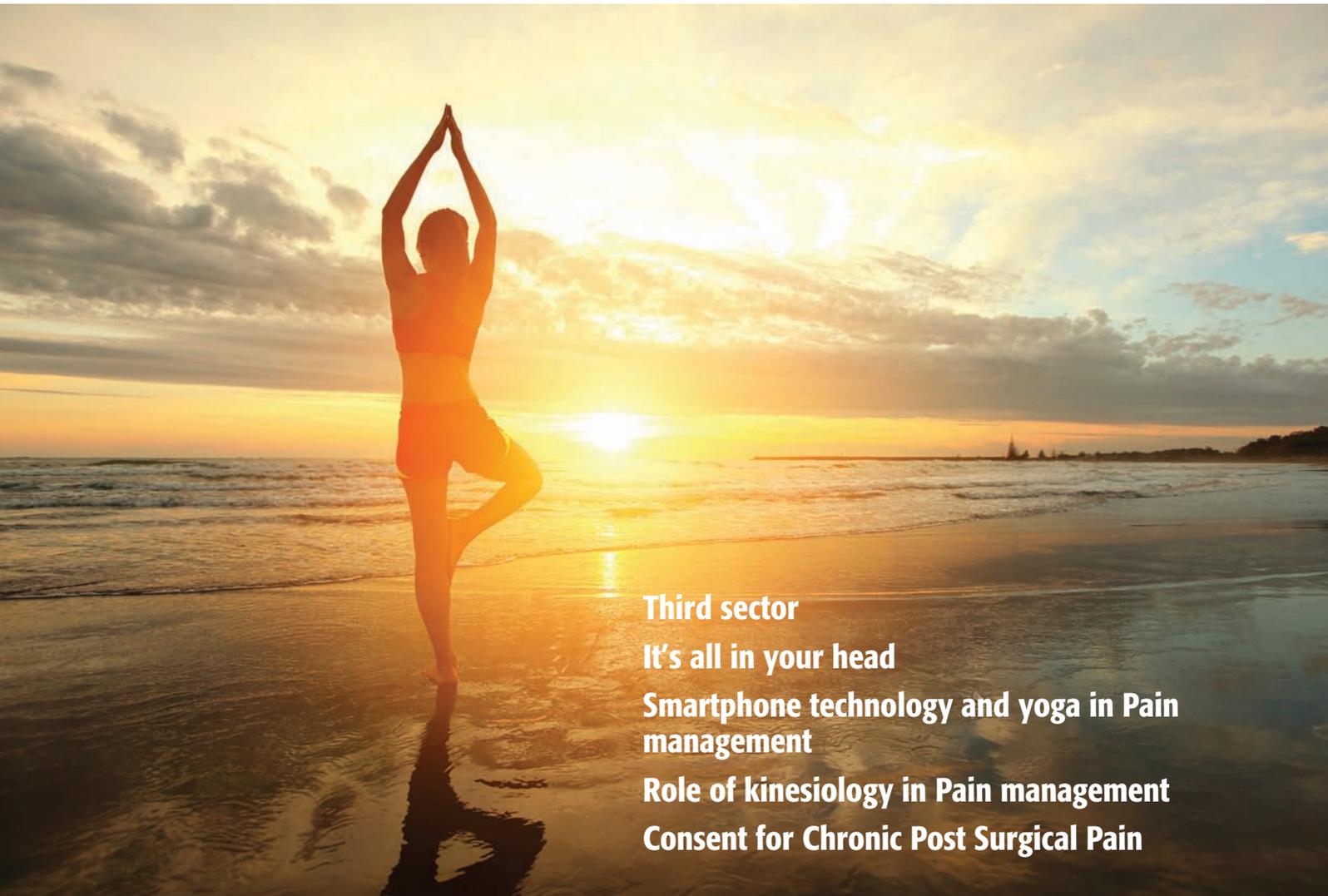


SEPTEMBER 2015 VOLUME 13 ISSUE 3

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Third sector

It's all in your head

Smartphone technology and yoga in Pain management

Role of kinesiology in Pain management

Consent for Chronic Post Surgical Pain

ISSN 2050-4497



THE BRITISH PAIN SOCIETY





THE BRITISH PAIN SOCIETY
An alliance of professionals advancing the understanding and management of pain for the benefit of patients

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PAIN NEWS is published quarterly. Circulation 1600. For information on advertising please contact

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The Editor welcomes contributions including letters, short clinical reports and news of interest to members, including notice of meetings.

**Next submission deadline :
20th October 2015**

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ISSN 2050-4497 (Print)

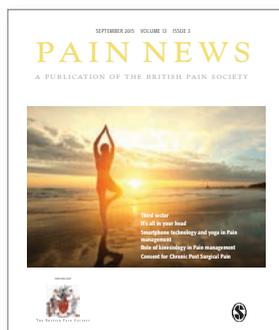
ISSN 2050-4500 (Online)

Printed by Page Bros., Norwich, UK

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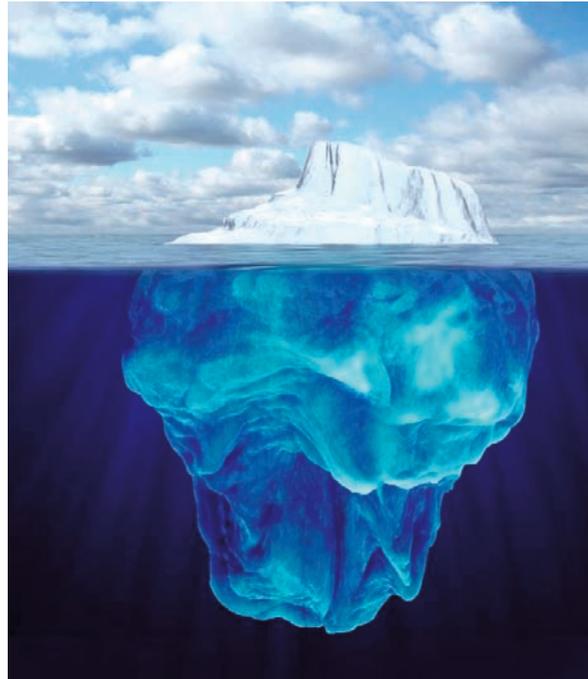


THE BRITISH PAIN SOCIETY

SAVE THE DATE!

Pain the Hidden Epidemic
Patient Liaison Committee Annual Seminar

Thursday 17th December 2015



The British Pain Society's Patient Liaison Committee will again be holding its annual seminar. 'Pain the Hidden Epidemic' will look at the prevalence and impact of pain and how to raise awareness.

The seminar will include a mixture of lectures about Pain and Neuropathic Pain, as well as an afternoon dedicated to working together to see how we can all make a difference and raise awareness of pain.

Open to All

This seminar is aimed at patients, professional, carers and people from the 3rd Sector.
A detailed programme for the day and information on how to register will be sent in due course

The seminar will be held at: Churchill House, 35 Red Lion Square, London
Should you have any queries in the meantime please contact Ken Obbard on:

Meetings@britishpainsociety.org or 0207 269 7840





Prescribing oxycodone prolonged-release tablets?

The CQC recommends prescribers use a brand name. There are significant risks of overdose when a fast acting product of short duration is used in error for the slow acting, longer duration products.¹

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Oxycodone prolonged-release tablets

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Presentation: Each prolonged release tablet contains 5mg, 10mg, 15mg, 20mg, 30mg, 40mg, 60mg or 80mg oxycodone hydrochloride corresponding to 4.5mg, 9mg, 13.5mg, 18mg, 27mg, 36mg, 54mg or 72mg of oxycodone. The prolonged-release tablets contain lactose monohydrate. Please refer to the Summary of Product Characteristics (SPC) before prescribing. **Indications:** In adults and adolescents aged 12 years and older: severe pain, which can be adequately managed only with opioid analgesics. **Dosage and Administration:** Adults and adolescents 12 years of age and older: the initial dose for opioid naïve patients is 10mg oxycodone hydrochloride given at intervals of 12 hours. Some patients may benefit from a starting dose of 5 mg to minimize the incidence of side effects. Reltebon prolonged release tablets are not indicated for the treatment of acute or breakthrough pain. In general, the lowest effective analgesic dose should be chosen. **Method of administration:** For oral use. Reltebon prolonged-release tablets should be taken twice daily based on a fixed schedule at the dosage determined. They may be taken with or independent of meals with a sufficient amount of liquid and must be swallowed whole, not chewed. **Discontinuation of treatment:** it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. **Paediatric population:** should not be used in patients under 12 years. **Elderly patient:** the dose adjustment is not usually necessary. **Patients with renal or hepatic impairment:** the recommended adult starting dose should be reduced by 50% and each patient should be titrated to adequate pain control according to their clinical situation. **Risk patients:** should initially receive half the recommended adult dose if they are opioid naïve. Dose titration should be performed in accordance with the individual clinical situation. **Contraindications:** hypersensitivity to oxycodone or to any of the excipients; severe respiratory depression with hypoxia and/or hypercapnia; severe chronic obstructive pulmonary disease; cor pulmonale; severe bronchial asthma; elevated carbon dioxide levels in the blood; paralytic ileus; acute abdomen, delayed gastric emptying. **Warnings and**

Precautions: **Paediatric population:** use in children younger than 12 years of age is therefore not recommended. **Elderly or debilitated patients:** Caution is required in elderly or debilitated patients, in patients with severe impairment of lung, liver or kidney function, myxoedema, hypothyroidism, Addison's disease, intoxication psychosis, prostatic hypertrophy, adrenocortical insufficiency, alcoholism, known opioid dependence, delirium tremens, pancreatitis, diseases of the biliary tract, inflammatory bowel disorders, biliary or ureteric colic, hypotension, hypovolaemia, conditions with increased brain pressure such as head injury, disturbances of circulatory regulation, epilepsy or seizure tendency and in patients taking MAO inhibitors. **Patients undergoing abdominal surgery:** use with caution following abdominal surgery. Patients with severe hepatic impairment should be closely monitored. **Respiratory depression:** in predisposed patients opioids can cause severe decrease in blood pressure. **Long-term use, tolerance and withdrawal:** it may be advisable to taper the dose gradually to prevent symptoms of withdrawal. Withdrawal symptoms may include yawning, mydriasis, lacrimation, rhinorrhoea, tremor, hyperhidrosis, anxiety, agitation, convulsions and insomnia. **Hyperalgesia:** an oxycodone dose reduction or change to an alternative opioid may be required. Dependence potential: in patients with a history of alcohol and drug abuse the medicinal product must be prescribed with special care. **Pre-operative use:** not recommended for pre-operative use or within the first 12-24 hours post operatively. **Abusive parenteral venous injection:** tablet excipients may lead to necrosis of the local tissue, infection, increased risk of endocarditis, and valvular heart injury which may be fatal, granulomas of the lung or other serious, potentially fatal events. **Tablets must not be chewed or crushed:** the administration of broken, chewed or crushed controlled release oxycodone tablets leads to rapid release and absorption of a potentially fatal dose of oxycodone. **Alcohol:** concomitant use should be avoided. **Reltebon prolonged-release tablets contain lactose:** patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not

take this medicine. **Interactions:** other opioids, sedatives, hypnotics, anti-depressants, antipsychotics, anaesthetics, muscle relaxants, antihistamines and antiemetics. MAO-inhibitors, alcohol, anticholinergics (e.g. antipsychotics, antihistamines, antiemetics, antiparkinson drugs), cimetidine, CYP3A4 inhibitors, such as macrolide antibiotics (e.g. clarithromycin, erythromycin and telithromycin), azol-antifungals (e.g. ketoconazole, voriconazole, itraconazole, and posaconazole), protease inhibitors (e.g. boceprevir, ritonavir, indinavir, nelfinavir and saquinavir), cimetidine, grapefruit juice, CYP3A4 inducers, such as rifampicin, carbamazepin, phenytoin and St John's Wort, drugs that inhibit CYP2D6 activity, such as paroxetine, fluoxetine and quinidine, isoenzyme inhibitors, coumarin anticoagulants. **Fertility, Pregnancy & Lactation:** should be avoided to the extent possible in patients who are pregnant or lactating. **Undesirable Effects:** **Very common:** somnolence, dizziness, headache, constipation, nausea, vomiting, pruritus. **Common:** decreased appetite, anxiety, confusional state, depression, insomnia, nervousness, abnormal thinking, amnesia, isolated cases of speech disorders, asthenia, tremor, dyspnoea, bronchospasm, dry mouth, rarely accompanied by thirst; gastrointestinal disorders such as abdominal pain; diarrhoea; dyspepsia; loss of appetite, skin eruptions including rash, in rare cases increased photosensitivity, in isolated cases urticaria or exfoliative dermatitis, hyperhidrosis, micturition disturbances (increased urge to urinate), sweating, asthenic conditions. See SPC for details of uncommon, rare and unknown frequency events, and for details of undesirable effects reported with use in special patient groups. **Driving or Using Machinery:** Oxycodone may impair the ability to drive and use machines. With stable therapy, a general ban on driving a vehicle is not necessary. The treating physician must assess the individual situation. This class of medicine is in the list of drugs included in regulations under 5a of the Road Traffic Act 1988. **Pack Size and NHS Price:** 5mg x 28 £7.51, 10mg x 56 £15.02 15mg x 56 £22.87, 20mg x 56 £30.05 30mg x 56 £45.74, 40mg x 56 £60.11

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Legal Category: CD (Sch 2) POM
Marketing Authorisation Holder: Actavis Group PTC ehf, Reykjavikurvegi 76-78, 220 Hafnarfjörður, Iceland
Marketing Authorisation Numbers: PL 30306/0464, PL 30306/0465, PL 30306/0466, PL 30306/0467, PL 30306/0468, PL 30306/0469, PL 30306/0470, PL 30306/0471
Date of PI Preparation: 24/10/2014

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
 Adverse events should also be reported to Actavis on 01271 385257.

References:
 1. NHS Care Quality Commission. Safer Use of Controlled Drugs – Preventing Harm From Oral Oxycodone Medicines. Available at: http://www.cqc.org.uk/sites/default/files/media/documents/safer_use_of_controlled_drugs_-_guidance_for_the_web_-_preventing_harm_from_oral_oxycodone_medicines_v2.0.pdf. Accessed May 2015
 2. Monthly Index of Medical Specialties (MIMS) June 2015. Accessed June 2015

British Pain Society Calendar of Events



THE BRITISH PAIN SOCIETY

To attend any of the below events, simply book online at:

www.britishpainsociety.org/mediacentre/events/

2015

Compassion in Pain Management Programmes Pain Management Programmes 15th National Conference Pain Management Programmes Special Interest Group

Thursday 17th & Friday 18th September
Manchester University

The biennial Pain Management Programmes Conference takes place in September this year. This multidisciplinary conference is hosted by local committees on each occasion ensuring the topics each year are varied. This year a team from Manchester have taken the reins and have put together what promises to be a thought provoking and stimulating conference.

For further information please visit: <https://www.britishpainsociety.org/mediacentre/events/pain-management-programmes-15th-national-conference/>

Neuropathic Pain Study Day Evidence based Assessment and Management

Saturday 17th October 2015
Liverpool

This study day aims to inform about and improve assessment and management of neuropathic pain in primary, secondary and tertiary care. (NICE GL 96 March 2010 updated November 2013, GMC: Good practice in prescribing and managing medicines and devices 2013). The study day will:

- Explain definitions and mechanisms of neuropathic pain.
- Explain and demonstrate assessment of neuropathic pain in a GP surgery or a non-specialist pain clinic and when to refer for specialist assessment and management.
- Explore the biopsychosocial character of neuropathic pain via a multidisciplinary workshop.
- Explore assessment and management of neuropathic pain in real life via two case studies.

For further information please visit:

<https://www.britishpainsociety.org/mediacentre/events/neuropathic-pain-stud-day/>

Stratified Care Study Day

Monday 23rd November
Churchill House, London

More information will be added to our website when available

www.britishpainsociety.org/mediacentre/events/

Understanding & Managing Headaches
Headache Special Interest Group Inaugural Meeting

Wednesday 25th November
Churchill House, London

A multidisciplinary educational event designed for physicians in pain medicine & neurology, general practitioners, researchers, nurse specialists and other health professionals involved in the care of patients with head, neck, and orofacial pain.

More information will be added to our website when available
www.britishpainsociety.org/mediacentre/events/

Pain the Hidden Epidemic
Patient Liaison Committee Annual Seminar

Thursday 17th December
Churchill House, London

The seminar will include a mixture of lectures about Pain and Neuropathic Pain, as well as an afternoon dedicated to working together to see how we can all make a difference and raise awareness of pain.

More information will be added to our website when available
<https://www.britishpainsociety.org/mediacentre/events/patient-liaison-committee-seminar/>

2016

Opioid Study Day

Monday 14th March
Churchill House, London

More information will be added to our website when available
www.britishpainsociety.org/mediacentre/events/

Annual Scientific Meeting

Tuesday 10th – Thursday 12th May 2016
Harrogate

The multidisciplinary nature of the Society's is pivotal to the continuing success of its Annual Scientific Meeting, which has attracted an average of over 600 healthcare professionals to its previous five Meetings. This multidisciplinary nature is reflected throughout the scientific programme, with lecture, workshop and seminar topics chosen specifically to be of interest to all participants, whatever their specialty. Further information can be found on: <https://www.britishpainsociety.org/2016-asm/>

Further details can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Now accepting primary research papers



Official journal of the British Pain Society

The Journal aims to broaden its scope and become a forum for publishing primary research together with brief reports related to pain and pain interventions. Submissions from all over the world have been published and are welcome.

Good reasons to publish in **British Journal of Pain...**

- Published by SAGE since 2012, the journal is now fully online and continues to be published in print. Browse full text online at bjp.sagepub.com
- Official journal of the British Pain Society, the journal is peer reviewed, with an international multidisciplinary editorial board
- Submit online and track your article on SAGEtrack
- High visibility of your paper: the journal is currently free to access and is always free to link to from cited and citing references on HighWire Press, the world's leading e-content provider

www.britishpainsociety.org

Now accepting original research and review papers in these areas:

Adjuvant therapies for acute and chronic pain
Basic science
Commissioning
Local anaesthetics
Mobile technologies
Neuraxial analgesia for acute pain
Neuropathic pain
NSAIDs and COX-2 inhibitors
Opioids
Pain management in palliative and end of life care
Pain management in patients with HIV

Pain management in the adolescent/young adult
Peripheral regional analgesia
Pharmacogenomics
Primary care management
Psychology of pain
Service re-design
Sleep and pain
Therapies including lifestyle orientated treatments
Transition between acute and persistent pain

For enquiries about your paper contact

newsletter@britishpainsociety.org

Submit your paper online on **SAGEtrack:**

<http://mc.manuscriptcentral.com/bjpain>





The Society needs you

Dr Arasu Rayen *Editor*

pns.rayen@gmail.com



I am writing this in the middle of British summer. By the time you read this, we may not be far from autumn.

This summer

had been fantastic with more sun than rain, which is extraordinary for our British Standard. I have had good time on the saddle. Tour de France had been fantastic with yet another British winner. Chris Froome has won the title second time. In the last 3 years, since Sir Bradley Wiggins has become the first British winner, British cycling had seen tremendous changes. A total of 31 world champions crowned across all cycling discipline since 2013; British Cycling membership have risen from 50,000 to 112,000; over a million people are now riding their bikes at least once a week; over 250,000 more women cyclist on the road and more than 100 new clubs now have formed in the last 12 months and so on and so forth (<https://www.britishcycling.org.uk/road/article/20150725-road-British-Cycling-president-praises-success-of-Chris-Froome-and-hails-golden-age-for-British-cycling-0>). You may be thinking why am I writing about cycling in *Pain News*. The reason I have written about the good

news of British cycling is to draw your attention to the common message in both President's and Honorary Secretary's column. For various reasons described in both President's and Honorary Secretary's messages in this issue, membership and income of the British Pain Society (BPS) have been less than what is expected. BPS is a true multi-professional society in the United Kingdom, which looks after the interest of its members and patients. It is for you and run by you. It just takes small steps from all of us to improve the membership, increase the income and keep BPS going. Please read both the messages. The Society needs you, more than ever.

As ever, this edition of *Pain News* is also packed with interesting articles. Where do I start? Michael Linnett's 'A combination of Smartphone technology and yoga may assist the progression of values-based goals with chronic pain patients' article explains with ample evidence how we can use one of the world's oldest and newest technique to manage chronic pain patients. The author describes elegantly what yoga is and shows the parallel between yoga and acceptance and commitment therapy. He also describes how smartphone technology can be used to set goals in chronic pain patients. He explains that there is a need for combining both yoga and smartphone technology.

Following on from our two previous articles on chronic pain in animals, this issue carries another article 'Chronic visceral pain: lessons from cats' by Tony Buffington. This article not only sheds some light on the scientific side of visceral pain it also draws parallels between visceral pain in human and in cats.

We all know that chronic post-surgical pain (CPSP) is not uncommon following surgeries. There are some surgical procedures, which are notoriously associated with high incidence of CPSP. It has been more than 15 years since CPSP has been recognised as a definite problem. We hope that surgical fraternity is aware of this debilitating problem and consent patients accordingly. Dr Bhadra's article written following an audit done in his hospital shows otherwise. He shows that only 17% of the surgical specialties consent for CPSP. A survey conducted by James Lind Alliance and the Royal College of Anaesthetists (RCOA) showed that answer to the question 'What can we do to stop patients developing chronic pain after surgery?' came as the top research priority in anaesthesia and pain management (<http://www.lindalliance.org/top-tens.asp>). Dr Bhadra's audit reinforces the fact that we need more research and national campaign to make medical professionals aware of this problem.

Dr William Campbell



THE BRITISH PAIN SOCIETY

Pain News

2015, Vol 13(3) 154–155

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Commissioning for specialised pain services

Almost 2 years ago, the British Pain Society (BPS) along with many other healthcare and patient representatives

had regular meetings and email contact for the National Health Service (NHS) England Clinical Reference Group on Specialised Pain Services (CRG-SPS). We were fortunate to have Michele Davis, Senior Service Specialist/Regional Programme of Care Lead – Trauma & Orthopaedics for support and guidance. Dr Andrew Baranowski was Chair of the CRG-SPS until recently, when Dr John Hughes superseded him. Some specialised treatments were reviewed by the group with a view to them being delivered at centres with expertise in the particular therapy. These included Intrathecal drug delivery systems and deep brain stimulation.

Despite the groups' considered deliberations and evidence, NHS England have only approved Intrathecal Drug Delivery services for cancer pain – not non-cancer pain. However, they reserve the right to finalise their decision on this after the National Institute for Health and Care Excellence (NICE) have concluded their Highly Specialised Technology Approval process. Occipital Nerve Stimulation for intractable headaches and migraine has been approved; but, Deep Brain Stimulation

for Chronic Pain has also not been approved.

See outcome at <http://www.england.nhs.uk/2015/07/02/annual-investment-decisions/>

The BPS wish to canvass at a high political level for the treatments that have been turned down, and we may be able to do so in the coming months. Our main concern is that some of the treatments initiated for chronic long-term pain will have no ongoing funding.

Business as usual?

Although the BPS is continuing with a very wide range of pain issues as usual, we have been affected by reduced income over the past few years, like many other organisations worldwide. Membership income provides the solid basis to continue with our key activities as usual, such as running the office and website, as well as having key meetings and publications – both Pain News and British Journal of Pain provided quarterly.

Over the past year, we have been introducing efficiency savings, which means that we have fewer face-to-face meetings and more teleconference activity. To date, this has been working well. Our Interim Honorary Treasurer and immediate past Honorary Treasurer have been addressing means of funding the very many other activities which we carry out for our members, for the benefit of people in pain. Previously, these additional activities (such as representation at CRG, NICE, Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM RCOA), as well as BPS meetings and

publications) were supported from any Annual Scientific Meeting surplus together with grants from various organisations, all of which have been less than in the past. The additional activities do support healthcare professionals working with people living with pain.

Thank you to all our members who keep their subscriptions up to date. It is disappointing that so many healthcare professionals (who have pain treatment as part of their job plan) are not members of the BPS which represents non-medical as well as medical colleagues. All the work that the BPS carries out helps support all disciplines. If your colleagues are not a BPS member, do encourage them to support their own speciality via BPS membership.

Understanding and Managing Long-term Pain

Over the past year, the Patient Liaison Committee have worked tirelessly on updating the previous edition of 'Understanding and Managing Pain' (UMP). Antony Chuter and Austin Leach in particular put a huge amount of time into reviewing and reformatting this document, with the support of Rikke Susgaard-Vigon for launch at our last Annual Scientific Meeting in Glasgow.

The annual Patient Liaison Committee seminar

This year, the Patient Liaison Committee (PLC) Seminar will be opened with the 'Sir Michael Bond Lecture'. Sir Michael has kindly agreed to give the inaugural presentation, and each year, the lecture is

to be loosely associated with rehabilitation and pain. As in previous years, both healthcare professionals and patients are invited to the seminar, which will be held at Churchill House, Red Lion Square, London on Thursday, 17 December. This is a continuing professional development (CPD) recognised activity, so please put the date in your diary!

People living with pain

At our last Council meeting, held in late June, it was agreed that our strapline 'An alliance of professionals advancing the understanding and management of pain for the benefit of patients' should

be altered slightly. The Chair of the PLC, Mr Antony Chuter, mentioned that all people with pain were not necessarily 'patients'. Those people undergoing pain management by a professional were patients (acute, cancer and non-cancer long-term pain), but many people live or self-manage their pain. As a result, it was agreed that 'patients' be replaced with 'people living with pain'.

The pain consortium

Currently, the consortium represented by the Royal College of General Practice, Chronic Pain Policy Coalition, FPM and the BPS (with the CRG-SPS

having representation) continues to meet on the morning of the BPS Council meetings. The group can speak on pain issues with a united voice from professional body representatives representing matters pertaining to pain. Recent matters that were discussed included undergraduate pain education (both medical and non-medical), Core Standards for Pain Management Services and media representation on topical issues such as opioid use and abuse. We continue to update each other on work streams following on from the Pain Summit of 2011.

National Institute for Health and Care Excellence (NICE)

The Society is a generic stakeholder for National Institute for Health and Care Excellence (NICE) guidelines. The Society is also a generic stakeholder for Interventional Procedures and Health Technology Assessments for NICE.

Since May 2015, the Society has received over 40 communications from NICE on topics with relevance to pain. Of those, the Society would like to bring your attention to the following topics:

- Headaches (Standing Committee B update): addendum consultation. NICE has updated its guidance on Headaches and new evidence on pharmacological treatment for migraine prophylaxis was identified. Anticipated publication date: November 2015
- New guidance; Care of the dying adult. Anticipated publication date: December 2015

Dr Martin Johnson



THE BRITISH PAIN SOCIETY

Pain News

2015, Vol 13(3) 156–157

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It is almost too hot to sit and write this column, as I sit and bask in glorious sunshine, plus a Sunday glass of Pouilly-Fume close to hand. When

you eventually read the column, summer will be almost over – I hope you all had excellent holidays. In the words of the Bard,

And summer's lease hath all too short a date

Membership

Avid readers of my column (well I can live in hope ...) will know that I have devoted a lot of space to discussing British Pain Society (BPS) membership. Unfortunately, I now have an apology to make. Those who attended the Annual General Meeting (AGM) in Glasgow will remember that a large cheer greeted my announcement that membership had risen for the first time in last few years (even if it was only by a meagre 75 people). I then consolidated this by describing this momentous occasion again in the June *Pain News*. I now know in the haste to extract the figures from the new computer system, an error was made in interpreting the information.

The actual total membership figures (presented at the last Council meeting in June 2015) were 1,229 (plus 43 at various stages of pending membership). Some of the major categories of membership are as follows (apologies if your category is not listed):

Anaesthesia	610
Nursing	172
Psychology	100
Physiotherapy	86
General Practice	20
Occupational Therapy	9
Palliative Medicine	9
Research/Science	54

Therefore, the bottom line is that the Society membership has decreased by 5% in the last year – apologies again for misleading you all.

William has asked Prof. Roger Knaggs, our new Honorary Secretary Elect, to lead the BPS Membership group. I know the group will be in very safe hands.

One of Roger's first jobs has been to send out a questionnaire to recently lapsed members to enquire about reasons for leaving the BPS, and so on. We haven't got the results as yet; however, I am told that one unexpected result of the questionnaire is that several people have re-joined the Society – if you are one of those members – welcome back!

Comparing membership

I have mentioned this topic in a previous edition. To attract more members/retaining existing members, it is important for us to understand what membership benefits are attractive and realistic. To this end, Niraj, the newest recruit to our excellent secretariat team, is researching a comprehensive review of other societies. What are their annual fees? What is the fee structure/banding like? What benefits do membership convey, for example, journals, conference attendance, insurance premium reduction, travel club, reduced costs for books, trainee benefits, and so on.

PLEASE – if you are a member of another society and want to give feedback on their fee structure and benefits, please contact the BPS Office, Roger or myself.

Pain News

If any of your colleagues mention that they have not received an edition of *Pain News* recently, could you encourage them to feed back the information to the BPS office? We have become aware that some members have not been receiving the newsletter in the post – and please, everyone, make sure your contact details are up to date!

How Many Special Interest Groups do you belong to?

One of the questions that Roger is asking in his membership survey is my recent suggestion of charging a nominal annual fee to support the work of the Special Interest Groups (SIGs). Niraj has done

another one of his splendid bits of analysis and come up with the following figures:

Members for 14 SIGs – 4
Members for 13 SIGs – 1
Members for 12 SIGs – 2
Members for 11 SIGs – 2
Members for 10 SIGs – 2
Members for 9 SIGs – 2
Members for 8 SIGs – 7
Members for 7 SIGs – 9

Members for 6 SIGs – 12
Members for 5 SIGs – 32
Members for 4 SIGs – 74
Members for 3 SIGs – 100
Members for 2 SIGs – 168
Members for 1 SIGs – 283

You can see that there is a huge spectrum of engagement with SIGs – of the 698 members who are a member of a least one SIG or more, 283 just belong

to one SIG and there are 4 people who are members of all 14 SIGs! Of course that also means that 43% of our membership don't belong to any SIGs.

This piece of work raises many questions:

- Can you truly engage with their activities if you are a member of a large number of SIGs?
- For all of the 43% non-members, doesn't the present diversity of SIG's appeal?
- How can we improve SIG membership? and so on

The BPS is nothing without you, its members, and we appreciate your continuing involvement and support. We recognise that, for many members, in recent years, the decision to pay the membership fee for a non-compulsory professional society has been more challenging so we will continue to look closely at our fees and we will take care to limit any increases. We hope that you will continue to encourage your colleagues to joins us.

May we also remind you that The BPS is a registered charity and we welcome funds received from legacies and through sponsorship. As we know from the numbers who have joined fun runs at previous Annual Scientific Meetings (ASMs), many of our members are actively engaged in sporting activities. So, if you are signing up for any marathons, half-marathons, triathlons, swims or tiddlywinks contests, please consider nominating The Society as your chosen charity.



Thank you for supporting the BPS!



Spotlight – Chris Barker



The width and breadth of BPS membership is testimony to the diversity within the organisation and in the pain world. The Editorial Board would like to acknowledge this richness by shining a spotlight on some of our members. In this edition, we speak to Chris Barker



*Chris Barker
Community Pain
Service – Southport
& Ormskirk NHS
Trust*

1. What first brought you in contact with the BPS?

I was a GP with Special Interest running a community pain clinic in Liverpool with an ESP Physio. I was working with colleagues at the Walton

Centre, in particular with Tim Nash who was a Pain Medicine Consultant and past president of BPS – he suggested I joined.

2. What is your role in the BPS? What excites you about this role?

I chair the Primary & Community Care SIG. I am passionate about the value of primary and community care in the delivery of pain services – I also feel strongly that harnessing the untapped expertise from people who live with pain is fundamental to how we will modernise long-term pain management.

3. What do you feel is the role of the Primary & Community Care SIG within the BPS?

At the moment, a developing presence. The BPS risks being a predominantly secondary care focused organisation. Primary & community care currently manage the vast majority of long-term complex pain problems; engaging with, and genuinely valuing their opinion, will help ensure the BPS stays relevant.

4. If you were President of the BPS for a day, what would you do?

I'd modernise the council so all multiprofessional groups have equal presence and voice. I'd also make sure we have elected patient representation on permanent council.

5. What are you known for professionally?

Not fitting in.

6. What are you most passionate about professionally?

Professional humility. Valuing patients and properly respecting their own problem solving skills

7. What do you have a knack for?

Getting lost

8. What are you passionate about personally? What do you really enjoy? What can't you stop talking about?

I love to play guitar or drums. I'm also surprising myself with a developing love for 20th century European history.

9. Where can we find you in your spare time? What is your favourite way to spend a weekend or a Sunday afternoon?

Staggering around a country run after driving the kids round to various dance classes, then back for a bacon sandwich and a muck about in the kitchen with loud music on.

10. Any other volunteer activities apart from the BPS that you're passionate about?

I like to do gigs for charities – I play in a band with healthcare mates and we play at balls, weddings and dodgy smelling pubs.

11. Any favourite non-profit organisations that you support and why?

Dementia research. My brother's wife was diagnosed with Alzheimer's Disease at 42.

13. How do you want to be remembered?

As someone who stood up for things that matter.

15. Anything else you'd like to tell people about yourself?

Not especially. I'm just me.

12. What would be impossible for you to give up?

Bacon.

14. Any life achievements you are particularly proud of?

I stuck with running when I hated it and it made me sick.

Have your say and contribute to *Pain News* today

Pain News is the Members newsletter and as such we encourage and welcome member contributions to share your news with the wider membership and beyond.

Do you have a news item to share?

Perhaps a professional perspective, or informing practice piece?

Maybe you would you like to feature as our 'Spotlight' member?

We'd love to hear from you so drop the Editor an email today at: pns.rayen@gmail.com.

Upcoming submission deadlines:

Issue	Copy deadline
December 2015	20 October 2015
March 2016	11 January 2016
June 2016	11 April 2016
September 2016	11 July 2016





Feedback from 2015 Annual Scientific Meeting and looking forward to 2016

Professor Kate Seers *Chair Scientific Programme Committee of British Pain Society*



Many thanks to all delegates at the 2015 Annual Scientific Meeting (ASM) in Glasgow for your very helpful feedback on the meeting. I have carefully read all 71 pages of

feedback. I would like to summarise what you said, and then outline some changes we have made as a result of the feedback for the next meeting.

We had 332 delegates completing feedback, a 65% response rate. The highlights were that 92% would recommend the ASM to a colleague. The plenary sessions were highly rated, with mean scores across all plenaries of 3.72–4.35 (on a 1–5 poor to excellent scale), and workshops were also very well rated.

Delegates were clearly very keen to enable development of trainee/students, with 97% supportive of giving the top

trainee/student posters the opportunity to present their work orally at the ASM.

We were clearly getting it right in several areas: 85% felt the number of plenary sessions and the time to view posters was about right, 83% felt the length of ASM was about right and 75% felt the number of parallel sessions was about right. When looking at why people came to the meeting, research was most valued, closely followed by networking time. In addition, 61% had learnt something that would change their clinical practice.

Areas for development were that 47% wanted more clinical sessions. While delegates appreciated the chance for students/trainees to present their work orally, there were many comments that non-trainee/student delegates would also value the opportunity to be selected for an oral presentation of their research. We also noted that delegates would find copies of plenary speakers' slides useful.

Poster tours were requested previously but not well supported, so we will not be running those again in 2016. There are still one-third of delegates who do not want a paperless meeting. We will thus not yet move to a paperless meeting, but will keep this under review.

Food is often hard to get right – at our ASM, we found some loved it, others were much less keen. It was noted that special diets were not imaginative, and we will keep working to improve for next year.

New for 2016

In response to your feedback, we will be ensuring that there are sessions with a clinical focus. We will be introducing two parallel sessions for oral presentations: when you submit a poster, you will be asked whether, if selected, you would be willing to give an oral presentation. We will also be asking plenary speakers to make a set of slides available for delegates. We also have workshops lined up on writing for publication and on statistics, with very experienced speakers who are skilled in making these things accessible and even fun!

The Scientific Programme Committee are working hard to ensure that we have an exciting Scientific Programme planned for 2016 and look forward to welcoming you to the 49th ASM in Harrogate, 10–12 May 2016. I look forward to seeing you there.



Bursary report, Annual Scientific Meeting 2015, Glasgow

Never having been to the Annual Scientific Meeting (ASM) before, I was very pleased to be granted the privilege of a bursary from the Scientific Programme committee, allowing me to attend Glasgow. I had a great week, travelling up on the train after my clinic on Monday evening, with a glorious sunset over the Howgills before heading into Scotland. I had booked three nights at the Glasgow Youth Hostel looking out over the city from the edge of Kelvingrove Park which I would highly recommend.

For me, the most helpful aspects of the ASM were hearing and meeting such a wide range of health professionals. As a physiotherapist working in a pain clinic and coordinating a Chronic Pain Management Programme, the networking side of the meeting was helpful, so breaks between sessions and communal lunch area as well as social events were very helpful to meet fellow physiotherapists and find out how they are working. Also, meeting a range of multidisciplinary team (MDT) members such as general practitioners (GPs), psychologists and consultants was very helpful. I am particularly interested in self-management so sessions such as the supported self-management parallel session with Neil Berry, Gary Hennessey and Pete Moore and Val Conway's talk on commissioning a community pain service were highlights. Similarly, the cognitive behavioural therapy (CBT)/cognitive analytic therapy (CAT)/acceptance and commitment therapy (ACT) session was interesting looking at similarities and differences in approaches. I found the Health psychology parallel session very rewarding and thought-provoking. I also

thought the poster prize awards were very enlightening presentations demonstrating the wide range of interests represented within the British Pain Society (BPS). I found presenting a poster a steep learning curve and enjoyed discussing my research with many delegates. I also attended the education SIG and met friends from the philosophy and ethics and PMP SIGs which I belong to. The plenary sessions were helpful in hearing about other areas of research with which I was less familiar, for example, Dr Jordi Serra's presentation. I tried to attend as many sessions as possible and to widen my perspective with sessions such as the Commissioning in England session. I have some concerns that there can be a tendency in conferences to attend to what we know and go where we feel comfortable and hence reinforce our own prejudices. The plenary sessions I think are helpful to broaden perspectives and I would petition for these to be as wide in scope as possible. I think the BPS is right to encourage strong MDT representation, and this will be an ongoing challenge made easier by keeping a balance between primacy of primary and secondary care, interventional and self-management approaches and qualitative and quantitative research (and financial sliding scales). In future ASMs, I would suggest a greater platform for people living with pain would be useful for delegates. Many thanks again for enabling my attendance.

Yours sincerely
 Steve Hunter *Advanced Physiotherapy Practitioner, Calderdale and Huddersfield NHS Foundation Trust*

2nd Bursary Report

I am a PhD student working within the University of Aberdeen's Epidemiology Group, researching prognostic factors for pain in the distal upper limb. I was delighted to be awarded a bursary for this year's British Pain Society Annual Scientific Meeting. Attendance helped to contextualise my research and stimulated consideration of links with other areas. Most importantly, at an early stage of my career, my awareness of work being conducted in the pain field was broadened.

Professor Andrew Rice's captivating plenary session on the past, present and future of neuropathic pain research commenced 3 days of presentations and thought-provoking conversations. I chose to attend a diverse range of parallel sessions with topics including diagnostic uncertainty, the epidemiology of foot pain and therapeutic laughter. The latter session was informative yet participatory: a great ice-breaker to get to know other delegates.

Recurrent themes at the meeting reflected a biopsychosocial perspective on pain. Of particular interest to me were sessions on the role of psychological therapies in pain management and Professor Dame Carol Black's closing presentation on pain in occupational contexts. The passion of presenters and attendees was palpable and has left me excited to continue my work with the aim of attending the Society's conference next year.

Daniel Whibley *PhD Student, Epidemiology Group, Institute of Applied Health Sciences, University of Aberdeen*



UK representation at the International Symposium on Paediatric Pain 2015

Matthew Jay *Data Administrator, Department of Anaesthesia and Pain Medicine, Great Ormond Street Hospital NHS Trust*

A mainly sunny Seattle greeted delegates to the 10th International Symposium on Paediatric Pain (ISPP) – the biennial meeting of the Special Interest Group on Pain in Childhood of the International Association for the Study of Pain (IASP). It was first held in Seattle in 1988. A four-and-a-half day programme was dedicated to a wide range of topics within the realm of paediatric pain. The United Kingdom had a particularly strong representation with plenary talks, parallel sessions and a host of posters.

The theme of the meeting was ‘Yesterday, Today, Tomorrow’. It was an opportunity to reflect on the extraordinary scientific advances made in children’s pain and on the exciting new ways in which we are trying to grapple with it. The symposium began with two talks on the impact of early life pain. It is now well known that neonates experience a significant number of painful procedures each day they are on an intensive care unit and that these repeated pain experiences have lasting, long-term effects on pain processing. Suellen Walker reviewed recent studies in this area and the potential analgesic interventions which could be used in this setting. Other plenary highlights for me included Charles Berde’s Distinguished Career Award presentation, providing a history of paediatric pain services and future challenges; Roger Fillingim’s talk on gender and ethnic differences in pain and Sulayman Dib-Hajj’s lecture on



sodium channelopathy-related pain disorders.

The parallel sessions were equally varied with 39 to choose from. They included a session chaired by Christina Lioffi on hypnotic analgesia. The evidence for the efficacy of hypnosis in acute and chronic pain management was reviewed; current data from brain imaging, genetic and neurocognitive studies regarding the mechanisms of hypnotic analgesia were discussed and the power of hypnosis was demonstrated beautifully through videos of young people receiving hypnotic analgesia. However, unfortunately, it was made clear that there is still much to be



done in dispelling myths about hypnosis (‘Will you summon the devil?’ was one reported question) and in training and disseminating good practice. Alison Twycross and Anna William along with Anna Taddio and Cathy Reid looked at other ways of helping children through painful procedures in their workshop. They each provided different perspectives from public health (Anna T) to novel apps and simple devices for use with the individual (Anna W). Alison also co-facilitated a session with Glyn Williams and colleagues on parents’ management of their children’s acute pain at home – an issue which is increasingly important with pressures to increase the use of day-case surgery.

There were 182 posters this year, representing a ‘smorgasbord’ of different research perspectives, methodologies and disciplines. There were studies from the United Kingdom on adolescent worrying using ecological momentary analysis, using information technology to

collect patient-reported outcome data, measuring interpretation bias, clinical app development, nurse prescribing, complex regional pain syndrome, paediatric pain management programmes, mindfulness with adolescents, anxiety and many, many more. Last but not least, among the oral poster presentation prizes was Sezgi Goksan, a PhD student at Oxford University, who presented her studies into the use of functional magnetic resonance imaging to measure pain-related brain activity in neonates.

If I were permitted just one criticism of this year's meeting, it would be its western focus. IASP aspires to be the leading global collaborative organisation

in pain research and policy but despite boasting delegates from 31 countries, ISPP's programme this year was dominated by North America. There were only a handful of posters from outside the developed 'west', only one parallel session and only one plenary presentation. There is a lot of interesting work being done in developing countries, as well as an urgent need to address gross inequalities between developed and developing regions. In an increasingly globalised world, we can and should also engage in cross-cultural comparative work on clinical management and the phenomenology of the pain experience. Hopefully, the

location of ISPP 2017, Kuala Lumpur, will encourage more colleagues from other regions to attend and present their work.

For something closer in space and time than ISPP 2017, the 11th Paediatric Pain Symposium will be held in London on 10–11 December 2015 (<http://www.gosh.nhs.uk/paincontrol-noticeboard>) – with an early bird discount available until October. There will be talks and workshops on acute and chronic pain as well as ethico-legal issues. Or, if you want something really close to home right away, try the paediatric pain section of the e-PAIN module which is free for all NHS staff through e-Learning for Health (<http://www.e-lfh.org.uk/>).

Headache SIG Inaugural Meeting

Wednesday 25th November 2015

Churchill House, London



THE BRITISH PAIN SOCIETY

This is the inaugural meeting of the Headache Special Interest Group;
the provisional sessions are planned as follows;

Pathophysiology of headache: Farooq Maniyar (Barts & Basildon)
Diagnosis of headache: Anish Bahra (Queen Square & Barts)
How much of headache is dental pain : Simon Ash (Orthodontist & oral surgeon)
Psychology of headache: TBC
BASH Guidelines & Pharmacological treatments: Fayaz Ahmed, Secretary BASH (Hull)
GON & Botox: Kevin Shields (Whittington)
Stimulation : Giorgio Lambru (Guys & St Thomas)
Emerging techniques : Prof Rigmor Jensen (Denmark)

More information can be found on our website

<https://www.britishpainsociety.org/mediacentre/events/>

THE BRITISH PAIN SOCIETY



Review of the International Symposium on Paediatric Pain 2015

Dr Abbie Jordan *Honorary Lecturer, Department of Psychology and Centre for Pain Research, University of Bath*

I was exceptionally pleased to be awarded a Patrick Wall Travel Bursary from the British Pain Society to enable me to attend the 10th International Symposium on Paediatric Pain (ISPP). The conference was held from 31 May–4 June 2015 in the amazing city of Seattle, USA. I had been looking forward to the conference for many months and it did not disappoint in terms of content or location.

For those who have not attended this meeting before, ISPP is ‘the’ conference for paediatric pain researchers across the globe. The 10th ISPP meeting attracted individuals from a wide variety of disciplines. As a relatively small conference, the event embraces the idea of new learning as well as a chance to talk with colleagues working in the area of paediatric pain. This idea of current learning, reflection on past work as well as future collaboration fits nicely with the particular theme of the conference which was ‘yesterday, today, tomorrow’.

The conference opened with a plenary by Professor Ruth Grunau titled ‘Impact of Neonatal Pain: The Big Picture’. This was an excellent session that reviewed the research concerning the effects of repeated procedural pain events on infants in a neonatal intensive care environment. This material was thought provoking and followed by a plenary conducted by Dr Suellen Walker which followed the focus on studying pain in neonates. Dr Walker’s session focused predominantly on examining long-term changes in neonatal sensory processing after surgery and/or care in a neonatal intensive care environment. These



plenaries both provided a fantastic start to the meeting. Additional plenaries took a different focus, examining specific issues in paediatric pain such as sex differences (Professor Roger Fillingim), treatment of complex ongoing pain in adolescents and young people (Dr Laura Simons) and factors involved in moving from acute to chronic pain in children and young people (Dr Joel Katz).

Due to the diverse and plentiful nature of the conference programme, it is impossible to describe all of the remaining conference content. Material included poster presentations, plenaries and concurrent sessions, with work ranging from the study of neonates to that of adolescents and young adults. Research focused on chronic pain and acute pain, both in clinical- and laboratory-based settings. Given the diversity of material, for the remainder of the review, I will focus on the conference highlights for me in relation to my research interests.

One such highlight was the concurrent session titled ‘Innovations, challenges, and future directions in peer relationships of adolescents with pain conditions’. With research interests in adolescent chronic pain and relationships, this session was of particular interest to me. As participants in the session, chaired by Dr Paula Forgeron, we learned about the different ways in which technology has been used to examine friendships with adolescents and young people with chronic pain. This session really encouraged me to think about new ways in which we can conduct research with young people to explore the impact of ongoing pain on their relationships.

Another highpoint of the conference for me was a session on the final day of the conference which focused on reviewing some of the latest work being conducted to examine the efficacy of remote-based treatment of paediatric pain. This was a fantastic session that was hosted by Dr Tonya Palermo and included contributions from Dr Palermo herself as well as from Dr Chitra Laloo and Dr Rona Levy. A variety of different remote treatment interventions were considered, along with different modes of delivery (smart phone, telephone and computer). In addition to being presented with a comprehensive review of the latest evidence concerning the efficacy of the different interventions, the audience members were strongly encouraged to engage with a larger discussion about the advantages and challenges of

remote-based treatment of paediatric pain. This resulted in an interactive and popular session, as well as providing some food for thought in terms of designing and evaluating treatment of paediatric chronic pain.

A further strength of ISPP was that of the poster presentations. Due to the large number of posters, sessions were themed and spread across the three full days of the conference. Themes focused broadly on assessment and outcome measurement, pharmacological, interventional and complementary treatment approaches in addition to disease entities, palliative care and psychological and rehabilitative treatment. As suggested by these broad titles, posters were

plentiful and included a diverse range of topics. It was really excellent to see these poster sessions so well attended with some great discussion. This was facilitated by the reception on Tuesday evening which complemented collaborative discussion with colleagues with that of drinks and canapes. It was a pleasure to read about the very latest developments in paediatric pain over a glass of wine.

Overall, this was a fascinating conference that really helped me to develop my research interests in a number of ways. These included learning about the most up-to-date developments in paediatric pain through attendance at taught sessions as well as facilitating collaborative discussion with colleagues

over coffee. As always, ISPP is a friendly conference that generates a large amount of the very highest quality work in the field of paediatric pain. At the 10th ISPP meeting, it was particularly great to see sessions embracing more recent broad technological developments to develop research ideas and treatment in paediatric pain (e.g. use of smartphones, remote treatment and imaging). I would like to say a huge thank you to the British Pain Society for providing funding to enable me to attend ISPP. Apart from being a very enjoyable experience, attending ISPP was incredibly useful in terms of helping me to develop my research ideas further and develop collaborations with colleagues working internationally.

Join our Special Interest Groups (SIGs)

The British Pain Society has developed a mechanism (similar to that of the International Association for the Study of Pain) by which members of the Society who have a specific interest are given a forum to discuss their interest in more depth. The Society actively encourages and supports the development of such Special Interest Groups, as they are an important element of our multidisciplinary Society and are a key member benefit. There are currently 14 SIGs;

- Acute Pain
- Clinical Information
- Headache
- Information Communication Technology
- Interventional Pain Medicine
- Medicolegal
- Neuropathic Pain
- Pain Education
- Pain in Children
- Pain in Developing Countries
- Pain in Older People
- Pain Management Programmes
- Philosophy & Ethics
- Primary & Community Care



For more information about any of our SIGs please visit: <https://www.britishpainsociety.org/for-members/special-interest-groups/>

Royal College of Nursing launches Pain made EasyRead – accessible information for patients

Felicia Cox *Chair, RCN Pain and Palliative Care Forum*

Email: f.cox@rbht.nhs.uk

The Royal College of Nursing (RCN) Pain and Palliative Care Forum (PPCF) launched three EasyRead patient information leaflets at an event at RCN Congress in June 2015. This first tranche of EasyRead information covers pain after surgery, epidurals and patient-controlled analgesia.

Background

An expert panel roundtable discussion on pain was held in late 2013 and chaired by Professor Nick Allcock. There was consensus that there was a dearth of information about pain and common treatment strategies in an accessible format.

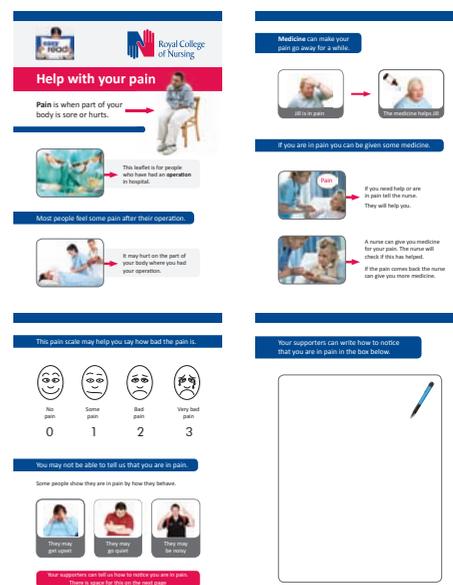
The Confidential Inquiry Into Premature Deaths of People with Learning Disabilities (CIPOLD, 2013) into the deaths of 2,417 people with learning disabilities (LD) over a 2-year period was tasked with investigating the avoidable or premature deaths of people with LD through a series of retrospective reviews of deaths. The report examined the patterns of care that people received in the period leading up to their deaths, identified errors or omissions that contributed to these deaths, to illustrate evidence of good practice and to provide improved evidence on avoiding premature death.

Pain as a concern

A lack of adherence to the Mental Capacity Act, poor documentation of Do Not Attempt Resuscitation orders, poor record keeping, use of unsuitable pain assessment tools and a failure to share safeguarding concerns were cited as contributing to poor outcomes. The need to have access to and utilise suitable pain assessment tools and information in accessible formats for people with LD has been under recognised by care providers. A key component of this project was its inclusive nature. Involving a lay member (Antony Chuter), who is a subject-matter expert on pain from inception, is supported by the publication *No decision about me, without me* (DH 2012).

Developing the final documents

The working party consisted of three pain specialist nurses (Felicia Cox – Chair RCN PPCF, Rachel Anderson and Pamela Taylor), a Learning Disability Practice Educator (Daniel Marsden – RCN Learning Disability Forum) and a person with pain (Antony Chuter – Chair Board of Trustees Pain UK and British Pain Society Patient Liaison Committee). We had valuable input from Mike Leat and a team of service users with LD employed by the Clear Communication People. After wide consultation with



professionals and service users, the final documents were launched in June. They are available to download as PDFs that can be printed as A4 documents from https://www.rcn.org.uk/development/nursing_communities/rcn_forums/pain_and_palliative_care/news_stories/new-easyread-patient-information-leaflets-available. If you want printer's proofs for local use as single fold A3, please contact me directly. Updated versions with different handsets and infusion devices will be available shortly.



THE BRITISH PAIN SOCIETY

Pain News

2015, Vol 13(3) 166

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A combination of Smartphone technology and yoga may assist the progression of values-based goals with chronic pain patients

Michael Linnett *Extended Scope Physiotherapist, Bury Physio*



Introduction

The International Association for the Study of Pain defines chronic pain as 'pain which has persisted beyond normal tissue healing time'.¹

Chronic pain is one of the most frequent reasons for seeking medical care, with cross-sectional survey indicating a prevalence of 30.7% in the US population.² The reported prevalence in the United Kingdom is 31% of men and 37% of women.³ It is a condition which involves physical, psychological and social processes.⁴ Consequently, modern treatment for chronic pain aims to address all of these components.⁵

Chronic pain impacts physical, psychological and social processes⁴ and has a serious effect on quality of life.⁶ Modern treatment for chronic pain aims to address all of these components.⁵ Pain clinics treat patients with chronic pain, for whom traditional disease-centred therapies have failed, with the emphasis on regaining quality of life.⁷

Patients who have not responded well to pain clinic treatments may be offered a Pain Management programme run by a multi-disciplinary team, which contains an element of psychology such as acceptance and commitment therapy (ACT). The aim of ACT is to improve quality of life by



developing a patient's psychological flexibility around obstacles, such as pain and negative thoughts and feelings, while encouraging them to engage in beneficial activities.⁸ ACT seeks to understand what is most important to each patient and uses this as a motivation for behavioural change with the aim of creating a 'rich, full and meaningful life while accepting the pain that inevitably goes with it'.⁹ It focuses on acceptance of negative experiences and a willingness to continue to be active without seeking to avoid pain.⁸

A 3-year follow-up of a cohort of 108 chronic pain patients, who had completed an ACT treatment programme, found that 64.8% of patients demonstrated reliable improvement in at least one measurement of acceptance, values, pain, disability or medical visits over that period.¹⁰ These interventions are relatively expensive to run, however, and as a result are limited to a subset of the patient population.²

One treatment approach which has evidence to support its use with chronic pain patients is yoga.¹¹ It is estimated that 15 million American adults have practised yoga at least once in their lifetime,¹² and an estimated 300,000–460,000 people are currently practising yoga in the United Kingdom.¹³ The aim of yoga is to produce positive behavioural changes by increasing awareness of mental and physical states and thereby enhance self-efficacy for pain control.¹⁴ The practice of yoga involves physical activity, breathing, relaxation and meditation.¹⁵ In addition, yoga has its own philosophy, comprising rules for personal conduct and the development of mindful awareness.¹⁶

Chuang et al.¹⁷ carried out a pragmatic randomised controlled trial (RCT) in the United Kingdom to evaluate the cost effectiveness of a 12-week yoga intervention consisting of 75-minute weekly classes, comparing yoga with a control group who received usual care. This study assessed costs from the perspective of the UK National Health Service (NHS) and societal costs and concluded that yoga was likely to be a cost-effective intervention from both perspectives.

Another treatment approach which is gaining prominence is the use of Smartphone apps. Smartphones have the capability to offer an inexpensive and broadly available means of self-management and have the capability to

provide detailed clinical information to improve a patient's ability to manage their condition.¹⁸ The market research firm Research2Guidance estimates the mobile health market will be worth US\$26 billion by 2017. Kristjánsdóttir et al.¹⁹ conducted an RCT, which found that a Smartphone intervention led to less catastrophising in women with chronic widespread pain. However, Rosser and Eccleston²⁰ found that Smartphone apps for pain management tended to be written with little clinical input and focused on maintaining pain diaries. This led to the creation of a specific app for pain patients to assist their progress towards personal goals (M Linnett, unpublished data, October 2013).²¹ The aim of this article is to propose the use of yoga in conjunction with a Smartphone app by discussing the literature surrounding their use in chronic pain and outline a feasibility study to test this hypothesis.

Physical rehabilitation interventions

In the first instance, patients are typically given physical and rehabilitation interventions. Middelkoop et al.²² conducted a systematic review on the effectiveness of physical and rehabilitation interventions for chronic non-specific low back pain. They found only low-quality evidence for the effectiveness of exercise therapy, transcutaneous electrical nerve stimulation (TENS) and behavioural therapy. They also found insufficient evidence to support the use of back schools, laser therapy, education, massage, traction, heat/cold and lumbar supports in the treatment of chronic low back pain. The conclusions of Middelkoop et al.²² were supported by a Cochrane review of exercise therapy for the treatment of non-specific low back pain by Hayden et al.²³ Kamper et al.²⁴ found biopsychosocial rehabilitation to be a more effective approach in the treatment of chronic low back pain.

Table 1. The eight limbs of yoga – Yoga Sutra of Patanjali

1. *Yama*: Universal morality
2. *Niyama*: Personal observances
3. *Asanas*: Body postures
4. *Pranayama*: Breathing exercises and control of prana
5. *Pratyahara*: Control of the senses
6. *Dharana*: Concentration and cultivating inner perceptual awareness
7. *Dhyana*: Devotion and meditation on the divine
8. *Samadhi*: Union with the divine

Sherman et al.²⁴ compared a 12-week yoga programme with a 12-week conventional exercise class programme. It concluded that back-related function in the yoga group was superior to the exercise group at 12 weeks.

This prompted a literature review to determine whether this represented an evidence-based approach for assisting chronic pain patients and whether parallels existed between ACT and yoga in the treatment of chronic pain.²¹ The key findings of this were as follows.

1. The practice of yoga involves physical activity, breathing, diet, relaxation and meditation.¹⁵
2. There is evidence to support the use of yoga in a chronic pain setting.¹¹ Two systematic reviews found that yoga has a moderate to significant effect on chronic pain-related disorders.^{4,14}
3. Yoga is likely to be a cost-effective intervention from both a healthcare and societal perspective.¹⁷
4. The term 'yoga' lacks a consensus of definition so that only half of the papers reviewed by Büssing et al.⁴ were reviewed by Posadzki et al.¹⁴
5. Yoga has its own philosophy, comprising rules for personal conduct and the development of mindful awareness.¹⁶ This is based upon the Yoga Sutra of Patanjali written around 200 AD,²⁵ which describes the eight limbs of yoga (Table 1).
6. Yoga may lead to greater body

awareness, positive behavioural change, enhanced self-efficacy and concomitant social activity.¹⁴ It can also lead to renewed awareness of the body, a transformation of the relationship with the body in pain and can lead to a transition from resisting the painful condition and striving to meet the expectation of others to acceptance of the painful state.²⁶

The findings of Posadzki et al.¹⁴ and Tul et al.²⁶ show parallels with ACT (Table 2).

The implication of these parallels is that a course of yoga which includes elements of philosophy can provide many of the elements of ACT, with the concomitant benefits in patient outcomes. One of the aims of ACT, however, is to lead patients towards committed action based upon personal values. Yoga teaches selfless service of humanity, which is an advanced concept rarely covered in a basic yoga class.

It was speculated that a Smartphone app may provide a way of assisting patients with this committed action, using the principle that a graded exercise therapy (GET) in which activity is gradually increased over time has been shown to be beneficial.²⁷ This prompted a literature review into the use of Smartphone apps with chronic pain patients.²¹ The key findings of this were as follows:

A combination of Smartphone technology and yoga may assist the progression of values-based goals with chronic pain patients

Table 2. Yoga and ACT parallels

ACT	Yoga Sutras of Patanjali
Mindfulness – A mental state of being completely aware of the present moment	Dharana means ‘immovable concentration of the mind’. The essential idea is to hold the concentration or focus of attention in one direction. ‘When the body has been tempered by asanas, when the mind has been refined by the fire of pranayama and when the senses have been brought under control by pratyahara, the sadhaka (seeker) reaches Dharana. Here, he is concentrated wholly on a single point or on a task in which he is completely engrossed. The mind has to be stilled in order to achieve this state of complete absorption’
Defusion – Process of observing thoughts rather than being caught up in them	Niyama (Svadyaya) – Paying attention non-judgmentally
Acceptance – Accept what you cannot change	Yama (Aparigraha) – Letting go of attachments to things and an understanding that impermanence and change are the only constants. In the context of chronic pain, Pearson (2008) interprets this as non-attachment to a pain-free future
Self as context – Make contact with a sense of self that is a safe and consistent perspective from which to observe and accept all changing inner experiences; http://contextualscience.org/self_as_context	Prathyhara/Dharana
Committed action	Selfless service

ACT: acceptance and commitment therapy.

- Smartphone apps have been developed and applied in a range of medical settings.²⁸
- The market research firm Research2Guidance estimates that by 2017, the mobile health market will be worth US\$26 billion.
- Smartphones have the capability to offer an inexpensive and broadly available means of self-management and have the capability to provide detailed clinical information to improve a patient’s ability to manage their condition.¹⁸
- A Smartphone intervention has been shown to lead to less catastrophising in women with chronic widespread pain who had completed a 4-week inpatient rehabilitation programme.¹⁹
- Attrition rates from health-promoting Internet interventions were high, and usability is an important factor in the chronic pain patient group who tend to have comparatively poor technology skills.²⁹

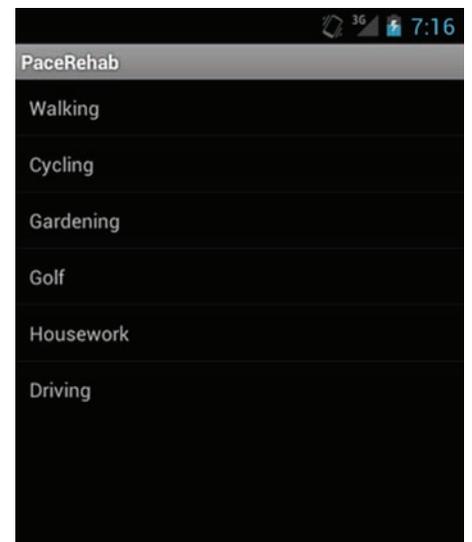
- A total of 86% of pain management apps had no healthcare professional involvement and reported little evidence to support the use of pain apps as they were developed without reference to the available research.²⁰

Methods

A preliminary survey of patients attending a pain clinic was initiated (M Linnett, unpublished data, October 2013).²¹ Patients were asked whether a Smartphone app which assisted them with their personal goals would be beneficial. Patients were given an outline of how such an app might look. From this, the researcher created a basic Smartphone app prototype, and a small group of patients were invited to try it and provide feedback, which led to the development of an instructional video for using the app and the ability to create and delete multiple goals.

Smartphone app graphical user interface

The prototype app was developed to run on any android Smartphone. It consists of two simple screens: The first displays a list of current goals. The second allows a patient to set a new goal. There are five fields on this screen:



A combination of Smartphone technology and yoga may assist the progression of values-based goals with chronic pain patients

- Their values-based goal;
- Details on what it is they wish to achieve;
- The date by which they wish to achieve this goal;
- How long they can do this for at present;
- How long they need to be able to sustain this activity in order to reach their goal.



A countdown timer is displayed every few seconds to show how much time is left to spend on the activity. The device vibrates when the time is up. The duration of the activity increases each day to reach the target duration on the target date.

Yoga instruction

The lack of consistent definition for yoga within the available research made it difficult to choose the best approach to teach a class of patients. Much of the research used standard yoga exercises, so a beginner's Sivananda yoga class was trialled in the pain clinic by a qualified physiotherapist and yoga teacher.

This yoga intervention consisted of a mindful body scan, Pranayama (breathing exercise), spinal twist, bridge pose, forward bend, dancer pose, Warrior pose and lion pose. The sessions concluded with a body scan and a 10-minute

meditation in relaxation pose. Emphasis was placed upon relaxed practice in each posture using mindful awareness of the body without striving to attain a particular position (such as reaching the toes). Patients were encouraged not to push through their pain, and postures are adapted to suit restricted mobility. For example, patients who were unable to get up from the floor are able to use a plinth. Those unable to lie down were given alternative exercises in sitting.

A rolling 4-week yoga class was run between November 2012 and March 2014. The aim of this was to assess the viability of running a yoga class in the pain clinic as part of a research trial and offer more activities to patients as part of a service improvement programme. From a group of 50 patients, 9 of the 18 patients (50%) in the yoga study group recorded a clinically important difference compared with 15 of the 32 patients (46%) in the control group.

Self-reported outcomes from patients included feeling less stressed, more flexible and sleeping better. Many of the patients in the trial went on to join external yoga classes after completing the 4-week programme.

The purpose of the Smartphone app is to support this patient group with their own values-based action once some of their physical and psychosocial barriers to activity have been addressed.

Discussion

The available yoga research shows a treatment effect for chronic pain patients in terms of pain reduction, increased function and reduced catastrophisation. However, within this research, yoga lacks a consensus of definition, which makes it difficult to synthesise the conclusions as a basis for further research. There are parallels between yoga and ACT; however, one significant difference is that ACT seeks to encourage patients towards values-based action, which may contribute to a long-term treatment effect.

Smartphone apps may be able to assist patients with achieving goals based around their values-based action as they have been found to be a viable treatment adjunct for patients including chronic pain patients. This has been recognised within the UK NHS by the creation of an app repository of approved Smartphone for use with NHS patients. A small number of patients trialled this Smartphone app using their own android mobile phone and downloading the app from an external site. Those who used it reported finding it helpful to progress towards their goals by gradually increasing the duration of their activity below the level of their flare-up pain.

There is evidence to support the use of yoga and Smartphone apps with chronic pain patients. To date, no trial has been conducted that combines these two. It must, however, be recognised that this intervention only targets a subset of chronic pain patients.

Trialling yoga in a pain clinic with chronic pain patients produced a variety of outcomes. Some patients did not wish to participate, citing a number of reasons. Some refused to attend on the grounds of religious belief, and others found the class too sedentary or too difficult or disliked an aspect of the class and did not return. As this was a service improvement, no randomisation of patients took place to compare outcomes with the existing Pain Management Programme. Similarly, the Smartphone app was only permitted to be trialled informally prior to obtaining funding for a research feasibility study. This limits the reliability and validity of the feedback. The trial was limited to patients with their own android phone. Even among this group, some patients did not wish to use the app or had a goal which was incompatible with using this app. A feasibility study has now gained ethical approval and the trial will commence in late 2015.

A combination of Smartphone technology and yoga may assist the progression of values-based goals with chronic pain patients

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The significance of Health and Social Care Sector involvement for Scottish chronic pain patients

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Introduction

This article will discuss Health and Social Care Sector (third sector) involvement with chronic pain patients from the perspective of Pain Association Scotland. This viewpoint is important because, as some observers¹ note, the third sector is by nature unsuited to singular definitions and often narrowly concomitant with the idea of voluntarism. The view of this proponent is that a third-sector organisation comprises a mixture of social organisations both private and public, hierarchic and anarchic, most certainly a societal process and far beyond deleterious provisions of something which is 'not-for-profit'. Additionally, to conclude an acknowledgement of differential focus, in that, on one hand, economic focus may be on the associated National Health Service (NHS) wealth distribution of long-term conditions, whereas sociologists maintain a perspective of value-driven motivation by a patient or cohort of patients. Therefore, it is important to reveal the underlying boundaries and parameters which encompass a third-sector organisation, specifically related to chronic pain patients.

Background

In addition to the chronic pain statistics quoted above, low back pain (LBP) is internationally recognised as a significant health, social and economic burden, for example, 0.8% and 2.1% of gross domestic product (GDP) in some US and



European countries.² In the United Kingdom, approximately one-third of the population suffers from chronic pain³ in some shape or form. The consequences of this have a significant impact on quality of life, suffering and disability. Chronic pain affects individuals and their families, and comes at a significant economic cost. Lower back pain is estimated to cost in the region of £12 billion per annum in the United Kingdom in 1998, and arthritis-associated pain costs around 2.5% of the gross national product of Western nations (SIGN 136 – management of chronic pain).⁴ More recently, it was estimated that people with chronic pain are responsible for almost 5 million general practitioner (GP) appointments in the United Kingdom by people seeking help and relief from chronic pain, and in many cases, they leave without answers and without effective pain relief⁵ with a related cost of almost £70 million to the NHS.⁶ On 29 May 2013, the Scottish Government announced the need to accelerate improvement across all levels of care for chronic pain sufferers. This

initiative resulted in Service Improvement Groups (SIGs)/Managed Clinical Networks (MCNs) established or in the process of being established within all NHS Boards in Scotland to drive improvements in the management of chronic pain. Informed by this national position, Pain Association Scotland has been developing support programmes for chronic pain sufferers for 25 years and more recently aligned to the Public Bodies (Joint Working) (Scotland) Act 2014, which puts in place the statutory framework for integrating health and social care in Scotland.

Is pain a reality?

Chronic pain has a high impact upon physical, psychological and family health. Issues include, but are not limited to, depression, long-term stress, isolation, high levels of medication, poor mobility, lack of self-esteem and fatigue. Pain can be interpreted as being an isolating experience, as there may be a stigma associated with the condition:

Chronic pain is not simply a physical problem. It is often associated with severe and extensive psychological, social and economic factors. Apart from poor general physical health and disability there may also be depression, unemployment, and family stress. Many of these factors interact, and the whole picture needs to be considered when managing individual patients. The impact of

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*chronic pain on patients' lives varies from minor restrictions to complete loss of independence.*⁷

One of the Health Report Chronic Pain Surveys⁸ found that 58% of the people surveyed felt that other people 'sometimes' doubt the reality of their pain. In this regard, chronic pain often sets the stage for the emergence of a complex set of physical and psychological changes which add greatly to the burden of the pain sufferer.

- Isolation from society and family;
- Anxiety, stress, fear, bitterness, frustration, depression, suicide;
- Over-dependence on family and other carers;
- Depression of the immune system and increased susceptibility to disease often associated with poor appetite and nutrition;
- Overuse and inappropriate use of professional healthcare systems.

This is not an exhaustive list, and in most cases, chronic pain eventually dominates the life and concerns of the sufferer, their family, friends and carers. In addition to the severe erosion in quality of life of the pain sufferer and those around them, chronic pain imposes severe financial burdens on many levels.

- Loss of income imposing financial burden on family, friends and employers;
- Job absenteeism and disruption in the workplace;
- Increased dependence on benefits;
- Costs of healthcare services and medication.

Self-management of pain

Supporting patients with chronic pain is more than just handing out medication. Over two-thirds (68%) of patients report that their medication is inadequate at times, and over one in five (22%) have discontinued prescribed pain

medication.⁹ The Association has continued to provide a high-quality staffed community-based service for people burdened with chronic painful conditions. This is because chronic pain is multifactorial, comprising neuropathic and nociceptive components, based on a bio-psycho-social understanding. To support patients with this condition, the Association has developed appropriate service delivery through collaborative working relationships with Health Care Professionals and extended new joint working opportunities with the majority of Scottish Health Boards. Through the delivery of training courses and self-management groups, service objectives continue to be focused on empowering people with self-management capabilities. This inevitably leads to the improvement in quality of life, health and well-being for many chronic pain sufferers, their families and carers and colleagues as our resources allow. Such self-management has the potential to improve health outcomes in many cases, with patients reporting increases in physical functioning. It can also improve patient experience, with patients reporting benefits in terms of greater confidence and reduced anxiety.¹⁰

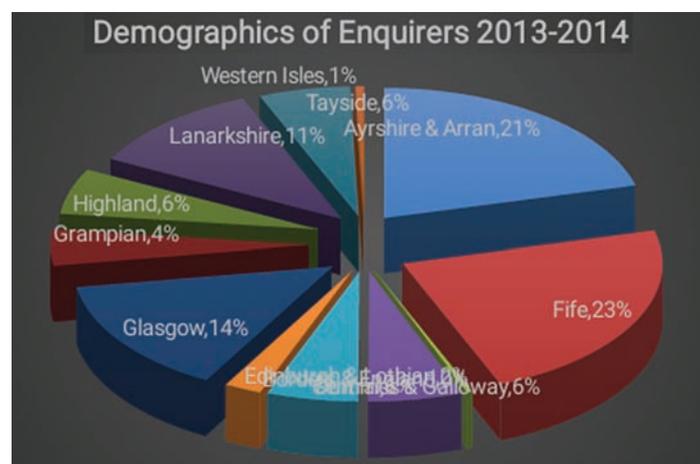
Service provision

The Association provides around 1,710 hours of staff-led self-management training for approximately 1,670 participants per month. The highest percentage of referrals come from NHS Ayrshire and Arran and Fife – 21% and 23%, respectively, with the lowest percentage from Edinburgh and Lothian and Borders at 2% and 0%, respectively. Figure 1 indicates the number of referrals into the service for 2013/2014 period.

For the intensive self-management course, the service delivers an average of 24 courses per year and receives an average of 850 clinical referrals from NHS Chronic Pain Services. Figure 2 indicates that the highest percentage of those referred to the intensive self-management courses are between the age of 40 and 59 years, and therefore of working age. As indicated in Figure 3, this position is in line with the outcomes of the National Scotland-wide Healthcare Improvement data collection.¹¹

This clearly demonstrates the importance of self-management to support patients back into employment, keep those who are in work at work and also to be able to enjoy and have the benefit of an improved quality of life in the long-term. Overarching the referral

Figure 1. Enquiries



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Figure 2. Age range

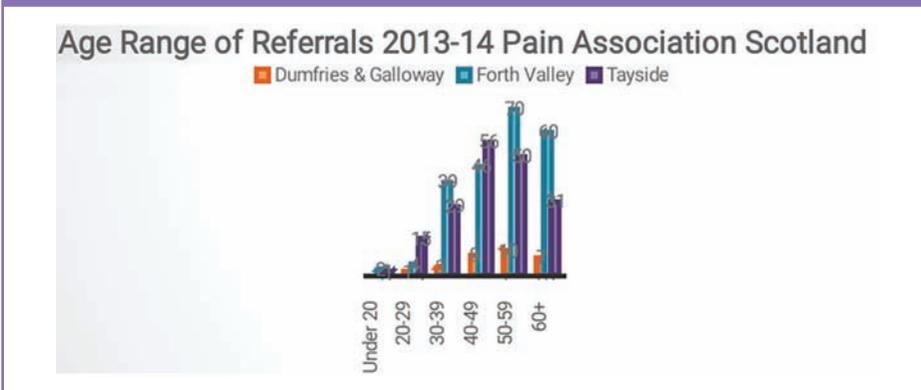


Figure 3. Age range – National indicator

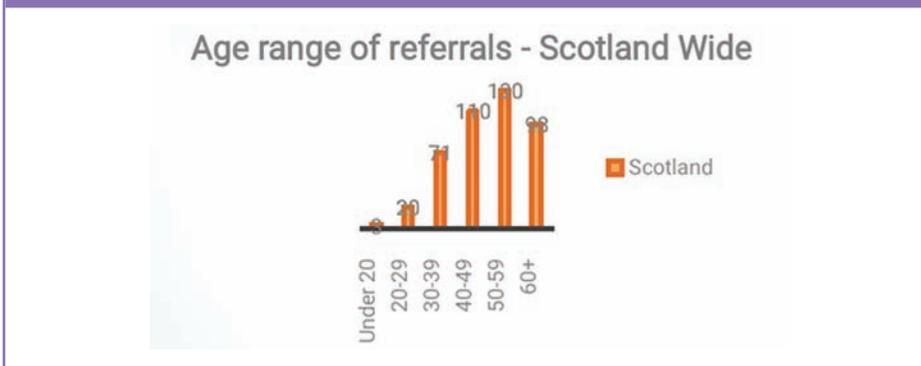
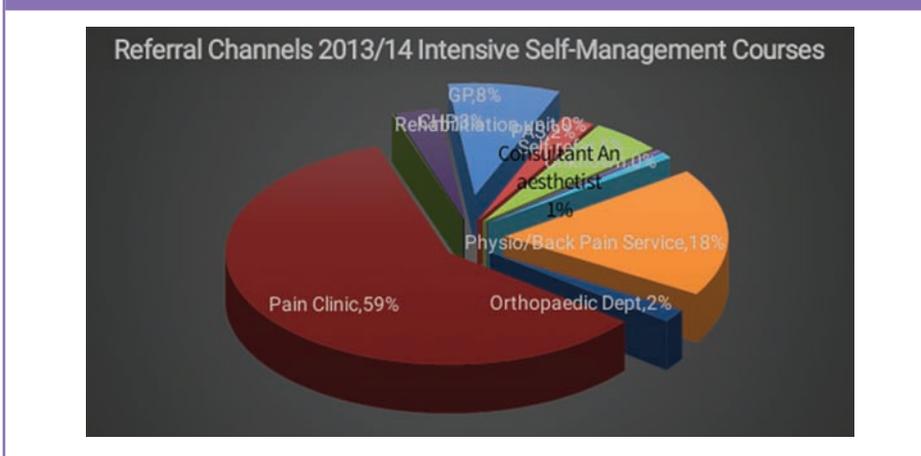


Figure 4. Referral channels



routes, Figure 4 indicates the referral channels of patients to the intensive self-management courses and shows that although the majority of referrals are from

pain clinics (59%) for 2013/2014, the percentage of GP referrals demonstrated an increase of 3% from 2012/2013. This increase relates to supporting

infrastructure from work going on with the respective SIGs in each health board.

This initiative encourages more referrals to self-management from primary care in order that chronic pain sufferers have the option to access self-management at a much earlier stage. This is a positive step in preventing unnecessary referrals to secondary care at an average cost of <£20 per patient per course.

The course content underpinning these figures includes the relationship between stress and health (bio-psycho-social); understanding chronic conditions, relaxation, breathing and distraction techniques; experience of combined breathing and gentle stress reducing movement; communication and understanding; pacing and goal setting and dealing with unhelpful thoughts and feelings. Since these topics are inter-related, the experienced staff member leading the group can guide the pace and individual needs of participants attending each session. Figure 5 indicates the completion rates for the self-managed courses for the period of 2013–2014, which cumulates to an overall average of approximately 95%.

Service alignment (Health and Social Care)

The NHS Board’s collaboration with voluntary sector organisations such as Patient Administration System (PAS) has significant potential to improve self-management, reduce inappropriate referrals and reduce the costs for acute and secondary care services.¹² PAS supports the current Scottish model of pain by delivering a series of self-management programmes

The service is accessible for all chronic pain sufferers, even in remote and rural areas and those who are often isolated; the website enables people access to online self-management 24/7. In this way, the service supports the vision of the Scottish Chronic Pain Service Model by shifting the balance of care to the

Figure 5. Completion rates



Figure 6. Spider model



community. Thus, supporting patients to self-manage their pain, this service structure can reduce the impact on both primary and secondary care resources, investigations and treatments. The Association meets the Scottish Government's objectives of being *safe*, *effective* and *person-centred* in the following ways:

Safe

A key feature of this type of service delivery is that it offers an open door policy to local self-management groups whether people are referred by a clinician or simply self-refer; at no time is anyone more than 4 weeks away from a group meeting in their local area. These groups provide the coping skills and

strategies which enable people to maintain and support an independent lifestyle.

Effective

The service provides an approved exit strategy for health and social welfare professionals, and this effectiveness has enabled more chronic pain sufferers to access our service as a first step in their pathway of care. The Scottish Government's Steering Group for Chronic Pain nominated the Association as the preferred/approved provider of self-management training and support and included our model as an integral part of the new service model for chronic pain services in Scotland enhancing local chronic pain services.

Person-centred

When someone is in pain, they may seek help at that specific time. Using this model of care delivery, no one has to wait longer than 4 weeks to access a local self-management group or the online self-management course, which enables people to have access to the support 24/7. Sufferers have access to our Pain Radar Graph at any time, enabling them to monitor their own progress over and period of time.

Service assessment

Monitoring and evaluation is important as it can reinforce service user benefits, and importantly, can record their improvement using standardised tools. Within Pain Association Scotland, the Pain Radar Graph (Figure 6, Spider model) is used to reflect progress and note unique anecdotal comments.

This tool is supported by *Depression, Anxiety, Positive Outlook Score* (DAPOS; Figure 7) and the *Pain Self-Efficacy Questionnaire* (PSEQ) tool, as shown in Figure 8. The use of appropriate evaluation tools underpins evaluation, and in most cases validates the patient report analysis, which indicates reduction in depression and anxiety and an increase in positive outlook and self-efficacy.

Ultimately, for any provision of service, and definitely within the healthcare sector, it is vital that both health professionals and potential funders acknowledge clear benefits of improved patient health and well-being, cost effectiveness which are overarched by the adoption of this tool and model architecture. As a consequence of this intense monitoring strategy, individuals who have participated in intensive self-management programmes report more vitality, less pain, less dependence on others and improved mental health and are more satisfied with their lives compared to those who have not taken part. Increased self-efficacy is closely

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Figure 7. DAPOS model

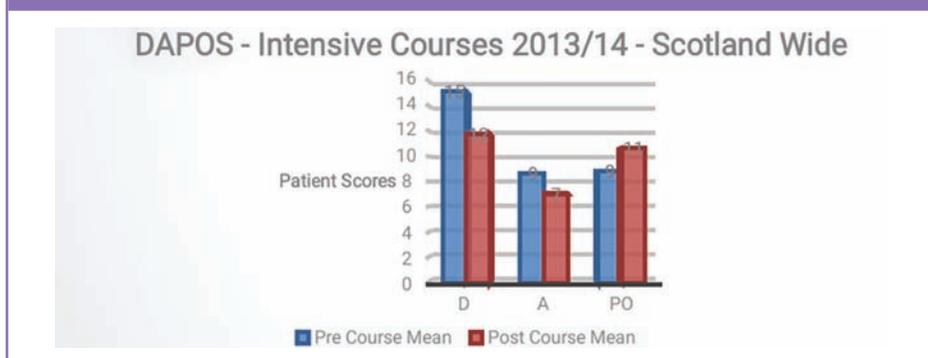
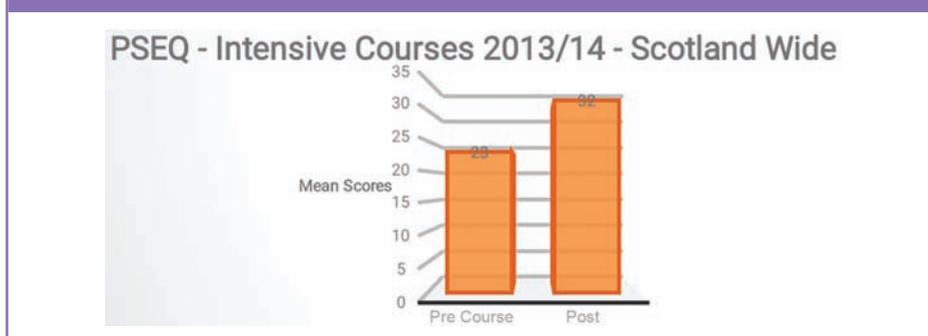


Figure 8. Pain Self-Efficacy Questionnaire



related to successful rehabilitation. The service provision is specifically designed to target those in the community who are affected by long-term (chronic painful) conditions. Service provision under this paradigm continues to address the non-medical issues which impact people's lives; thus, self-management programme offers a different paradigm – it is not a replacement for medicine – rather it focuses on highly relevant topics and can facilitate the change in locus of control and improves those aspects of life that only that person can improve by regaining control. In this way, the benefits are equated as giving a practical next step for someone who has reached the limits of medicine. This focus helps introduce people to, and quickly build,

self-management skills, thereby creating practical positive change and leading to an improved quality of life and well-being. Chronic non-malignant pain continues to present a challenge not only for those affected but for all health professionals involved in their care. Additional feedback comes from staff working directly with our users, questionnaires, forums, calls to free 0800 enquiry line and positive collaboration with healthcare professionals.

Conclusion

Sufferers of chronic pain have been poorly supported in the past, and many sufferers report that their pain is not believed or apathy to the condition. This

discussion has shown that through a network of staff-led community-based self-management groups and training programmes, utilised service provision can be developed to help with this situation. Utilised in this way, the correct service structure empowers chronic pain sufferers, their carers, family and colleagues to make positive practical changes leading to improved levels of coping, well-being and quality of life, without impacting the already under-resourced NHS services. Clear, focused, managed and monitored resource can help sufferers understand and manage their chronic pain condition and unwanted changes in health outlook by seeking positive adaptive and coping mechanisms which can ultimately lead to a better quality of life.

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Chronic visceral pain: lessons from cats

Professor Tony Buffington *Emeritus Professor of Veterinary Clinical Sciences, The Ohio State University College of Veterinary Medicine*

Understanding of chronic abdominal and pelvic pain syndromes has advanced dramatically in recent years. Interstitial cystitis (IC)/bladder pain syndrome (BPS) has been noted in domestic cats (which we incorrectly called 'Feline Interstitial Cystitis (FIC)')¹ and human beings, both men and women are afflicted roughly equally.²⁻⁴ In cats, developments in management has led to a focus on implementing multimodal environmental modification (MEMO), which reliably results in relief of lower urinary tract signs (LUTS).⁵ Moreover, patients of both species commonly have co-morbid health problems, and in cats, effective MEMO results in resolution of these as well.^{5,6}

Some urologists still disagree on whether IC/BPS is a primary bladder disorder or whether the bladder symptoms are secondary to some other cause; both may be correct (in some cases).⁷ IC may be an 'ulcer disease' of the bladder that afflicts a minority of patients, whereas BPS may represent a central sensitivity syndrome.⁸

The absence of an accepted aetiopathogenesis has left many basic and clinical scientists interested in contributing to a better understanding of IC/BPS to view the syndrome through the lens of their particular discipline. Thus, cell physiologists have focused on epithelial surfaces, immunologists on immune cells and molecules, endocrinologists on hormones, neurophysiologists on peripheral sensory nerves and clinical scientists on their medical specialty. This has resulted in most animal models of IC/BPS consisting



of inflicting some kind of injury to the bladder of healthy animals of various species and measuring various parameters of interest to the investigator.^{9,10} Unfortunately, such approaches are akin to attempting to study migraine by applying blunt force to the head; one might learn something useful about acute head pain, but precious little about the aetiopathogenesis of migraine.

Even the classification or identification of 'chronic abdominal and pelvic pain syndromes' is problematic. Feinstein¹¹ concluded that

An important principle in naming apparently new ailments is to avoid etiologic titles until the etiologic agent has been suitably demonstrated. A premature causal name can impair a patient's recovery from the syndrome, and impede research that might find the true cause.



Many diseases were named for their symptoms long before research identified their aetiology and pathogenesis. For example, traditional terminologies such as 'abdominal and pelvic pain', 'IC (and its many recent variant names)', 'irritable bowel syndrome', 'vulvodynia' and 'endometriosis' seem to suggest to many patients, clinicians and basic science researchers that the organ included in the name must represent the source of the problem (hence, inappropriate terms such as 'pain generator' are applied to organs other than the brain). Moreover, whereas terms such as 'abdominal and pelvic pain', 'IC', 'irritable bowel syndrome', 'vulvodynia' and 'endometriosis' may describe some organ-specific aspects of these disorders; recent clinical research has revealed that they no longer capture the extent of the problems occurring in many patients to whom these labels are applied.^{12,13} Such names mostly are limited to describing obvious presenting signs and organ-focused diagnostic testing specific to the particular medical or surgical (sub) specialism rather than



THE BRITISH PAIN SOCIETY

Pain News

2015, Vol 13(3) 177-180

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the results of a comprehensive evaluation of the entire patient.¹⁴

Comprehensive investigations of these patients also have resulted in the proliferation of vague descriptive terms such as 'medically unexplained syndrome'¹⁵ or 'functional somatic syndrome'¹⁶ to describe the multiple abnormalities which may be observed in these patients. The list of chronic disorders proposed to be covered by these names is long and includes problems addressed by most of the medical subspecialties.¹⁷ These names also seem to violate Feinstein's admonition, however, so it seems that some generic umbrella term comparable to 'cancer' or 'infection' might be preferable for the present; I recently suggested adoption of 'Pandora Syndrome' as an interim name for FIC until the most biologically appropriate term is identified in cats.³

Recent research, in related fields pertinent to chronic visceral pain, has shown that adverse experiences early in life can confer vulnerability for development of chronic diseases later in life,¹⁸ including a variety of chronic pain and related syndromes.^{19–25} This field, known as 'Developmental Origins of Health and Disease', has exploded in the last 40 years, providing novel explanations for a variety of previously poorly understood diseases. Some animal models of these events have been developed, including maternal separation,²⁶ provision of limited nesting material²⁷ and neonatal irritation of the colon²⁸ or bladder.²⁹ Animals subjected to the maternal separation or limited nesting material interventions develop changes in hypothalamic-pituitary-adrenal activity and have been used extensively in mental health-related research.³⁰ It also has been found that these stimuli can result in visceral hypersensitivity in adulthood.³¹ Additionally, irritation of the colon by infusion of mustard oil or repeated distension,²⁸ or instillation of zymosan

into the bladder of neonates,²⁹ has been shown to result in persistent visceral hypersensitivity.

These models might be even more useful if investigators with interest in different organs or processes could collaborate to more comprehensively investigate the effects of these manipulations on the animals subjected to them. Examples of the value of such integration are presented in recent reviews,^{31,32} which describe the components of the brain-gut axis individually and how they are altered by maternal separation and stress in rodents. Animals that had been exposed to maternal separation had alterations of intestinal barrier function and balance of enteric micro flora, as well as exaggerated stress responses and visceral hypersensitivity as adults, all of which occur in humans with the modelled disease – irritable bowel syndrome. It is easy to imagine that thorough scrutiny of other organs might yield additional insights.^{33,34}

My interest in IC/BPS developed during the course of investigations of the aetiopathogenesis of LUTS in domestic cats, which in the 1980s was thought to be a nutrition-associated problem.³⁵ We documented that many of these cats shared a comparable disease history and course, and met all the applicable inclusion and exclusion criteria for the research diagnosis of IC promulgated by the National Institutes of Diabetes, Digestive and Kidney Diseases in 1988³⁶ that could reasonably be applied to animals, so we termed the syndrome in cats FIC.¹ Other naturally occurring models of abdominal and pelvic distress also have been reported, including colitis in cotton-topped tamarins³⁷ and endometriosis in primates.³⁸

In contrast to induced models of bladder injury, FIC is a common, naturally occurring disease of cats. FIC accounts for some 5% of diagnoses in cats older than 1 year of age at a large US veterinary practice in 2014³⁹ and was the

most common claim for cats in 2013 at the largest American veterinary pet insurance company.⁴⁰ FIC is diagnosed in 55%–75% of cats presented for evaluation of signs referable to the lower urinary tract.⁴¹ FIC has the greatest face validity for IC/BPS of any animal model currently available and is remarkably similar to the disease in humans.⁴² FIC most closely resembles non-ulcer IC in humans¹ (BPS type 2 according to the European Society for Study of Interstitial Cystitis (ESSIC) criteria⁴³), although ulceration and inflammatory infiltrates have been reported in a cat.⁴⁴ Patients of both species have abnormalities of local bladder factors, as well as involvement of the afferent, central and efferent limbs of the nervous system⁴² and a common serum infrared spectral pattern.⁴⁵ Variable combinations of co-morbid disorders also have been identified in patients of both species.^{5,42,46} Moreover, the occurrence of co-morbid disorders often precedes the occurrence of LUTS and symptoms in these patients.^{47–49} These co-morbid disorders also appear to occur more commonly in close relatives of human patients,^{50–52} and evidence of adverse early experiences has been reported in patients with FIC⁵³ and IC/BPS.¹⁷

Like the induced bladder injury models, FIC also has limitations as a model of IC/BPS. One limitation is the seemingly different gender distribution between affected males and females of the two species. In cats, both genders are affected roughly equally, whereas early studies in humans suggested that 90% of patients were women.⁵⁴ Recent reports, however, suggest that the sex difference in humans may not be as large as originally thought^{54,55} if it exists at all.^{2,56}

Another limitation, to using cats with FIC to study IC/BPS, is that affected animals are not easy to acquire without both veterinarian and owner cooperation. Additionally, cats are more expensive to maintain in laboratory animal facilities

than are rodents, are outbred, and lack many of the molecular tools available for rodents. Despite these limitations, studies of cats with FIC have duplicated many results obtained in humans with IC/BPS and even predicted some abnormalities that were subsequently found in humans with IC/BPS,^{57,58} in ways not currently possible in humans or induced models.

Different kinds of BPS may occur,¹³ although the extent to which these represent distinct diseases or variability in the clinical manifestations of a common underlying aetiology currently is unknown. Baranowski, et al.⁵⁹ suggested that there may be three groups: patients with bladder symptoms only, patients with more generalised pelvic pain and patients with multiple systemic symptoms. Since then, at least five studies have reported on additional symptoms in patients with BPS.^{47,60–63} Unfortunately, differences in the number of systemic symptoms considered (from 2 to 11) preclude determination of just how many subsets are present.

Animal models also have been employed to attempt to study treatment approaches to IC/BPS. Pharmacological treatment of rodents with induced abdominal and pelvic pain has been reported, but to my knowledge none of the agents tested has been translated into effective clinical therapy to date.⁶⁴ This is not to say, however, that more valid models have not been proposed or tested,^{64,65} for example, effects of social and environmental manipulations of mice 3 months after induction of chronic neuropathic pain recently were reported.⁶⁶ In this study, 7 to 8 week-old male CD-1 mice underwent surgery to induce the spared nerve injury model of neuropathic pain or sham condition, after which they were assigned to one of four groups: nerve injury with enriched environment, nerve injury with impoverished environment, sham surgery with enriched environment or sham surgery with impoverished environment

(n = 8–9 per group). The effects of environmental manipulations on cutaneous mechanical heat and cold sensitivities, motor impairment, spontaneous exploratory behaviour, anxiety-like behaviour and depression-like phenotype were assessed. At both 1 and 2 months after the environmental changes, environmental enrichment attenuated nerve injury-induced hypersensitivity to mechanical and cold stimuli, while the impoverished environment exacerbated mechanical hypersensitivity; no antidepressant effects of enrichment were observed in this study. The authors concluded that environmental enrichment was a safe, inexpensive and easily implemented non-pharmacological intervention that might play an important role in the rehabilitation of chronic pain patients well after the establishment of chronic pain. Although this study investigated chronic somatic rather than abdominal and pelvic pain, similar effectiveness has been found in cats with FIC, as described below.

Our goal for MEMO is to establish and sustain an environment wherein the cat's perception of control exceeds its perception of threat. This is done by educating and supporting client efforts to create a situation wherein the cat feels safe is permitted to choose critical resources (e.g. food, litter) and can engage in species-typical behaviours.^{67,68} Laboratory studies have repeatedly found that environmental enrichment reduces LUTS,^{6,69,70} normalises circulating catecholamine concentrations, bladder permeability, cardiac function^{69,70} and reduces acoustic startle responsiveness in cats with FIC.⁷¹

We also conducted a prospective observational study of client-owned cats with moderate to severe FIC.⁵ In addition to their usual care, clients were offered individualised recommendations for MEMO based on a detailed environmental history obtained from the owner. During 10 months of treatment, we observed significant ($p < 0.05$) reductions in LUTS,

fearfulness, nervousness, signs referable to the respiratory tract, and a trend ($p < 0.1$) towards reduced aggressive behaviour and signs referable to the lower intestinal tract.

Recent research also suggests that clinical signs of some 'co-morbid disorders' might be sickness behaviours.⁶ Sickness behaviours refer to a group of non-specific clinical and behavioural signs and symptoms that include variable combinations of vomiting, diarrhoea, anorexia or decreased food and water intake, fever, lethargy, somnolence, enhanced pain-like behaviours, and decreased general activity, body-care activities and social interactions. These behaviours are well-documented physiologic and behavioural responses to infection, inflammation and aversive environmental events in a variety of species.⁷²

We have observed sickness behaviours in response to unusual external events, both in healthy cats and in cats with FIC. We noted that increasing age and weeks when unusual external events occurred, but not disease status, resulted in a significant increase in total sickness behaviours observed in the cats when controlled for other factors. Unusual external events were associated with significantly increased risks for decreases in food intake and elimination and for increases in defecation and urination outside the litter box. These results suggest that some of the abnormalities observed in cats with FIC may represent amplifications of responses observed in healthy animals, possibly due to variable combinations of differences in genetics, early life experience or disease chronicity, as appears to be the case in humans with IC/BPS and other chronic abdominal and pelvic pain syndromes.⁵⁰

Warren et al.¹³ recently suggested three hypotheses about the causes of IC/BPS that accommodate the presence of multiple systemic symptoms (1) that IC/BPS initiates some process that results

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in other disorders, (2) that other disorders initiate processes that also result in IC/BPS and (3) that a preceding pathophysiology results in both. One way to exclude one or more of these hypotheses would be to conduct a prospective longitudinal study of healthy individuals. Another would be to treat patients with IC/BPS to determine the effect on their systemic symptoms. If other symptoms remained in recovered patients, hypothesis 1 would be excluded; if other symptoms were treated and IC/BPS remained, hypothesis 2 would be excluded and if a hypothesised underlying pathology was effectively treated and multiple symptoms remained, hypothesis 3 would be excluded.

Effective environmental enrichment might be conceptualised as one treatment approach to test the hypothesis that FIC and IC/BPS is the result of an underlying abnormality in the brain. As described, we have found that this approach results in statistically and clinically significant improvements in all disease signs, both in cage-confined and client-owned cats, arguing against exclusion of hypothesis 3. The fact that these improvements occurred in the absence of any treatment directed at the bladder or any other peripheral organ provides evidence for exclusion of hypotheses 1 and 2. I await comparable studies in human beings with IC/BPS to learn the extent to which results of

enrichment in cats are predictive of responses to comparable approaches in human beings.

Others also have suggested that environmental enrichment might be a beneficial adjunctive approach to treatment of patients with chronic pain⁷³ and other central sensitivity syndromes including IC/BPS.^{4,74,75} Many, perhaps most, patients with IC/BPS have a chronic medical problem, currently more amenable to management than cure. Unfortunately for both, they often find themselves in the care of acute surgical subspecialists (urologists), most of whom naturally have neither the time nor the training to address these patient's complex needs.

While the goal for environmental enrichment for human beings would be the same as for cats, to permit the person's perception of control to exceed their perception of threat, the approach would necessarily be different. For example, while the environment may be less amenable to change, physicians might help improve one's perception of their situation by ensuring safe, empathic interactions, effective medical communication and implementing a therapeutic approach that fits with the patient's rather than the clinician's preferences – patient-centred care. While patient-centred care means different things to different people,^{76,77} it is defined by the International Alliance of Patients' Organisations as based on five principles:

(1) respect, (2) choice and empowerment, (3) patient involvement in health policy, (4) access and support and (5) information.⁷⁸ Hoffman⁴ recently asserted that 'allowing her [the patient] to participate in and negotiate the treatment plan is at the core of patient centred care'.

It seems truly extraordinary that hypotheses about the pathophysiology of IC have gone from inflammation of the bladder to hypersensitivity of the brain ('central sensitization') to external events in response to perception of threat in three decades.⁴¹ Despite this, MEMO is now the standard of practice for care of cats with the syndrome,⁷⁹ and comparable approaches are being recommended for patients with IC/BPS by professional organisations.^{80,81} Impressive as this progress is, there is likely much more to be learned from both patients and carefully chosen induced and naturally occurring animal models about the causes of chronic visceral pain. Notwithstanding MEMO however, innovations in treatment have been slow, particularly for pharmacological approaches.⁸² For the foreseeable future, I hope that patient-centred care of patients with IC/BPS will be as beneficial to them as effective environmental enrichment has been for cats with Pandora Syndrome.

A full reference list can be downloaded from the following page: <https://www.britishpainsociety.org/pain-news-members-access/>



'It's All in Your Head'*

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The medical fraternity has gradually moved away from labelling conditions with physical symptoms that mask emotional distress as *psychosomatic disorders*. This in turn lead to a

tangled classification of *somatisation* and *somatoform disorders*, with its controversial terminology such as 'medically unexplained symptoms' and 'symptoms unaccounted for by pathological findings'. The criteria for *somatisation* were so arcane and difficult to satisfy that the diagnosis was almost never made, while *undifferentiated somatoform disorder* criteria were too easy to satisfy.¹ The American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (5th edn; DSM-V) has attempted to simplify the nomenclature, replacing previous confused terminology with a rubric term of *somatic symptom disorder* (SSD).²

In her excellent book *It's All in Your Head: True Stories of Imaginary Illness** (I commend it highly to anyone working within pain management), the neurologist Suzanne O'Sullivan defines SSD as

the prominent presence of somatic (bodily) symptoms that cause significant distress and disruption to

*normal life for which there is no, or little, medical explanation. Pain is the most prominent symptom. The behaviour surrounding the symptom is key, not the symptom itself. There is disproportionate worry, anxiety and excessive energy spent on health concerns. It isn't enough just to have pain, what's important is how the person is disabled by that pain. They may stop exercising first. When the pain continues they stop working. Then they begin to avoid the normal activities of daily life.*³

Dr O'Sullivan, who is a consultant neurologist at the National Hospital for Neurology and Neurosurgery London, goes on to say,

Patients often find themselves trapped in a zone between the worlds of medicine and psychiatry, with neither community taking full responsibility. Those who struggle with the diagnosis may seek the opinion of doctor after doctor in the hope of finding a different explanation – and validation of their suffering. Repeatedly normal test results begin to seem a disappointment, so desperate is the patients' search for another answer. Some find themselves pushed into a corner where they accept the role of the undiagnosed, someone who cannot be helped, because anything is better than the humiliation of a psychological disorder ... In its place they develop physical disabilities.

*Against all logic, people's subconscious selves choose to be crippled by convulsions or wheelchair-bound rather than experience the anguish that exists inside them.*³

Dr O'Sullivan's words appear prescient in the context of fibromyalgia. According to Wolfe et al., in the American College of Rheumatology (ACR) 1990 fibromyalgia criteria, musculoskeletal pain was the only symptom evaluated; hence, fibromyalgia is considered a pain disorder within the rheumatology and pain communities. However, in other disciplines, particularly psychiatry, psychology and general medicine, fibromyalgia is more often considered to be a psychosomatic or SSD.⁴ The ACR made amends with the updated 2010 criteria for diagnosing fibromyalgia, replacing the (in my view, simplistic) 1990 'tender point' criteria with a more nuanced one wherein fatigue, sleep, cognition and mood are also evaluated. Wolfe et al. found that 51.4% of patients with fibromyalgia had fatigue, sleep or cognitive problems that were severe, continuous and life-disturbing. It is their opinion that most patients suffering from fibromyalgia satisfy the DSM-V criteria for a diagnosis of SSD. However, as they eloquently put it, 'we are dubious that the DSM-V approach can distinguish validly and reliably which fibromyalgia patients are and which are not mentally ill, particularly in clinical care settings where diagnosis will come most often from generalists'.⁴

'It's All in Your Head'*

Häuser and Henningsen feel that the DSM-V category of SSD can lead to a 'psychiatrisation' of people with somatic diseases and warn against the risk of mislabelling people with somatic diseases as mentally ill. It is their view that while the clinical features of fibromyalgia and persistent somatoform pain disorder or somatisation disorder according to the International Classification of Diseases (ICD)-10 overlap, fibromyalgia is not synonymous with somatoform disorder, though psychosocial factors play a major role in the onset, exacerbation or

maintenance of fibromyalgia syndrome (FMS) symptoms in the majority of patients.⁵

There is, however, greater consensus among the various warring factions in the 'fibromyalgia wars' on the biopsychosocial concept of fibromyalgia, in which biological and psychosocial factors are important in the predisposition, exacerbation and maintenance of fibromyalgia symptoms.⁵

To quote the eminent psychiatrist Henry Maudsley, 'The sorrow which has no vent in tears may make other organs weep'.

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The screenshot shows a web browser window displaying the 'Update Details' page of the British Pain Society (BPS) website. The URL in the address bar is <https://www.britishtainsociety.org/my-bps/my-account/update-details-delegate/>. The page has a navigation menu at the top with links for 'FOR MEMBERS', 'BECOME A MEMBER', 'EVENTS', 'MEDIA', 'PEOPLE WITH PAIN', and 'ABOUT'. On the left side, there is a 'MY BPS' menu with links for 'TIMELINE', 'MY ACCOUNT', 'UPDATE SIG DETAILS', and 'MEETING BOOKINGS'. Below this menu is a blue button that says 'DONATE TO THE SOCIETY'. The main content area is titled 'MY ACCOUNT' and 'Update Details'. It contains a form with the following fields: 'Email Address *', 'Given name *', 'Surname *', 'Address 1 *', 'Address 2', 'Town *', 'County', 'Country *' (with a dropdown arrow), 'Postcode *', and 'Phone Number *'. At the bottom right of the form, there is a 'SUBMIT' button and a link that says 'BACK TO YOUR ACCOUNT'.



The role of kinesiology in chronic pain management

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Introduction

Kinesiologists, university graduates with a specialised degree in the study of human movement, are becoming steadily recognised as healthcare professionals in

North America, although a similar profession is yet to be solidified in the United Kingdom. A kinesiologist's role lies in-between that of a personal trainer and physiotherapist due to his or her knowledge on both exercise and health science. This article explores the role kinesiologists could play in the management of chronic pain. Much of the relationship between kinesiology and chronic pain lies in the evidence of exercise as a tool for pain management through physiological and psychological means. Due to its young nature, kinesiology is still creating a footing for itself in the health care system; therefore, it is important to define kinesiology before analysing its role in chronic pain management. Thereafter, it can be evaluated for its role in improving practices that benefit chronic pain patients.

Kinesiology as a health care field

Kinesiology, the study of human movement, performance and function in



relation to anatomy, physiology, biomechanics and human health, is a growing allied health field in North America.^{1–3} With over a 50% increase between 2003 and 2008 in kinesiology undergraduate degree enrolment, Thomas⁴ analysed the long-term ambitions of kinesiology students in the United States. Although a sizeable group of students still pursue kinesiology with interests in athletic training, sports leadership and general physical activity programmes, the majority (77%) enters the degree with interests in allied health fields.⁴ These findings parallel personal experience from attending the University of British Columbia's School of Kinesiology where many of my peers have shown interest in combining kinesiology academics with healthcare practices. Current healthcare professionals who could potentially work with kinesiologists¹ (p. 467) propose that

the field will help close the gap between 'wellness and disease to increase total care for [the] patient'; however, they first suggest that the profession be clear about its role in healthcare. In certain provinces/states in Canada and the United States, kinesiologists are now a registered allied health service with specified roles; however, further clarification can still be provided.

Kinesiology is a growing discipline that is still creating its territory in the healthcare field. Most often kinesiology is scrutinised for its similarity to physiotherapy, and on rightful grounds. Both physiotherapists and kinesiologists look to use movement and exercise to aid with prevention of or rehabilitation from injury, disease or disability.^{2,5} The most prominent distinction between the two is the ability of a physiotherapist to diagnose and prescribe treatment for a specific injury or disease, whereas a kinesiologist uses his or her knowledge for general exercise guidance related to healthcare.⁶ To put into lay terms, the title of kinesiologist could be synonymous with exercise specialist who has a degree in anatomy, physiology, motor learning, psychology and biomechanics.^{2,3} Each university may have different requirements for completing a kinesiology degree; however, each graduate must then register with an official kinesiology association, which has stringent academic requirements that endorse a kinesiologist. For example, at the University of British Columbia, students must have completed the

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health sciences stream in the kinesiology programme in order to register with the British Columbia Association of Kinesiologists (BCAK). In contrast, the Simon Fraser University, which is also located in British Columbia, requires all kinesiology students to take health science courses thereby qualifying all graduates to register with BCAK. Education is the second distinguishing factor between the two professions: physiotherapists require post-graduate education, whereas kinesiologists can be certified upon completion of an undergraduate degree.⁶ This difference will prove to be beneficial during the discussion of chronic pain management as it could help decrease the widespread downfall to exercise therapy, which is loss of supervision.^{7–10}

Relationship between chronic pain and exercise

Chronic pain is defined as pain that persists for over 3 months or for intermittent periods over the course of a year.^{11–13} Unlike acute pain, it can be difficult to identify the physiological cause of pain sensations and thus proves challenging to treat.¹¹ In conjunction with physiological symptoms, chronic pain can also have adverse effects on psychological health through causing stress, anxiety and depression due to constant pain.^{14,15} At some point, 20%–25% of the population suffers from chronic pain, with adolescents specifically carrying anywhere between 20% and 60% of that burden.^{11,13,16} When reported, chronic pain management is commonly advised to children and adults through pharmacological and physical interventions such as the use of opioids, non-steroidal anti-inflammatory drugs (NSAIDs), transcutaneous electrical nerve stimulation (TENS) and acupuncture.^{13,15} Growing research, however, is showing associations between exercise and managing chronic pain symptoms. Pain

is a multifaceted phenomenon that involves emotional, cultural, social and physiological stimuli. In the same breadth, exercise is not only beneficial for physiological changes but also for psychological changes.^{11,14,17}

The specific physiological pathway in which exercise modulates pain in chronic pain patients is yet to be solidified; however, several hypotheses have been made. A popular hypothesis is that exercise impacts endogenous opioid systems and central pain modulatory systems by releasing natural opioids and inhibiting pain stimulating pathways, respectively.^{14,18} Animal studies have shown that intense bouts of aerobic exercise can decrease allodynia, as well as reverse hypersensitivity in the sciatic nerve, while human studies have shown increased tolerance to pain with increased exercise.¹⁸ Various chronic conditions show sensitivity to different modalities of exercise. For example, fibromyalgia benefits from moderate aerobic exercise, whereas complex regional pain syndrome is better treated with intense exercise.^{14,18} Therefore, the effect of exercise therapy on chronic pain is dependent on the type of chronic pain diagnosis and the prescribed exercise.

Despite the physiological knowledge gap, studies have demonstrated that the multimodal effect of exercise can lower perceptions of pain and improve emotional health.^{7,11,19,20} Previous research has proven acute mood changes associated with exercise bouts in healthy persons. More research is needed to solidify long-term effects of exercise on mood in chronic pain patients; however, a study by Sullivan et al.²¹ observed improved mood for chronic pain patients immediately after a short exercise bout.¹⁷ The most generalisable study on the relationship between chronic pain and exercise, to my knowledge, was undertaken by Landmark et al.⁷ The study completed an audit on pain perceptions and the intensity, frequency and duration of

recreational exercise across a large group of chronic pain patients. There was an association between decreased pain and moderate exercise sessions 1–3 times a week for the working age population of 20–64 years, whereas intense exercise for 3+ days increased pain levels for this age group. In contrast, older adults (65+ years) benefited from more than four exercise bouts a week. Similarly, a population study in Finland found that the second most common method to ease pain for persons with chronic pain for at least 6 months was through physical exercise (57%). This was particularly popular for people with musculoskeletal pain and back pain.¹⁹ As presented, there is growing indication that exercise can play a role in pain reduction if it is particularly prescribed;^{14,18} however, the specific mechanism by which this is facilitated requires further research.

Kinesiologists and chronic pain management

The greatest barrier to using exercise as a medical prescription or as a pain management strategy is compliance.^{7–10} Compliance is affected both by physiological symptoms and by motivation and self-efficacy beliefs. Chronic pain patients have shown fear-avoidance behaviours towards movements that once caused pain.^{9,13,21} Additionally, exercises that cause an increased pain sensation before reducing pain can also deter patients from continuing with physiotherapist advice.²² Typically, patients will complete prescribed exercises while under supervision of a physiotherapist or other health care worker; however, once the patient has left the clinical setting, adherence rates drop. A study looking at the effects of aerobic training on fibromyalgia had patients exercise with a physiotherapist 3 times a week for a 14-week period. Despite decreases in pain sensations, at a 4.5-year follow up,

only 2% of participants still continued with exercise routines. These participants showed reduced symptoms of fibromyalgia, whereas most participants ceased exercise and returned to baseline symptom levels.⁹ Increasing compliance to physiotherapist exercise is important for obtaining the maximal benefit from exercise therapy. As noted earlier, a physiotherapist is responsible for diagnosing and prescribing specific exercises to target rehabilitation. Most commonly, a physiotherapist's advice will be sought to rehab a particular injury; however, there is a growing trend to use physiotherapy for chronic pain management.

A loss in supervision generally leads to a loss in exercise habits that are targeted towards healthcare diagnosis. The emergence of kinesiologists will bridge the disconnection between diagnosis, prescription and treatment. While physiotherapists are very well versed in diagnosing problems related to human movements, kinesiologists are experts in using exercise as a method of preventative and management treatment. Kinesiologists can either work with physiotherapists to increase adherence to exercise prescriptions or they can work independently to provide exercise guidance with attention to healthcare. Kinesiologists can be seen as readily available resources that are more economically friendly. Commonly, kinesiologists work with public health outreach programmes or with private companies and are placed in community centres, long-term care facilities, fitness centres, disease-specific fitness centres and in various other exercise settings.¹ Currently, kinesiologists most often guide patients through physiotherapy-prescribed exercises in either community-based centres or at patients' homes (Dodhia S, personal communication, 3 July 2015). The degree requirements for a kinesiologist also play a factor in expanding their availability and regulating the economic

burden a chronic patient may carry for undergoing supervised exercise. Kinesiologists can be certified after completing an undergraduate degree, thus completing academic requirements in a short period of time. Economically, kinesiologists have an average annual salary that is approximately²³ US\$12,500 lower than that of physiotherapists, which translates to lower user fees for patients. Kinesiology's strongest contribution to chronic pain management is the ability to increase the possibility for chronic pain patients to use exercise therapy for pain relief through affordable, safe and knowledgeable supervision. A study examining diabetes treatment centres in Nova Scotia compared adherence to exercise prescription between groups who were provided with enhanced exercise support to groups provided with a general training programme. Specifically, a kinesiologist was present for exercise sessions conducted with the enhanced support group. This study found that although both groups completed exercises, the group receiving instruction from a kinesiologist had lower blood glucose levels and also retained self-efficacy perceptions about exercise ability.⁸ This new and emerging healthcare field will help to fine tune the existing healthcare system to improve patient adherence to exercise therapy.

Summary

Kinesiology is a popular undergraduate degree choice for students, especially in North America, who are interested in future healthcare professions. Upon completion of a Bachelor of Kinesiology, students have the ability to register with a recognised association to become certified kinesiologists, which ensures their specialisation in the health sciences and exercise. Through this profession, kinesiologists present immense potential to utilise exercise as a pain management strategy for chronic pain patients. In

addition, they are able to bridge the disconnection between a physiotherapist's exercise prescription and a patient's exercise adherence. Ultimately, the growth of kinesiology shows positive potential to impact the use of non-pharmacological treatments in the use of chronic pain management.

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Understanding benefits: a brief overview with relevance to chronic pain

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I argued in my previous *Pain News* article¹ that healthcare professionals need to understand the social security (welfare rights) system in the United Kingdom

as socioeconomics and inequality are important in the presentation and management of pain patients. Social adversity manifests itself biologically partly through chronic stress; this stress in turn may contribute to the aetiology of chronic pain via dysregulation of homeostasis maintaining subsystems.^{2,3} At the same time, social security advice is associated with positive health outcomes.⁴ Social security could therefore play a role in helping chronic pain patients take control over their socioeconomic situation and deal effectively with social stressors which affect their pain. In any event, all clinicians working with pain patients may at some point be presented with a request for assistance with some aspect of benefits administration. The response should be non-judgemental and come from a place of understanding.

This article explains the main UK benefits, drawing on the pain literature at relevant intervals. Section 'Means-tested benefits' outlines means-tested benefits, followed in section 'Other benefits' by

non-means-tested benefits. Section 'Benefit appeals' considers the position of claimants undertaking an appeal and emphasises the importance of distinguishing social security from compensation. Section 'Welfare cuts' concludes with a consideration of welfare cuts.

Means-tested benefits

The three main means-tested benefits are Jobseeker's Allowance (JSA), Employment and Support Allowance (ESA) and Income Support (IS). A person may claim one of these depending on their circumstances. Other important means-tested benefits include Tax Credits, Pension Credit (PC) and Housing Benefit (HB). Importantly, if a member of the household gets a disability benefit, the claimant may be entitled to a higher amount of the means-tested benefit. Any earnings and capital are normally taken into account to reduce the award.



JSA

JSA is paid to people aged 16+ years who are looking for work. Someone with chronic pain can claim JSA though they would need to consider the nature of the work they are able to do. Claimants are normally required to apply for full-time work (at least 40 hours per week) within a certain distance (e.g. 90 minutes). They may be able to negotiate these requirements down on the basis of their pain. Someone who is unable to meet the jobseeking requirements because of chronic pain or another condition might consider ESA instead.

ESA

A person aged 16+ years can claim ESA if they have limited capability for work. After a period of submitting fit notes, they must undergo a medical examination. If deemed to have limited capability for work or work-related activity, their claim will continue at a higher rate. If found 'fit for work', their claim will be terminated. Someone claiming ESA may engage in employment as long as the work is within the 'permitted work' limits.

Watson and Main⁵ demonstrated that benefit type had no impact on return to work outcomes in two groups of pain patients undergoing an occupationally oriented rehabilitation programme. They compared Incapacity Benefit (IB, which has been replaced by ESA, though there is no reason to expect the results to be different with ESA) claimants with JSA claimants, all of whom had chronic pain.

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They report that although the IB claimants had different presenting characteristics, the employment outcomes were the same in both groups.

It must be recalled that ESA is not an alternative to work. People may be disparaged by the terminology of being 'unfit for work' or being 'signed off'. Such phrases should be avoided. Numerous barriers against pain patients returning to work have been explored,⁶ and these include the pain itself, uncertainty about health and working capacity, healthcare barriers (e.g. healthcare providers telling patients that they are unfit for work), psychological barriers (e.g. perceived inability to take control); interaction with benefits agencies (lack of support), personal barriers (e.g. lack of qualifications), lack of available jobs and problems with the workplace (e.g. fear of letting an employer down).

For employment to be effective, it must offer the individual the right degree of control, effort and reward. Low control, poor rewards and high demands are key contributors to stress and poor health.^{7,8} Such factors may be especially important for patients with chronic pain where employers and colleagues cannot provide the right level of support or where they hold stigmatising attitudes. Chronic pain patients whatever they claim may therefore benefit from occupationally focused pain management and rehabilitation.^{5,9,10}

IS

IS is paid to certain groups of people, for example, carers. Having chronic pain will not give rise to entitlement but someone with chronic pain would not for that reason be excluded. A carer looking after someone who has chronic pain may be eligible for IS.

Child Tax Credits and Working Tax Credits

Tax Credits are paid to people who either have children (Child Tax Credits (CTC)) or work full-time (Working Tax Credits

(WTC)), or both (CTC and WTC together). Pain may be relevant in at least two ways. First, if a child whom a CTC claimant is looking after gets certain elements of Disability Living Allowance (DLA) or Personal Independence Payment (PIP), then the CTC award may be increased. Alternatively, if a WTC claimant gets a disability benefit, their WTC may be increased and the amount of hours they are required to work to qualify may be reduced.

HB

HB helps people pay their rent. The amount received depends on personal circumstances and rules such as the under-occupancy penalty (the 'bedroom tax'). Additionally, HB is reduced if the claimant's total benefit income exceeds the relevant threshold, known as the benefit cap. The cap will not apply if a member of the household gets a disability benefit.

PC

PC is for men and women who are of state pension age for women. This is at least 60 years though for many claimants the required age will be higher and depends on their date of birth.

Other benefits

The following benefits are not linked to employment. A person can get them whether or not they are working and earnings and capital are ignored.

DLA

Perhaps, until recently, the most important disability benefit was DLA. For people aged 16–64 years, DLA has been replaced with PIP but existing DLA awards will continue until reassessment. This is happening gradually. People under 16 years can still claim DLA. DLA has two components: care and mobility. The care component is paid at either the lowest, middle or highest rate; mobility is paid at either the lower or higher rate. A person may receive either or both components.

Eligibility for DLA is on the basis of supervision or attention needs and is regardless of diagnosis. Claimants will be entitled to the care component if, in summary, they require supervision to keep safe or attention in connection with their bodily functions. The mobility component is for people with walking difficulties. Generally, the more severe the difficulties the patient has, the higher will be their entitlement though the rules are complex and potential claimants may wish to seek help from an adviser, particularly with completing the lengthy claim form.

Among other important rules is that the symptoms must have been extant for at least 3 months at the date of claim and must be expected to last for at least 6 more. Additionally, any attention or care given must be 'reasonably required' if to be taken into account. In the context of pain, it may be considered perfectly reasonable, for example, for a parent to spend time with their child to help them carry out a home exercise plan. It might be considered unreasonable to keep that child home from school and prohibit them from all activities. Awards are usually time-limited with the minimum duration being 6 months. Once an award expires, the claimant will be invited to submit a renewal application if they wish. This will be scrutinised in the same way as a new claim.

PIP

As noted above, PIP has replaced DLA for adults. It covers broadly the same 'subject matter' but is far more restrictive. The main difference is that instead of referring to broad categories of needs, PIP stipulates a series of activities. Within those activities are descriptors. A claimant is assessed by their ability to carry out the descriptors and they are awarded points. An example is if someone requires supervision, prompting or assistance to carry out therapy that lasts for no more than 3.5 hours per week, they will be awarded 2 points (at least 8 points are needed).

Attendance Allowance

Attendance Allowance (AA) is for claimants aged 65+ years at first claim. The tests are the same for the middle and highest rate of DLA care and there is no mobility component. The prevalence of disabling chronic pain tends to rise with age¹¹ so AA may be of particular relevance to older populations.

Carer's Allowance

Carer's Allowance (CA) is paid to people who care for someone who gets a disability benefit. It is not available if the carer earns more than £110 per week (at 2014/2015 rates).

Do disability benefits predict poor outcome?

It has been suggested that receipt of a disability benefit is linked to poor outcome in chronic pain. This, however, does not mean that getting such a benefit makes pain worse or impairs outcome. A study from Denmark¹² provides an interesting view into the role that disability benefits might actually play. They compared three groups of patients: those not getting a Danish disability pension, those getting that pension and those currently applying for it. The groups who were getting the pension or not getting it at all had equivalent outcomes; the group applying did worse. This study should be interpreted with care as there is no disability pension in the United Kingdom and social conditions in Denmark are different. The authors' suggestion that it is likely the financial precarity which exists in the cases of those who do not have a stable income, however, is salient in the context of DLA, PIP, AA and other benefits and warrants investigation in the United Kingdom.

Benefit appeals

Often, decisions are against the claimant. These are challengeable through internal

review and the tribunals. Tribunal cases are very different to court cases such as negligence suits. Tribunals are inquisitorial in nature, rather than adversarial. Claimants do not litigate. There is no examination or cross-examination. Often, there is no representative for the decision maker. The setting and proceedings are informal; hearings are short. These distinctions are important. Even where there is a dispute, benefits cases are radically different to litigation. A trial, which is a stressful, drawn-out affair, is imbued with notions of justice and morality (the word 'negligence' suggests wrongdoing). Perceived injustice is predictive of poor outcome in chronic pain¹³ so it is perhaps no surprise that on-going litigation is a yellow flag.

Two observations are called for. First, the literature on 'compensation' and the oft-cited problems of secondary gain may be explained more by the morally charged and stressful nature of litigation than by malingering (which is rare) or any desire to 'play the system'. As Sullivan et al.¹³ note, discussions around secondary gain 'have typically taken to the form of fixing blame on patients for their lack of rehabilitation progress', rather than focusing on the psychological barriers to rehabilitation. Second, readers should be critical of papers which use the term 'compensation' when referring to social security payments. The two are disparate, and these phrases better be strictly confined to their legal usages.

Welfare cuts

I touched on welfare reform in my previous article. Inequality and deprivation are inextricably linked with health. Economic policies affect health too.¹⁴ It is easy to see how a patient with chronic pain, already living in financial deprivation, could suffer by further cuts. This potential for harm highlights the essential need for healthcare teams to properly support disadvantaged chronic

pain patients and their families using a 'whole person' approach within the biopsychosocial model.

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Consent for chronic post-surgical pain

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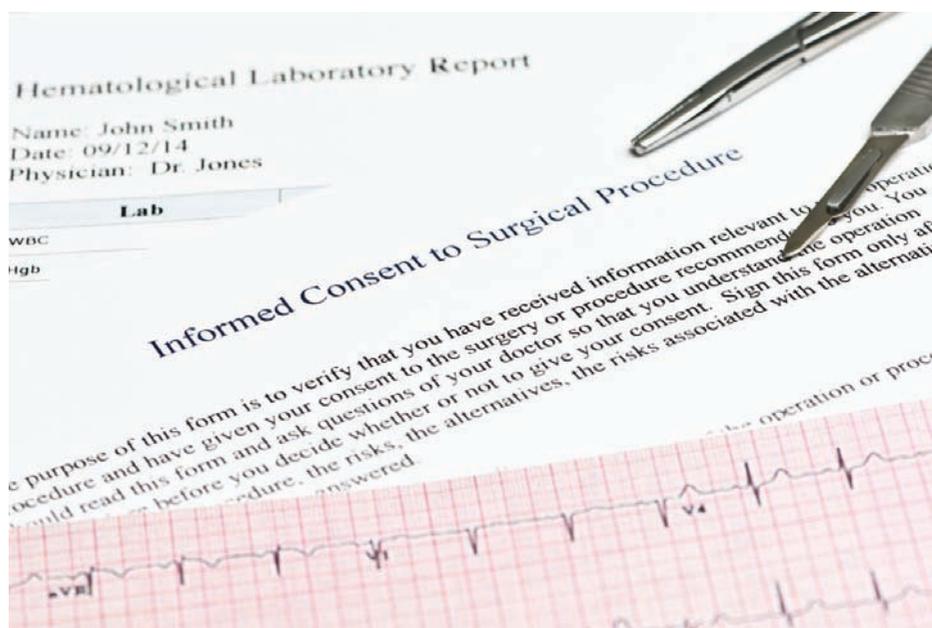
Introduction

Chronic post-surgical pain (CPSP) has been a known complication of surgery and trauma since at least 1998.¹ The International Association for the Study of Pain defines it as:² (a) pain that develops after surgery, (b) lasting at least 2 months and (c) where all other causes of the pain have been excluded, including pain from a condition preceding the surgery. Chronic pain is not limited to major surgery and can occur with various types of surgery.

CPSP poses a large problem to the health service. It is associated with reduction in quality of life, chronic analgesic usage and increased health care utilisation. There is a wide range of incidence of CPSP in various reported studies and between various procedures.³ According to a review of the literature, the estimated incidence of CPSP for various procedures is as follows:³

- Amputation 30%–85%
- Cholecystectomy 3%–56%
- Hip arthroplasty 28%
- Knee arthroplasty 19%–43%
- Hysterectomy 25%
- Mastectomy 11%–57%
- Vasectomy 0%–37%
- Inguinal hernia 0%–63%

Work being done to identify the incidence and risk factors for developing CPSP – such as the work being done by the University of Oxford (Oxford Persisting Post-Operative Pain Study (OxPPOPS)) is to be commended.⁴ With



a better understanding of the incidence of and risk factors for CPSP, it may be possible to develop further strategies to reduce an individual's risk of developing CPSP.

At Blackpool Victoria Teaching Hospital, we looked at CPSP from a slightly different angle. We wanted to see whether patients were being informed about CPSP as a potential complication during the informed consent process.

The General Medical Council (GMC) document released in 2008: 'Consent: patients and doctors making decisions together'⁵ states that a patient must be consented for – 'An adverse outcome resulting in death, permanent or long-term physical disability or disfigurement, medium or long-term pain, or admission

to hospital; or other outcomes with a long-term or permanent effect on a patient's employment, social or personal life'.⁵

The recent Montgomery v Lanarkshire Health Board case emphasises on the issue of discussing the risks associated with the treatments and whether reasonable care has been taken to establish patient's understanding of the risks as well as on providing other reasonable alternatives to the proposed treatment.⁶

Method

We undertook a retrospective service evaluation of adult surgical cases over a 1-month period at Blackpool Victoria

Teaching Hospital. We inspected the consent forms of the patients undergoing following surgeries:

- Total abdominal hysterectomy
- Amputation
- Inguinal hernia repair
- Cholecystectomy
- Breast surgery – mastectomy/ lumpectomy
- Hip and knee arthroplasty
- Vasectomy
- Nephrectomy
- Thyroidectomy

We recorded data on:

- Age and gender of the patient
- Procedure performed
- Type of admission (elective vs emergency)
- Whether risk for chronic pain was documented
- Whether risk for possible 'nerve damage' was documented

Results

A total of 215 data sets were identified, of which 10 were excluded due to missing notes. Of the remaining 205 data sets, 121 were female and 84 male, ages ranged from 18 to 91 years with an average age of 60 years. The surgical specialties covered were as follows:

- General/breast surgery – 117
- Orthopaedics – 61
- Gynaecology – 14
- Urology – 7
- ENT – 6

The overall rate of written consent for CPSP was 17%, split for surgical specialty, the rates were as follows:

- General/breast surgery – 23%
- Orthopaedics/trauma – 7%
- Gynaecology – 0%
- Urology – 71%
- ENT – 0%

It was noted that 40% of patients were consented for the possibility of nerve damage.

Figure 1 shows the rate of written consent for CPSP among the general/ breast surgery group, split by procedure type. Figure 2 shows similar data for the orthopaedic/trauma group.

Discussion

The results show a significant lack of documentation of formal consent for

CPSP taking place across the board. Overall, there was a consent rate of only 17%. Very few patients undergoing cholecystectomy and even mastectomy seem to be consented for CPSP. Higher percentage of patients but still less than 50% undergoing hernia repair operation were consented for CPSP. Similarly, consent rate was very poor for total knee replacement and even more so for total hip replacement. In a few small areas, the results were more positive with 100% of vasectomy cases receiving written

Figure 1. Consent for CPSP among general/breast surgery group

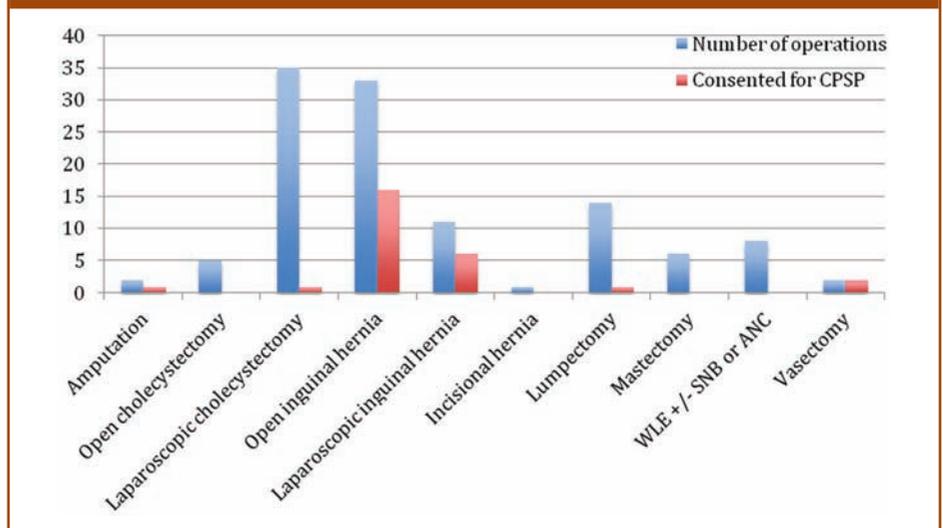
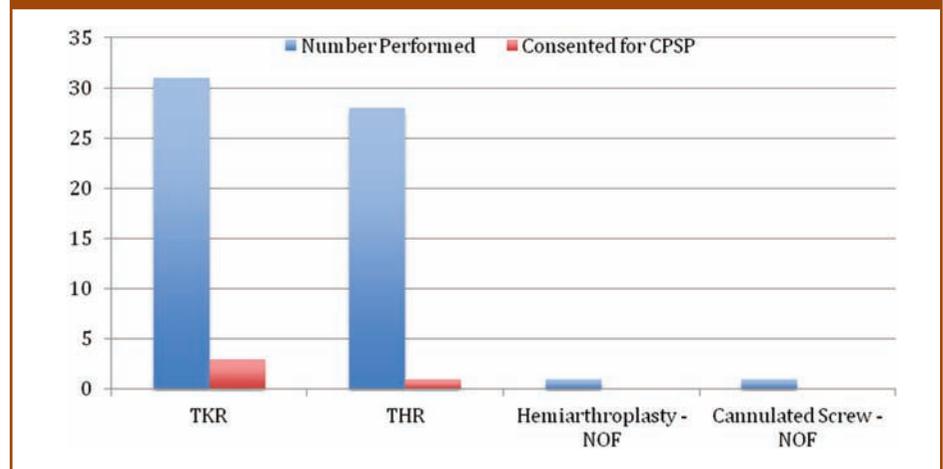


Figure 2. Consent for CPSP among orthopaedic/trauma group



Consent for chronic post-surgical pain

consent for CPSP and 71% of all urology cases. However, it is worth noting the small total number of cases that are included in these groups.

As well as recording the above data, we also collected data on consent for possible 'nerve damage'. Overall, we found that 40% of cases were consented for possible nerve damage. This data raise a couple of issues. First, it is possible that surgical doctors may believe that consenting patients for nerve damage covers the possibility of CPSP. Second, would a layperson understand what is meant by nerve damage and the implications of such a complication? This service evaluation did not explore the answers for these questions but we feel that lay people may not make the link between nerve damage and CPSP.

There are some shortcomings of this study, for example, retrospective data looking only at consent from only within one surgical directorate for a period of a month. We have not looked whether there has been any discussion around CPSP in the notes or noted the grade of the surgeon consenting the patients. It has given us some insight around the issue despite its limitations.

This service evaluation raises the important question about whether we should be consenting all patients undergoing surgical procedures for the possibility of CPSP. There are advantages of including the risk of CPSP in the consent procedure.



It is possible that if some patients were aware of this risk, they may opt not to proceed with the operation, as they may perceive a different balance of the risk benefit ratio, although patients undergoing cancer and emergency surgery may well see it in a different light.

It may also mitigate possible medicolegal issues surrounding CPSP. If patients feel that the risks have been adequately explained to them, then they may be more willing to accept these outcomes if they occur.

A large aspect of chronic pain therapy is acknowledgement and recognition of the problem, both from the patient and the clinician perspective. If both patient and clinician have started a dialogue about CPSP prior to undergoing the procedure, then we may hopefully see less delays and barriers to acknowledgement of the problem

post-operatively. This may hopefully improve patient outcomes.

We propose a couple of ways of improving the consent process. We suggest developing procedure-specific consent form and patient information leaflet on CPSP. This well may need input from consultants in pain medicine. Perhaps guidance could be developed regarding consenting for CPSP at the national level.

Although our data have shortcomings, it has prompted us to plan a further study looking prospectively at the issue of consenting for the CPSP in specific procedures. We acknowledge that there has been some discussion⁷ surrounding the issue of informed consent for CPSP, but as far we are aware, there have been no studies which have specifically looked at this issue.

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A survey of UK practice on lumbar epidural injection for the management of pain of spinal origin

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Introduction

In 2011, the Faculty of Pain Medicine (FPM) of the Royal College of Anaesthetists¹ published their consensus on standards of good practice in the conduct of single-shot epidural steroid injection for the management of persistent spinal pain. We recognised that our own practice did not meet all the recommendations. We carried out a national survey to ascertain the current practice of pain physicians based on aspects of the recommendations.

Methods

The British Pain Society provided addresses of practising consultants in pain management and a postal questionnaire was sent to each. Microsoft Excel was used to aid data analysis.

Results and discussion

We received 83 replies from 207 questionnaires giving a response rate of 40%.

Question 1: Do you routinely obtain written consent?

Yes – 79 (95.2%)

No – 4 (4.8%)

The General Medical Council² has provided guidance on 'Consent: Patients and doctors making decisions together',



and this must be adhered to as part of the core ethical guidance in 'Good Medical Practice'.

Question 2: Do you routinely inform patients of the 'off-label' nature of the epidural steroid?

Yes – 22 (26.5%)

No – 61 (73.5%)

The FPM recommended supporting the discussion with a written consent including potential complications, and that the onus is on us to inform patients of the 'off-label' administration of the corticosteroid.

Question 3: Do you routinely site a peripheral cannula?

Yes – 54 (65.1%)

No – 29 (34.9%)

The FPM recommended establishing an intravenous cannula prior to an

epidural injection based on various reasons. A previous comparable survey of British pain practice carried out by Coupe et al.³ in 2006 revealed that 79% would establish venous access. Approximately 35% in our survey do not routinely do so citing, 'not administering local anaesthetic in the epidural space', as the main reason.

Question 4: Do you routinely fast patients prior to epidural injection (as per College guidelines)?

Yes – 44 (53%)

No – 39 (47%)

Approximately half of the practitioners surveyed do not fast patients and no specific reasons were offered.

Question 5: Which of the following aseptic precautions do you routinely take?

1. Sterile gloves: Yes – 83 (100%)
2. Sterile gown: Yes – 70 (84.3%); No – 13 (15.7%)
3. Sterile drapes: Yes – 80 (96.4%); No – 3 (3.6%)
4. Hat: Yes – 70 (84.3%); No – 13 (15.7%)
5. Mask: Yes – 52 (62.7%); No – 31 (37.3%)

It is both interesting and alarming to note that a few of those surveyed do not

A survey of UK practice on lumbar epidural injection for the management of pain of spinal origin

use sterile drapes, and approximately 37% do not wear a mask during epidurals. The latest recommendations concerning 'optimum' aseptic techniques for central neuraxial blockade have just been published.⁴ Without a full aseptic technique, it would be difficult to defend and justify if a serious spinal infection did occur even though such incidents are extremely rare.

Question 6: Do you routinely use fluoroscopy to confirm epidural spread?

- Yes – 52 (62.7%)
- No – 31 (37.3%)

Accurate deposition of steroid solution in the epidural space is vital in order to optimise patient response and to minimise any potential harm due to incorrect placement such as in the intrathecal space.⁵

Overall, 62.7% in this survey reported using fluoroscopy for epidurals. The same survey by Coupe et al.³ reported the incidence of fluoroscopic guidance in cervical, thoracic and lumbar epidurals as 61%, 35% and 31%, respectively. Nevertheless, this is one of the most common aspects of change with increased use in our survey. Lack of resource was cited as the most common reason for inaccessibility to fluoroscopy.

Question 7: Which steroid do you routinely use?

1. Depo-Medrone: 37 (44.6%)
2. Triamcinolone: 45 (54.2%)
3. Dexamethasone: 1 (1.2%)

The choice of injectate appears to be physician-dependent. Majority preferred particulate depo-steroids. Available evidence appears to favour depo-steroids in providing superior relief than non-depo-steroids.⁶

Question 8: Which diluting agent do you routinely use?

1. 0.9% saline: 22 (26.5%)
2. <0.25% bupivacaine: 19 (22.9%)
3. 0.25% bupivacaine: 17 (20.5%)
4. 0.5% bupivacaine: 2 (2.4%)
5. <1% lidocaine: 8 (9.6%)
6. 1% lidocaine: 8 (9.6%)
7. 2% lidocaine: 1 (1.2%)
8. Other: 6 (7.2%)

Question 9: Are you aware of the recommendations published by the FPM?

- Yes – 72 (86.7%)
- No – 11 (13.3%)

Question 10: Did the recommendations change your practice?

- Yes – 16 out of 72 responses (22.2%)
- No – 56 (77.8%)

Conclusion

The FPM of the Royal College of Anaesthetists¹ published 'Recommendations for good practice in the use of epidural injection for the management of pain of spinal origin in adults' in April 2011. It outlines the standards expected in the following aspects, namely, consent, preparation and identification of patients, environment and facilities, infection control, anticoagulants, fluoroscopy, monitoring, assistance, record keeping, and follow-up and discharge planning. Our survey covers most of the salient points of the guidance. In our survey, the most common aspects of change to practice reported were the use of fluoroscopy, full aseptic techniques and IV access.

In conclusion, we feel that despite a low survey response rate which might

not be representative enough of current UK practice and in the current increasingly litigious environment, the degree of compliance with these recommendations among pain practitioners has a long way to go to improve the quality and safety of clinical care for our patients, according to the best practice as recommended by the FPM. Some dissatisfaction with the evidence-base behind the recommendations was expressed. Further studies to reinforce this evidence-base and improved means of disseminating recommendations may help to increase compliance.

Acknowledgements

The authors thank Lynne Cameron for her administrative assistance. This survey was presented as an E-poster at the ESRA Annual Congress, Seville, 2014.

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Review – *Fast Facts: Chronic and Cancer Pain*

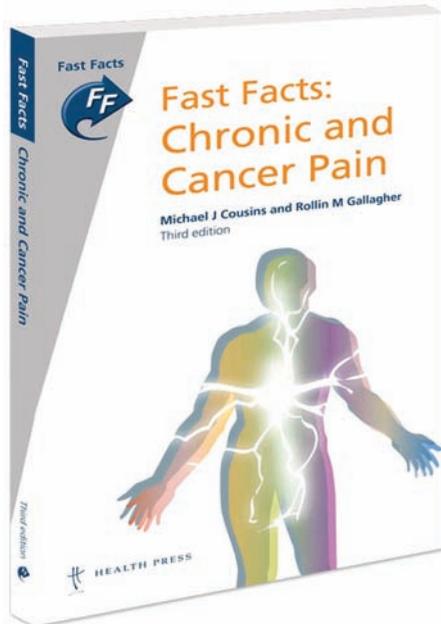


THE BRITISH PAIN SOCIETY

Pain News

2015, Vol 13(3) 195–196

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Reviewed by: Dr Ashok Kumar Das, Consultant in Pain Management Sandwell and West Birmingham NHS Trust

Fast Facts: Chronic and Cancer Pain book, third edition, is one of the over 60 topics covered in a series selling over 3 million books from Health Press. As the name suggests it is written for clear intended readership to help them manage chronic pain including primary care providers, physical therapist, clinical psychologists, nurses, nurse practitioners, occupational therapists, pharmacists and students who are thinking of pursuing a career in pain medicine.

The authors Professor Michael J. Cousins from Australia and Professor Rollin M Gallagher from United States have succeeded in making the theory

and practice of pain management feel far more manageable for busy practising professionals.

The book is divided into 12 chapters covering various aspects of chronic and cancer pain. Each chapter gives a succinct method to understand and retain the major topics by sub-division, tables, diagrams, key points and key references with nice colour combinations.

The first three chapters cover general principles, definitions and mechanisms, assessment of pain and treatment options. Reorganisation of neurons, glial cell activation, genetics and pain, pain chronification and novel therapies for pain management are well illustrated. The importance of neurological and musculoskeletal system examination and different assessment scales along with imaging modalities are stressed.

The concept of stepped care model for pain management is nicely explained. Pharmacology of opioid is well written with some possible mechanisms for opioid-induced hyperalgesia – prolongation of neuronal action potential, activation of descending facilitatory pathways, activation of glial cell facilitatory mechanisms, modulation of *N*-methyl-*D*-aspartate (NMDA) receptors and increased release of dynorphin in the spinal cord provides interesting concepts.

The trigeminal neuralgia chapter provides a good overview; it is interesting to know that lignocaine infusion targeting a blood concentration of 1–2 µg/mL can be used for unresponsive patients.

Budapest Criteria and new strategies in reprogramming the brain may be able to address the motor cortex and

neuroplastic changes that occur in complex regional pain syndrome. Mechanism of pain such as immune cell mediation, sympathetically maintained pain, motor neuron changes and treatment involving calcitonin and bisphosphonates provides some food for thought.

Various types of possible neuropathy and pathophysiology of diabetic neuropathy are well written. Natural history and paediatric and adult varicella zoster virus (VZV) vaccination is given importance as preventive strategy for post herpetic neuralgia.

The International Association for the Study of Pain (IASP) taxonomy of pain following spinal cord injury and post stroke pain syndrome, including thalamic pain syndrome, is well documented. Intravenous propofol, cannabinoids, morphine, clonidine, deep brain and motor cortex stimulation provide some new insights into central pain management.

Persistent Post Surgical Pain (PPSP) pathogenesis, preoperative, intraoperative, post-operative factors and genetics suggested give some ideas for future therapy. The whole gamut of pain syndromes and therapy is well described for cancer patients, including metastasis, cancer therapy and cancer survivors.

Chapter on musculoskeletal pain gives a flavour of chronic low back pain, spinal stenosis, osteoporosis, fibromyalgia, osteoarthritis and rheumatoid arthritis.

Autonomic nervous system, persistent activation of visceral fibres and central sensitisation are the principles driving the visceral pain in the form of chronic pelvic

Review – Fast Facts: Chronic and Cancer Pain

pain syndrome, interstitial cystitis, endometriosis and irritable bowel syndrome.

Headache chapter stresses the importance of acute headache, other causes of secondary headache and psychological stressors in 75% of cases and also specific therapies for specific headaches, for example,

indomethacin for chronic paroxysmal hemicrania.

Useful resources site mentions some reputable UK and US societies with useful information. For interested students, there is a test section on <http://www.fastfacts.com> where the readers can test their knowledge after reading the book.

In summary, it is a very useful book for anyone interested in multidisciplinary and interdisciplinary aspects of pain management. Although the book cannot replace standard text books or the current Internet knowledge, it will definitely generate inspiration, insight and integrity to take up chronic pain as a challenge.

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Launch of *Understanding and Managing Long-Term Pain*

Understanding and Managing Long-term Pain

Information for People in Pain



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At the Annual Scientific Meeting (ASM) in Glasgow this year, we were proud to have available on the Patient Liaison Committee's stand the new guide for patients: *Understanding and Managing Long-Term Pain* (UMLP). This replaces the previous guide 'Understanding and Managing Pain' and has been completely rewritten to encompass the latest evidence, guidance and expert opinion.

The editorial and publication team worked tirelessly to have the booklet ready for the ASM, and the interest generated in Glasgow certainly justified their efforts. The feedback from delegates was uniformly positive.

The 44-page booklet covers all aspects of long-term pain that might raise questions or concerns in the

minds of patients, such as why acute pain may become chronic, why physical activity and relaxation techniques are therapeutic, what drugs may be prescribed, what constitutes a Pain Management Programme and what services may be available to help.

The content has been compiled by a truly multidisciplinary team, including expert patients and so should be considered as a valuable resource of significance for patients with long-term pain, their carers and responsible healthcare professional partners.

If you would like to order copies of UMLP to distribute to patients and colleagues, please contact Rikke Susgaard-Vigon at the British Pain Society (BPS) at rikke@britishpainsociety.org



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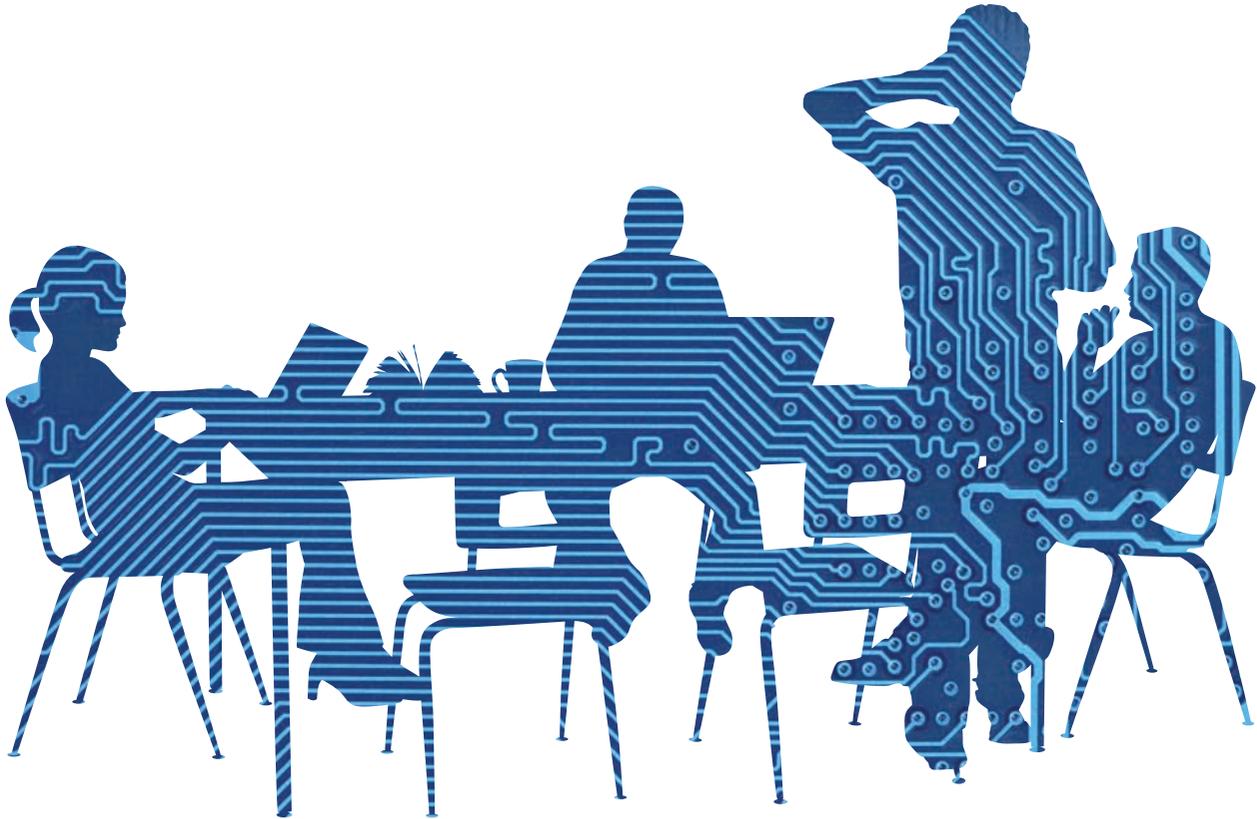
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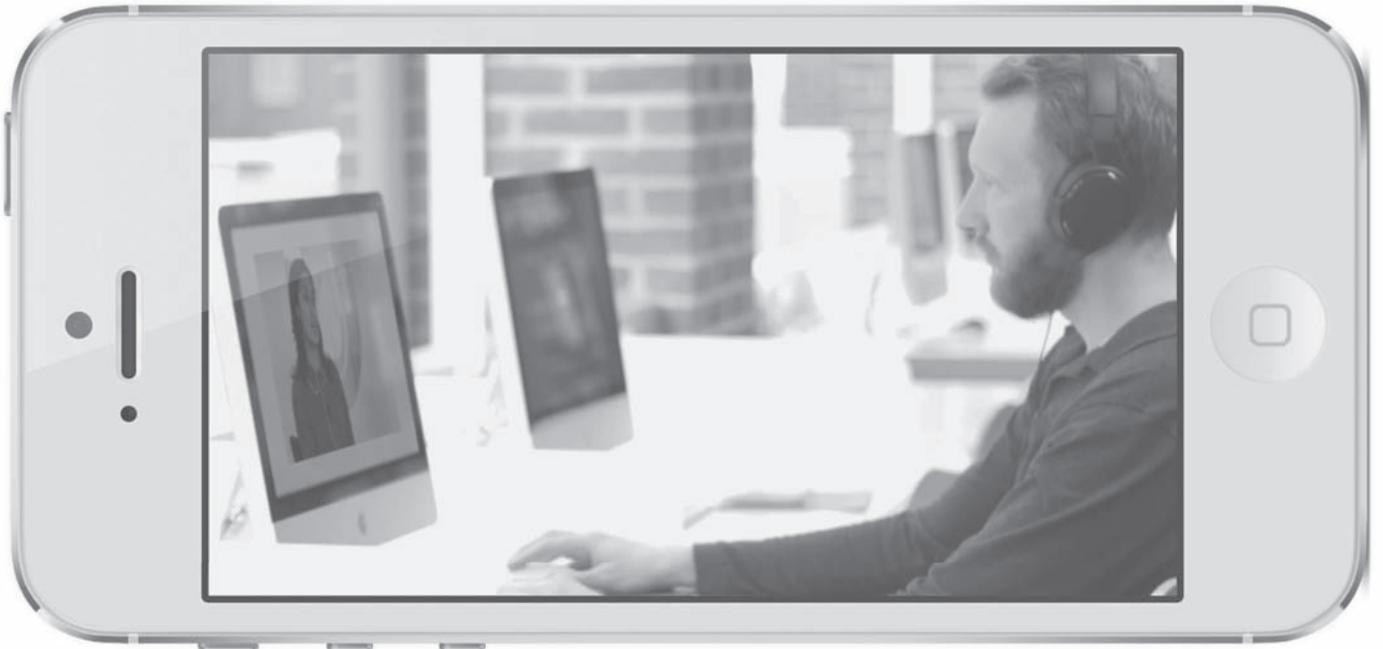
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We look forward to seeing you in Harrogate.



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