

MARCH 2013 VOLUME 11 ISSUE 1

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Octave analgesia

National Pain Audit launch

Trust me, I'm a patient

Numbers needed to heal



THE BRITISH PAIN SOCIETY

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

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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Chair Peoples, Chair Pain in Developing Countries SIG, with contributions from SIG members including Dr. M. Elmaghrabi

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Please refer to the Summary of Product Characteristics (SmPC) for full details of Prescribing Information

Effentora ▼ 100 micrograms, 200 micrograms, 400 micrograms, 600 micrograms, 800 micrograms fentanyl buccal tablet

Abbreviated Prescribing Information:

Presentation: Each buccal tablet contains 100, 200, 400, 600 and 800 micrograms fentanyl (as citrate).
Indications: Effentora is indicated for the treatment of breakthrough pain (BTP) in adults with cancer who are already receiving maintenance opioid therapy for chronic cancer pain. BTP is a transitory exacerbation of pain that occurs on a background of otherwise controlled persistent pain. Patients receiving maintenance opioid therapy are those who are taking at least 60 mg of oral morphine daily, at least 25 micrograms of transdermal fentanyl per hour, at least 30 mg of oxycodone daily, at least 8 mg of oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer. **Dosage and administration:** See SmPC for full information. Patients should remove the tablet from the blister unit and immediately place the entire Effentora tablet in the buccal cavity (near a molar between the cheek and gum). Effentora should be placed and retained within the buccal cavity for a period sufficient to allow disintegration of the tablet which usually takes approximately 14-25 minutes. Alternatively, the tablet could be placed sublingually (see Section 5.2). After 30 minutes, if remnants from the Effentora tablet remain, they may be swallowed with a glass of water. **Adults:** Treatment should be initiated by, and remain under the guidance of, a physician experienced in the management of opioid therapy in cancer patients. Effentora should be individually titrated to an "effective" dose that provides adequate analgesia and minimises undesirable effects. Patients should be carefully monitored until an effective dose is reached. The initial dose of Effentora should be 100 micrograms, titrating upwards as necessary through

the range of available tablet strengths (100, 200, 400, 600, 800 micrograms). Due to different absorption profiles, switching must not be done at a 1:1 ratio. If switching from another oral fentanyl citrate product, independent dose titration with Effentora is required as bioavailability between products differs significantly. However, in these patients, a starting dose higher than 100 micrograms may be considered. During titration, if adequate analgesia is not obtained within 30 minutes after the start of administration of a single tablet, a second Effentora tablet of the same strength may be used. If treatment of a BTP episode requires more than one tablet, an increase in dose to the next higher available strength should be considered to treat the next BTP episode. During titration, multiple tablets may be used: up to four 100 micrograms or up to four 200 micrograms tablets may be used to treat a single episode of BTP during dose titration according to the following schedule. If the initial 100 micrograms tablet is not efficacious, the patient can be instructed to treat the next episode of BTP with two 100 micrograms tablets. If a single 200 micrograms tablet of Effentora (or two 100 micrograms tablets) is not considered to be efficacious, the patient can be instructed to use two 200 micrograms tablets (or four 100 micrograms tablets) to treat the next episode of BTP. For titration to 600 micrograms and 800 micrograms, tablets of 200 micrograms should be used. **Children:** Effentora is not recommended for use in children and adolescents below 18 years due to a lack of data on safety and efficacy. **Elderly:** In clinical studies, patients older than 65 years tended to titrate to a lower effective dose than younger patients. It is recommended that increased caution should be exercised in titrating the dose of Effentora in elderly patients. **Hepatic or renal impairment:** Effentora should be administered with caution to patients with moderate or severe hepatic or renal impairment (see Section 4.4). **Patients with xerostomia:** Patients experiencing xerostomia are advised to drink water to moisten the buccal cavity prior to administration of Effentora. If this recommendation does not result in an appropriate effervescence, then a switch of therapy may be advised. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Patients without maintenance opioid therapy (see Section 4.1), severe respiratory depression or severe obstructive lung conditions. Treatment of acute pain other than breakthrough pain. **Precautions and warnings:** Keep all tablets out of the reach and sight of children. It is imperative that patients be monitored closely by health professionals during the titration process. It is important that the long acting opioid treatment used to treat the patient's persistent pain has been stabilised before Effentora therapy begins and that the patient continues to be treated with the long acting opioid treatment whilst taking Effentora. There is a risk of clinically significant respiratory depression associated with the use of fentanyl.

*Effentora® helps relieve his breakthrough cancer pain
Today, his focus is her smile*

TEVA

Pain Care

Don't miss life's moments

 **EFFENTORA** 
fentanyl buccal tablet

Improper patient selection (e.g. use in patients without maintenance opioid therapy) and/or improper dosing have resulted in fatal outcome with Effentora as well as with other fentanyl products. Particular caution should be used when titrating Effentora in patients with non-severe chronic obstructive pulmonary disease or other medical conditions predisposing them to respiratory depression. Extreme caution should be taken with patients who may be particularly susceptible to the intracranial effects of CO₂ retention, such as those with evidence of increased intracranial pressure or impaired consciousness. Effentora should be used with caution in patients with pre-existing bradyarrhythmias. Careful consideration should be given to patients with hypovolaemia and hypotension. Special care should be taken by patients on a controlled sodium diet. **Interactions:** Potential interactions may occur when Effentora is given concurrently with agents that affect CYP3A4 activity. Agents that induce CYP3A4 activity may reduce the efficacy of Effentora. Strong or moderate CYP3A4 inhibitors may result in increased fentanyl plasma concentrations, potentially causing serious adverse drug reactions including fatal respiratory depression (refer to the SmPC for a full list). Effentora is not recommended for use in patients who have received monoamine oxidase inhibitors within 14 days. The concomitant use of partial opioid agonists/antagonists is not recommended. **Pregnancy and lactation:** Effentora should not be used in pregnancy unless clearly necessary. Following long-term treatment, fentanyl may cause withdrawal in the newborn infant. It is advised not to use fentanyl during labour and delivery (including Caesarean section) because fentanyl passes through the placenta and may cause respiratory depression in the foetus. If Effentora is administered, an antidote for the child should be readily available. Fentanyl should not be used by breastfeeding women and breastfeeding should not be restarted until at least 48 hours after the last administration of fentanyl. **Effects on ability to drive and use machines:** No studies of the effects on the ability to drive and use machines have been performed. However, opioid analgesics impair the mental and/or physical ability required for the performance of potentially dangerous tasks (e.g. driving a car or operating machinery). Patients should be advised not to drive or operate machinery if they experience somnolence, dizziness, or visual disturbance while taking Effentora and not to drive or operate machinery until they know how they react. **Adverse reactions:** Typical opioid undesirable effects are to be expected with Effentora. Frequently, these will cease or decrease in intensity with continued use of the medicinal product, as the patient is titrated to the most appropriate dose. However, the most serious adverse reactions are respiratory depression (potentially leading to apnoea or respiratory arrest), circulatory depression, hypotension and shock, and all patients should be closely monitored for these. The following adverse reactions

have been reported with Effentora during clinical studies and post marketing experience. **Very Common:** Dizziness and headache, nausea and vomiting, application site reactions, including bleeding, pain, ulcer, irritation, paraesthesia, anaesthesia, erythema, oedema, swelling and vesicles. **Common:** Weight decrease, tachycardia, anaemia, neutropenia, dysgeusia, somnolence, lethargy, tremor, sedation, hypoaesthesia, migraine, dyspnoea, pharyngolaryngeal pain, constipation, stomatitis, dry mouth, diarrhoea, abdominal pain, gastroesophageal reflux disease, stomach discomfort, dyspepsia, toothache, pruritus, hyperhidrosis, rash, myalgia, back pain, anorexia, oral candidiasis, hypotension, hypertension, peripheral oedema, fatigue, asthenia, drug withdrawal syndrome, chills, depression, anxiety, confusional state and insomnia. Consult the SmPC in relation to other side effects. **Overdose:** The most serious significant effects being altered mental status, loss of consciousness, hypotension, respiratory depression, respiratory distress, and respiratory failure, which have resulted in death. Immediate management of opioid overdose includes removal of the Effentora buccal tablet, if still in the mouth, ensuring a patent airway, physical and verbal stimulation of the patient, assessment of the level of consciousness, ventilatory and circulatory status, and assisted ventilation (ventilatory support) if necessary. For treatment of overdose (accidental ingestion) in the opioid-naïve person, intravenous access should be obtained and naloxone or other opioid antagonists should be employed as clinically indicated. The duration of respiratory depression following overdose may be longer than the effects of the opioid antagonist's action (e.g. the half-life of naloxone ranges from 30-81 minutes) and repeated administration may be necessary. For treatment of overdose in opioid-maintained patients, intravenous access should be obtained. The judicious use of naloxone or another opioid antagonist may be warranted in some instances, but it is associated with the risk of precipitating an acute withdrawal syndrome. **Price:** Effentora all strengths (4 pack): £19.96. Effentora all strengths (28 pack): £139.72. **Legal category:** CD (Schedule 2) POM. **Marketing Authorisation Number:** EU/1/08/441/001-010. **Marketing Authorisation Holder:** Cephalon Europe, 5 rue Charles Martigny, F-94700 Maisons-Alfort, France. **Date of Preparation:** March 2012 **Job Code:** MED/12/004

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British Pain Society Calendar of Events 2013



Information & Communication Technologies in Managing Pain (27th Study Day)

Monday 25th February
Churchill House, London

Annual Scientific Meeting

16th – 19th April
Bournemouth International Centre, Bournemouth

Commissioning Pain Services (28th Study Day)

Monday 10th June
Churchill House, London

Changing the Culture of Pain Medicine (*Philosophy & Ethics SIG Conference*)

Monday 10th June to Thursday 13th June
Launde Abbey, Leicestershire

Visceral pain (29th Study Day)

Tuesday 3rd September
Churchill House, London

To do, or not to do, that is the question: Unintended Negative Consequences in Pain Management and Rehabilitation – (*Pain Management Programmes SIG Biennial Conference*)

Wednesday 25th to Friday 27th September 2012
Hotel de France, Jersey

Interventional Pain Medicine SIG Annual Meeting

Friday 18th October
Churchill House, London

Topic TBC (30th Study Day)

Tuesday 19th November
Churchill House, London

More information can be found on our website http://www.britishpainsociety.org/meet_home.htm
Or email meetings@britishpainsociety.org

United we stand!



THE BRITISH PAIN SOCIETY

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SAGE



I hope that you all had a nice Christmas and the New Year 2013 has started with happiness. We had lots of feedback for the December issue; I sincerely thank you for all these constructive comments.

United we stand, divided we fall.
Aesop (620–560 BC)

Pain services have been going through huge changes in recent times; in fact, the whole National Health Service is enduring this change. During these difficult times, our efforts to unite are essential for the sake of good care to our patients. In this financially difficult era, it is very easy to criticise other specialties or even question their methodologies. Some might even be extreme supporters of the techniques they use. For example, I have seen a few who believe that injections

are a solution to all problems; on the other hand, some believe that psychology is the only available solution and that all the pain is related to the patient's catastrophising behaviour. The former give evidence from patients who have had significant benefit after their injection (even to the extent that the patient considers them as equal to God for the success of the injection); the latter give evidence from patients who present to them in pain management programmes after many failed interventions. These are the arguments most commonly seen in many discussion forums or meetings. But, we forget that the majority of us work in multidisciplinary clinics, working together, respecting each other and getting help from their colleagues. Most of us recognise the limitations of the interventions that we use; we also appreciate the way to use them appropriately, to help patients manage their pain themselves in a better way.

Home Run!

I thank Dr Andrew Skinner for his thoughts, as he approaches his retirement from pain medicine, in this issue of our newsletter. Although he begins his article with feelings of despair after 30 years of practice in pain medicine, his request for collecting more evidence especially with regards to the outcome should be reiterated: he stresses that every failed intervention is a serious iatrogenic harm. Dr Skinner condemns that taking polar views in our specialty has been the worst failing. He makes many thought-provoking comments and I am sure that many of you will be feeding back your comments after reading this article.

Octave analgesia

I sincerely thank Dr Arasu Rayen for his interesting column in each issue; I am amazed at the variety of topics that he finds to discuss every time. In past issues he has discussed applications for smartphones, Health on Net, needles and syringes, synaesthesia, SMS, additives – all related to pain management. In this issue, he talks about *music analgesia*. Once again, it is the same as for many other interventions in pain management: although we strongly believe that it can help, the literature lacks a definitive conclusion. As the famous composer Beethoven commented: '*Music is higher revelation than wisdom and philosophy... Music is the mediator between the spiritual and the sensual life.*' I recommend music not only to our patients but also ourselves to help with the difficult job that we perform in our clinics. I have started to learn piano recently and find that the results are similar to meditation and relaxation.

What's the benefit?

After the article on benefits in the last issue by Jenkins and McGurk (*Pain News* Dec 2012; 10:4, 239), we have a few interesting articles related to the same problem in this newsletter. Dr Peter Wright has kindly written an article about the reformed welfare system from the point of view of a medical member of the Judicial Appointments Commission. He has clearly outlined the changes involved in transition of Incapacity Benefit to Employment Support Allowance; many of these facts were new to me and I assume that this is the same for many of our readers. Dr Alan Roberts, a general practitioner and a member of the Tribunal Service, also has elaborated on how the

United we stand!

Disability Living Allowance (DLA) is processed, including details of the mobility and care components. Given his facts that the number of appeals are steadily increasing and that many of our clinicians will be involved in these queries from patients and others, it is time that we keep ourselves aware of these changes. He further points out that a full DLA equates to £250,000 for one person for 40 years. It is interesting to note that about 30%–40% of appeals are allowed and he gives suggestions of how to improve this process. I thank them both for their valuable suggestions and contributions to *Pain News*.

Organising meeting – help *Pain News* please

I thank Dr Rajesh Munglani for the interesting articles that followed from the Medico-Legal Conference in Cambridge last year. The interesting discussion about the central sensitisation in different pain conditions has motivated Dr Gaspar to provide a detailed article on this topic in this issue of our newsletter; he discusses the role of the chronic pain specialist in court as an expert witness. Dr Munglani follows this with yet another article on the medico-legal value of pain and the debate on diagnosis versus disability. In this issue, we also have an article as feedback from a Pain Masterclass meeting held last year – thanks to Dr Martin Johnson for this suggestion. Dr Arun Bhaskar gives feedback from the London Pain Forum winter meeting held in Tignes, France. Can I request other meeting organisers to follow this pattern of either giving a summary of the meeting as learning points or asking few speakers to contribute to our newsletter please? Already a few special interest groups

(SIGs) do this successfully and I thank them sincerely. These are days of financial difficulties; many of our study budgets are significantly limited; these sorts of feedback and summaries will help us keep up to date with the ever-developing knowledge.

United we stand...

As you will see from our Interim Honorary Secretary's report in this issue, our British Pain Society is made of members from various disciplines, numbering more than 30 at least. It is encouraging to see that the number of general practitioners in the members list is on the rise. I strongly believe that the salient strength of our Society is the respect that each discipline has towards the other disciplines. We all work towards the same goal; our paths may differ, our



techniques might be different, we might use different interventions, but the goal is the same – *to help patients manage their pain*.

In an ideal world, the pain multidisciplinary team will function well if the team members not only perform their individual role, but also respect the role of others and work together in a cohesive manner. *Bhagavad Gita* is a part of the famous Indian epic

Mahabharata that was delivered more than 5,000 years ago. In this scripture, Lord Krishna, who drives the chariot for Arjuna, advises him in the battlefield of Kurukshetra on a variety of philosophical and theological matters. *Gita* has inspired many leaders – Albert Einstein, Robert Oppenheimer, Mahatma Gandhi (who mentions this as his spiritual dictionary) and Carl Jung - to name a few. Allow me to quote from this literature a verse that preaches the theory of dedicated karma without a desire for results (a condition that is precedent to spiritual awakening):

*Karmanye vadhī karasthe maa
phaleshu kadachana,
Maa karmaphal hetur bhurma te
sanghastva akamani*
(*Gita*, chapter 2, verse 47)

*Your right is to work only, but never at
anytime to its fruits;*

*Let not the fruit of action be thy
motive, nor let thy attachment be to
inaction*

Maybe this is a time that we need to work hard and not think about the results. We have to do this for our pain specialty to survive these difficult times.

Now, please enjoy this edition of our newsletter and feed back your views to us.

Thanthullu Vasu
Bangor

Professor Richard Langford



THE BRITISH PAIN SOCIETY

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In writing my previous message as 2012 came to a close, I focused on a number of major British Pain Society (BPS) milestones and achievements. In this, my final message, as well as covering contemporary issues and further news items, I will reflect on some key themes and the challenges and opportunities for 2013.

Pain epidemiology and public health: National Pain Audit and Health Survey England 2011

In just one extraordinary week of pain metrics and epidemiology, the Final Report of our National Pain Audit was published, and we learned of the chronic pain findings of Health Survey England.

Hosted by the BPS and Dr Foster Intelligence, this Healthcare Quality Improvement Partnership (HQIP)-funded collaboration culminated in the official launch of the Final Report (BPS website or <http://www.nationalpainaudit.org/media/files/NationalPainAudit-2012.pdf>) on the evening of 17 December 2012, at a well-attended reception held in the *Pain Less* Exhibition at the Science Museum. We were pleased with the wide representation of healthcare professional groups, patient organisations and Department of Health policymakers and commissioners.

Three of the key findings of the audit were summarised as follows in the joint HQIP/BPS/Dr Foster press release:

Quality of life: The overall mean quality of life score (EQ5D-3L) of 0.4 represents severe impairment, and is lower than many individual conditions. This low score might be attributed to the collective impact of the comorbidities present in these complex cases. In total, 56% of

providers reported post-treatment improvement in EQ5D-3L score, and 76% improvement in specifically pain-related quality of life.

Healthcare resource utilisation:

Sixteen percent of respondents recalled visiting accident and emergency (A&E) in the six months prior to clinic attendance, seeking additional help despite having seen their general practitioner (GP). By contrast, only 9% of respondents recalled visiting A&E in the six months after attending their pain clinic for pain-related events.

Variation in availability of services:

Only 81 out of 204 English pain clinics (40%) were able to fulfil the criteria for a fully multidisciplinary pain service, as defined by the presence of a psychologist, physiotherapist and physician. In Wales, 60% of pain clinics were multidisciplinary.

This has been a good example of the very high achievements that can be realised through the combined efforts of so many members and their patients. In addition, I would like to particularly thank two individuals: Dr Stephen Ward for chairing the Project Board; and Dr Cathy Price, chair of the Scientific Advisory Committee, for her dedication and outstanding contribution throughout this project and for leading the authorship of the Final Report.

Just four days later, 20 December witnessed the publication of the Health Survey for England 2011, which for the first time included chronic pain questions as recommended by the then Chief Medical Officer, Sir Liam Donaldson, in his 2008 report. This chapter (<https://catalogue.ic.nhs.uk/publications/>

National Pain Audit Final Report

2010–2012



public-health/surveys/health-survey-eng-2011/HSE2011-Ch9-Chronic-Pain.pdf) presents authoritative data, and which should provide further persuasive evidence to influence policymakers and commissioners. The following is adapted from the NatCen Press Release:

Health Survey for England 2011 reveals more than 14 million sufferers of chronic pain – pain that has lasted for more than three months.

Certain groups are more likely to experience chronic pain:

- 37% of women, in comparison to 31% of men, reported chronic pain.
- 42% in the lowest-income households had chronic pain, compared with 27% in the highest.
- Although chronic pain was most prevalent in older people, one in six 16–34-year-olds were affected.

Professor Richard Langford

The survey demonstrates a burden on health services and employers:

- Almost one in four said that pain had kept them from usual activities (including work) on at least 14 days in the last three months.
- 37% of sufferers had used specialist pain services, rising to 57% among those with the most severe pain.

Pain has serious psychological impacts:

- Levels of positive well-being were lower than those with no pain and fell according to the severity of pain.
- Sufferers were more likely to be anxious or depressed – 69% with the severest pain reported this.

It is envisaged that these two major data sets will serve the Pain Summit work package, allocated to the BPS, on pain epidemiology.

Guidelines, pathways and commissioning: North and south of the border SIGN guideline

Continuing their pioneering work, the Chronic Pain Steering Group within Health Improvement Scotland (http://www.healthcareimprovementscotland.org/our_work/long_term_conditions/chronic_pain.aspx) led by Dr Steve Gilbert, National Clinical Lead for Chronic Pain in collaboration with the Scottish Intercollegiate Guidelines Network (SIGN) (<http://www.sign.ac.uk>). The SIGN guidelines are evidence based and seek to make recommendations on interventions where there is currently doubt over use or variation in practice throughout Scotland. Chaired by Dr Lesley Colvin, the guideline development committee commenced work in August 2011, and having developed key questions, they then conducted a systematic literature review on which the final guideline will be based. The initial

findings and proposals were discussed in an open consultation meeting on 12 December 2012 in Edinburgh, and we will report further on this important project in future issues of *Pain News*. The estimated date of publication of the SIGN guidelines is spring 2014.

Scotland is also awaiting the result of an analysis by the Public Petitions Committee of the following petition on pain (<http://scottish.parliament.uk/GettingInvolved/Petitions/chronicpain>) calling on the Scottish Parliament to:

urge the Scottish Government to (a) hold a debate on the matter with a vote or voting rights (b) transfer more of the management for chronic pain into primary care (c) provide more social model care instead of medical model (d) change its policy to provide direct funding to ensure radical improvements to the service can be made including establishing a residential unit in Scotland to prevent Scottish pain patients being sent to Bath in Somerset for treatment.

BPS-endorsed pain patient pathways

The five evidence- and consensus-based pathways have been published on the Map of Medicine (MoM) website and the 'microsite' on our BPS website now enables unrestricted viewing with full functionality. I would again like to thank Andrew Baranowski and all involved in this mammoth project.

Commissioning: Clinical commissioning groups, specialised commissioning, senates, Any Qualified Provider and the BPS

For England, this will clearly be a major topic for at least the next year or two, and as you will know from previous messages, articles and our 2012 Annual Scientific Meeting (ASM) Satellite, the

BPS has concentrated a great deal of resources and effort to address the issues. In addition to the MoM pathways, we have been closely following the evolving commissioning systems, and where possible engaging with the development process.

As I write this at the end of January, the National Health Service Commissioning Board (NHSCB) has just authorised and established the second wave of clinical commissioning groups (CCGs), adding another 67 groups, which will come into being in April 2013. This brought the total across the country to 101, almost halfway to the anticipated total of 211 CCGs. For everyone involved in pain services in England, in such a fast-moving landscape with potentially major implications for our services, I strongly recommend following the weekly NHSCB bulletins written by Dame Barbara Hakin, National Director, Commissioning Development (accessed via <http://www.commissioningboard.nhs.uk/category/publications/ccg-bulletin>).

Another very important component progressed this week, with the NHSCB publication on 25 January 2013 of 'Developing Clinical Senates: The Way Forward' (<http://www.commissioningboard.nhs.uk/2013/01/25/clinical-senates>).

Twelve clinical senates will be established across the country from April 2013 to play a unique role in the commissioning system by providing strategic clinical advice and leadership across a broad geographical area to CCGs, health and well-being boards (HWB) and the NHSCB.

Clinical senates will span professions and include representatives of patients, volunteers and other groups. They are directed to work with strategic clinical networks, academic health science networks, local education and training boards and research networks to develop an alignment of these organisations to support improvements in quality.

Having a voice on your clinical senate will be crucial to having oversight and influence over the CCGs, so in each you should explore strategies to achieve this representation.

Having a specialised pain services centre is one way to guarantee senate representation, and specialised commissioning is covered below.

Specialised commissioning

Intended by the NHSCB to serve previously struggling areas such as 'Rare Conditions' and highly specialised services of national or supra-regional coverage, this is another key element to ensuring that pain services prosper in the new NHS order. Andrew Baranowski has led on this, by chairing the NHSCB's Chronic Pain Clinical Reference Group (CRG), and ensured that pain professional and patient organisations were represented. He is striving to ensure that each region has its own specialised centre, and to build a system in which the CCGs are obliged to maintain locally commissioned multi-professional pain services staffed and led by trained and accredited staff, respectively. To ensure that this occurs with equity and excellence, the CRG is working with its Programme of Care Board within the NHSCB structure, to obtain a full NHS service review of pain services in England.

Equally importantly, paediatric chronic pain services have been recognised by the NHSCB as a separate sub-specialty, with John Goddard representing the BPS and playing a leading role. This really is a major step forward and offers an opportunity to develop a national network that will enable training, research and equity of service delivery to patients.

Again at this week of writing, the BPS responded to both the Adult and Paediatric Chronic Pain Specialised Commissioning consultations, which can be viewed on our website.

Any Qualified Provider

Any Qualified Provider (AQP) is an area about which we need to be vigilant. (<https://www.supply2health.nhs.uk/AQPResourceCentre/AQPMap/pages/default.aspx>).

Although to date, there is minimal take-up of 'Community Chronic Pain Services', there are more actual and planned Musculoskeletal: Neck and Back Pain AQP services. We have no issue with the development of such services – on the contrary, if well delivered, they may improve access and quality. Rather, it is the as yet purely conjectural possibility that a CCG may see AQP as a substitute for a proper multi-professional clinic able to provide the full spectrum of required methods of assessment and treatment, including the capability to refer patients appropriately to the highly specialised centres, as mandated in the Chronic Pain Specialised Commissioning proposal.

In response to such concerns, we have written to the NHSCB to request that senates and CCGs are advised regarding the need for appropriate CCG pain service commissioning.

Pathways and Commissioning Roadshows

The proposed series of regional meetings to roll out the pathways and our commissioning strategy in the Implementation and Dissemination phase of our Pathways and Commissioning project (led by Andy Nicolaou) will get under way in March and run until May. That much of the commissioning landscape is only now unfolding (as you will have appreciated from the narrative above), has necessitated waiting until we were sure that we could deliver the right information and advice.

Patient Liaison Committee

As a result of mounting commitments, Douglas Smallwood stood down as Chair of the BPS Patient Liaison

Committee (PLC), and we would like to thank him for the PLC's major progress and contributions during his tenure. We also extend a very warm welcome to Antony Chuter, who replaces Douglas, and brings both his interest in pain, and the considerable expertise and experience of having been chair of the Royal College of General Practitioners' (RCGP) Patient Liaison Group.

Looking forward

In this, my final President's message, I have not catalogued every detail of the past three years, but rather looked to how this period may act as a springboard to reach the next level. The Society has maintained its multi-professional (primary and secondary care, medical, nursing, physiotherapy, psychology and patient) ethos throughout its structure: membership, SIGs, committees and Council.

Immediately prior to taking up the presidency, I spent a period as Clinical Director, and was given a coffee mug inscribed with the following helpful advice: 'If at first you don't succeed..., DELEGATE.' Well, I can honestly say that over the past three years, I have been in the extraordinarily fortunate position of having so many outstanding individuals to drive forward and deliver the Society's ambitious targets. Through dedication and exemplary teamwork, the BPS has raised the profile of 'pain', and can be justifiably proud of its achievements. During this period, we have strengthened our relations with the Faculty of Pain Medicine (FPM), the Chronic Pain Policy Coalition and the RCGP, so that now it is assumed that many of our projects will be conducted in collaboration.

In addition to the headline projects, achievements and issues already featured above, I feel compelled to note the important step of professionalising our publishing with SAGE, and relaunching *Reviews in Pain* as the *British Journal of Pain*, the selection of chronic pain as a Quality Standard topic, the

From the President

Professor Richard Langford

inclusion of pain in the National Early Warning System (NEWS) chart, the ongoing e-Lf Pain project with the FPM, and the move declared by National Institute for Health and Clinical Excellence (NICE) to start afresh with guidelines for low back pain, thereby consigning Clinical Guideline 88 to the history books.

Of course, with so much activity over the past three years there are so many to thank for their great enthusiasm, skill and personal time. We should always remember that all these major contributions are unpaid and in addition to 'the day job': Council Members, Editors (Mike Basler; Dr Thanthullu Vasu; Mike Platt; Felicia Cox), ASM leads (Suellen Walker/Maria Fitzgerald; Gary Macfarlane), Committee chairs (Paul Watson; Nick Allcock; Douglas Smallwood; Antony Chuter, Mick Serpell) and their members, SIG officers, and

those who have contributed to specific major projects: NPA, Pain Pathways group leads and members.

I especially wish to personally thank my executives John Goddard and Pat Schofield, who also took up office three years ago, and William Campbell and Martin Johnson, for their support, sound advice and their outstanding contributions during such a demanding period.

Finally, unless you have seen it first hand, you cannot begin to gauge the contribution of Jenny Nicholas and her Secretariat, whose hard work and attention to detail enable the Society to conduct itself in a highly professional manner, and quite simply to 'punch way above its weight'.

It has truly been a privilege to serve in this role, and as I enter the relative tranquility of the Immediate Past President role, I would like to thank

everyone for their support over the past three years.

It is with great confidence and warmest wishes that, at the Annual General Meeting in Bournemouth on 18 April 2013, we will welcome our new President, William Campbell and his executives for the next three years: Martin Johnson, Honorary Secretary, and Andrew Baranowski, Honorary Treasurer, as well as the new Vice-president and Council. I know that the Society will continue to go from strength to strength.

I look forward to seeing you all in Bournemouth.

With kindest regards,



New Members

Ratified at the November 2012 Council Meeting

Name	Position	Institution
Mr James Lees	Senior Director Analgesia	Premier Research Group
Dr Rajesh Chella Naraendran	ST7 Anaesthetics	University Hospital of Wales
Mrs Susan Jenkins	Acting Senior Lecturer	Cardiff University
Dr Rebecca Chasey	Lead Clinical Psychologist	Torbay District General Hospital
Mr Peter Farley	Pharmacist	Staffordshire & Stoke-on-Trent Partnership Trust
Mrs Laura Butler	Specialist Physiotherapist	Norwich Community Hospital
Mrs Julia Stenhouse	Band 6, Pain Management Nurse	Heart of England Foundation Trust

Dr Martin Johnson



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Well, here it is – the read that you have all been waiting for! My first report as the Honorary Secretary – sorry, I do get carried away... (Yes... I know I should be!). I write the report with the

world outside freezing and covering itself with a white blanket. I feel very humbled and honoured to be selected for this position; it only seems like yesterday when I joined the British Pain Society (BPS) and realised that the prioritisation of chronic pain within the community was virtually non-existent. Thus began a long crusade!

As many of you will be aware, I have taken over this position of Honorary Secretary slightly earlier than anticipated – or to be exact Interim Honorary Secretary until the Annual Scientific Meeting in April. My predecessor, our friend and colleague Professor Pat Schofield, wishes to concentrate on her wonderful pioneering work with pain management in older patients, especially with the joint venture between the BPS and the British Geriatric Society. The new joint guidelines for pain management in the elderly are arguably the most thoroughly researched in the world and are a tribute to Pat's dedication and attention to detail. May I express my sincere thanks to Pat for all of her hard work as Honorary Secretary for the last few years and wish her well with her continuing and new projects.

I am now grappling with the intricacies of BPS procedures and getting to know the Memorandum and Articles of Association and the Regulations – Pat informs me I will know them inside out

after three years! I am very grateful for Pat's support as I commence my role (as well as the support from Richard and John), but I particularly want to thank Jenny and her team who actually keep all in order.

Over the last few weeks, we have seen the publication of two superb surveys that will support the work of the BPS immensely: the National Pain Audit and the Health Survey for England. Both of these powerful reports are really influential documents following in the footsteps of the CMO's report and the Pain Summit report. I urge you to read them.

Coming back to BPS figures, Ken has kindly prepared for me a complete breakdown of the membership of the BPS (Figure 1). This really shows our true multidisciplinary nature. Our total membership is relatively stable at 1,443 but this time last year it stood at 1,531. Do not forget to encourage your

colleagues to join or let us know what the barriers to joining BPS are or what would encourage others to join. (Sorry, we cannot make it free membership!) This is *your* society – keep us in the loop!

At the BPS Council meeting next week, I will be proposing a further special interest group – Information Communication & Technology SIG. We have to take advantage of all of the technological advances for both ourselves and our patients. The hope is that this SIG will help us grasp developments even further. For example, do you know what this means: >8-O-(&)? It is a message from someone who realises that they have a tapeworm! How *do* they think of them? If one of your patients sends you a text saying I:/ it means they are constipated. I have not found the reply yet! This could create a whole new column for *Pain News*.

See you all in Bournemouth!

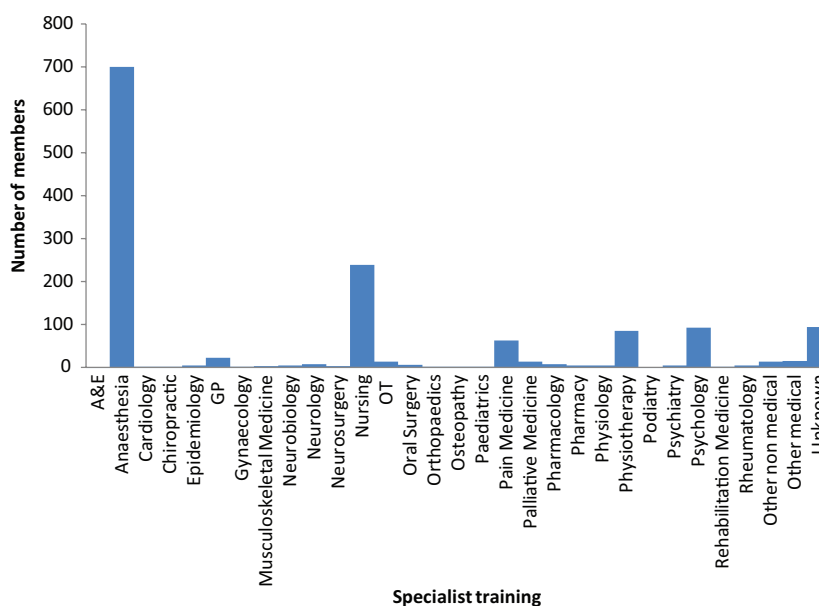


Figure 1. BPS members by speciality

Dr John Goddard



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As an insert to this edition of *Pain News* you will find a form that I would be most grateful if you would complete and return to the Secretariat. This form asks you to confirm your current taxable income.

It is a fact that is of no surprise to many of us that many members of the Society are longstanding: the benefits of membership are clearly substantial. Membership fees for the Society are somewhat unusual, being banded on taxable income rather than a flat rate or a trainee / qualified basis. Over the years our careers progress and, not uncommonly, our salaries and income increase due to promotion, incremental uplifts and changes in activity. It is surprisingly unusual that we are informed of changes to individuals banding and we wonder sometimes at the Secretariat whether members have remembered to inform us of changes to their income.

One outcome of the recent review of the Society's finances was to have a look at our current banding structure and to consider the introduction of a further band for individuals with a gross income of more than £100,000 pa. We, Council, will have made a preliminary decision on these proposals by the time you receive this edition of *Pain News*. If we agree to recommend any changes to our banding

structure for membership fees, a vote will be required at the Annual General Meeting in Bournemouth. As usual, you will also be informed of and asked to approve membership fees for the next year, 2014.

In order to inform our deliberations we need to know the current taxable income of our members and hence the insert in this edition of *Pain News*. Clearly, return of these forms depends on your goodwill and I encourage you to be forthcoming in that respect. We are unfortunately unable to provide a stamped addressed envelope to facilitate your return.

So, as you read this article, please be reminded to promptly return your form. If you are reading this and have not noticed the insert, please fish it out of the bin and return it in whatever state you find it! If you have already mislaid the form, we will be happy to receive confirmation by email or telephone.

My best wishes for 2013.

Dr John Goddard
Honorary Treasurer

**The last date for submission of articles
for our next issue is Friday 19th April 2013**



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National Pain Audit

Final Report Launch at the Science Museum 17 December 2012

The British Pain Society (BPS), with Dr Foster Intelligence, was delighted to launch the final report of the National Pain Audit at a prestigious reception held at the Science Museum, within the *Pain Less* exhibition, on the evening of 17 December 2012.

The evening proved to be a vibrant and resounding success, with attendees representing patients, healthcare professionals, policymakers (from the Department of Health and the National Health Service (NHS) Commissioning Board), Health Survey England, the BPS and Dr Foster Research.

Guests were welcomed on arrival at the Science Museum from 7pm, and brief presentations were given by Prof Richard Langford and Dr Cathy Price who outlined the process and key findings of the audit.

Dr Price highlighted the following key findings:

- **Quality of life:** The overall mean quality of life score (EQ5D-3L) of 0.4 represents severe impairment, and is lower than many individual conditions. This low score might be attributed to the collective impact of the comorbidities present in these complex cases. In total, 56% of providers reported post-treatment improvement in EQ5D-3L score, and

76% improvement in specifically pain-related quality of life.

- **Health care resource utilization:** Sixteen per cent of respondents recalled visiting accident and emergency (A&E) in the six months prior to clinic attendance, seeking additional help, despite having seen their general practitioner (GP). By contrast only 9% of respondents recalled visiting A&E in the six months after attending their pain clinic for pain-related events.
- **Variation in availability of services:** Only 81 out of 204 English pain clinics (40%) were able to fulfil the minimum criteria for a basic multidisciplinary pain service, as defined by the presence of a psychologist, physiotherapist and physician. In Wales, 60% of pain clinics were multidisciplinary.

The presentations were followed by a thought-provoking question and answer (Q&A) session, which served to reinforce the importance and timeliness of such an audit. The wide range of attendees provided a balanced and detailed discussion.

Following the presentations and Q&A session, Dr Stephen Ward, project lead for the National Pain Audit, gave thanks to those involved in this important project, one of the largest projects ever undertaken by the BPS, with special notes of thanks to Dr Foster and the Healthcare Quality Improvement Partnership (HQIP).

Mr Paul Harvard-Evans attended on behalf of Pain Concern and the Airing Pain radio station to interview some of the guests for an Airing Pain special edition on the National Pain Audit, due to be broadcast in February 2013.

Many useful connections, conversations and exchanges of ideas took place, with strong

indications that they will translate into tangible outcomes.

During the evening, guests also had the opportunity to view the *Pain Less* exhibition (supported by the BPS, among others). *Pain Less* is a free exhibition that explores the future of pain relief and the different ways that pain management is being developed. The exhibition runs until the end of June 2013 in the Antenna gallery at the Science Museum. More information about the exhibition can be found at: <http://www.sciencemuseum.org.uk>

The final report of the National Pain Audit can be found on the BPS website at: http://www.britishpainsociety.org/members_articles.htm

Next steps

The National Pain Audit has been granted a 12-month extension by HQIP, and further research is now being planned in preparation for future work. This includes analysis of questionnaires distributed to hospitals as part of the 'How safe is your hospital?' campaign. This had a focus on safety protocols in specialist pain services as well as an update of the pain clinic directory (<http://www.nationalpinaudit.org/search.aspx>). The audit intends to first test the degree of collaboration between providers in a local area to support reduction of the 'pinball' journey that patients follow in search of help as identified by Earl Howe. Second, it will focus on the journey taken to specialist pain services using the BPS Pain Patient Pathways (on Map of Medicine) to support reduction in the time taken for patients to get the help they need to manage their pain as highlighted by Sir Bruce Keogh, Medical Director of the NHS, at the First English Pain Summit.

If anyone would like to support the work of the audit or has ideas on how we should take it forward then please could you email Cathy Price (cathy.price@nhs.net) or Stephen Ward (spslward@gmail.com).



Interprofessional working and learning: news from the Pain Education SIG

Dr Emma Briggs (*SIG Chair*) on behalf of the Pain Education SIG Committee

emma.briggs@kcl.ac.uk

The Pain Education Special Interest Group (SIG) continues to lead exciting and innovative developments in the world of education. We are a network of over 110 lay members, clinicians and academics that are passionate about advancing pain education for professionals. At the heart of this interprofessional group is the SIG Committee, which has been working hard on a number of initiatives in the last year.

2012 Seminar – Improving patient education: Making a difference

One of our annual highlights is the SIG seminar, which provides a fascinating and stimulating day at Churchill House. This year over 30 delegates enjoyed exploring the topic of educating patients, with keynote speakers Mr Pete Moore (trainer and co-author of the Pain Toolkit) and Dr Frances Cole (General Practitioner and pain rehabilitation specialist) setting the scene. They provided an enlightening session discussing the challenges, innovations and top practical tips for improving patient education in our areas.

In the post-prandial slot (always a challenge), Dr Chris Holland (King's College London Learning Institute) facilitated a delightful session on 'Pain Free Pedagogic Practice', challenging all our assumptions about people's learning styles and addressing learners' needs.

Dr Clare Daniels (University College London) then gave us an expert's overview of motivational interviewing and some excellent tips on how to use the principles for patients' benefit.

The final sessions of the day focused on the activities of the SIG and the British Pain Society (BPS). We are privileged to have Dorothy Helme, lay member of the Patient Liaison Committee (PLC), working with us on the SIG committee and she gave us insight into the work of the PLC on patient education and inspired us to continue to want to enhance patient education around pain. One of the startling statistics she presented was that in the UK, 800,000 people have dementia, yet recent statistics suggest that 10 million people suffer chronic pain.¹ Pain management needs the research and development funding that dementia has rightly attracted in recent years.

Despina Karargyri, chair of the SIG's Patient Education Working Party, presented the work of the group that has mapped out its strategic aims:

- Raise awareness of the importance of effective patient education among healthcare professionals providing pain management, working in conjunction with the PLC.
- Promote the assessment of health literacy by healthcare professionals and the range of available resources in order to improve patient education.

- Provide an interprofessional forum for discussion, research and development around patient education.

We want to hear your thoughts and would love people to get involved. Please contact us through the BPS Pain Education SIG website: http://www.britishpainsociety.org/members_sigs_education.htm

The 2012 seminar drew to a close with a Q&A session (chaired by Ethel Hili) and everyone had activities and things to try out the next day. Always a highlight is the time for sharing practice, networking and group discussion. Thank you to everyone who attended, contributed and organised the day – and to Grunenthal for providing financial support. Everyone's contribution and enthusiasm made the day such a success.

Please visit our Pain Education SIG secure website for further details and the day's presentations.

Undergraduate Interprofessional Core Curriculum Group

Prof. Nick Allcock continues to lead an experienced team to develop an undergraduate interprofessional document that would support specialist and non-specialist educators and enhance pain education in the curriculum. A number of barriers hinder the inclusion of pain and education in



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an interprofessional context. The document being developed will offer some practical and realistic solutions for those involved in undergraduate education.

Annual Scientific Meetings (ASMs)

In 2012 we joined forces with the Primary Care SIG to offer a participatory workshop called '*Citius, Altius, Fortius: Launching our Olympic Pain Education Campaign*'. Nick Allcock introduced the undergraduate work and Val Conway (Eastern and Coastal Kent Primary Care Trust) offered a strategic view of primary care provision. Dorothy Helme provided the all-important lay member perspectives on the priorities for education.

In 2013 we are looking forward to presenting at the ASM with the Developing Countries SIG to explore the benefits and challenges of providing pain education in low-resource countries. We hope to see you in Bournemouth for an interesting discussion and debate.

British Journal of Pain

The SIG was delighted to be invited to commission papers for the second issue of the *British Journal of Pain* (formerly *Reviews in Pain*). National and international experts have written some interesting articles on contemporary issues in pain education. If you missed it, it is free to download from the journal's website: <http://bjp.sagepub.com/content/6/2.toc>

International activities

Finally, committee members are also active on an international level linking in with the International Association for the Study of Pain (IASP) Education SIG, where co-opted committee member Dr Paul Wilkinson is editor of the newsletter. Committee members are working with IASP SIG Chair Professor Eloise Carr on a paper exploring the barriers to pain education across disciplines.

The European Federation of IASP Chapters (EFIC) is developing a research and development project around medical education across Europe and at a meeting in Barcelona in November,

I presented the UK research we have conducted illustrating how we are moving the agenda forward in the UK.²

Onwards and upwards

With so much achieved in 2012, we are looking forward to focusing our attention on the undergraduate curriculum document, supporting professionals to deliver patient education, implementing our communication strategy and planning our next missions.

For those of you who are not SIG members, we would love you to join us (see the BPS website: http://www.britishpainsociety.org/members_sigs_join.htm). For existing friends and colleagues, we look forward to a fruitful 2013 with you.

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Save the date



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Annual Scientific Meeting
29th April – 2nd May 2014
Manchester



News update from the Pain in Developing Countries SIG

Clare Roques, *Chair, Pain in Developing Countries SIG, with contributions from SIG members including Lou Millington*

clareroques@hotmail.co.uk



At first glance, the aim of the Pain in Developing Countries Special Interest Group (SIG) to improve pain management overseas, is an overwhelmingly ambitious project. Indeed, as we have described before, the World Health Organisation (WHO) estimates that 5 billion people live in areas where there is inadequate access to pain relief.¹ This lack of access has often been described in relation to a triad of problems: drug availability, policy and education. These complex issues have been the subject of projects led by large international organisations including WHO and Human Rights Watch. However, given that education plays a

key role, this is an area that perhaps we, as a small group, can help in some part to improve pain management. Not only should increased knowledge lead directly to improved clinical care, but it can also potentially influence policy and drug availability through local empowerment.

Many of you will have heard of an educational project set up by Roger Goucke from Australia and Wayne Morris from New Zealand with support from the Australian and New Zealand College of Anaesthetists called Essential Pain Management (EPM). Roger presented this work at our first SIG workshop (arranged by Mike Basler) in 2011 at the British Pain Society (BPS) Annual

Scientific Meeting (ASM) in Edinburgh. The course has been run in many countries in the Asia-Pacific region and in Africa, has been translated in to Vietnamese, Spanish and Mongolian, and has been supported by several organisations including the International Association for the Study of Pain (IASP). The EPM workshop is a one-day interactive course that aims to teach basic skills regarding the recognition, assessment and treatment of pain management to health care workers. One of its greatest strengths is that it provides a very broad base incorporating acute, chronic and cancer pain management, and encourages consideration of non-pharmacological



treatments as well as clear coverage of the WHO ladder that we are all now so familiar with.

I have recently returned from Kuching, a city in the Malaysian area of the island of Borneo where I was assisting and observing Roger Goucke and other pain specialists running a series of EPM workshops over three days. A key concept of the EPM course is to encourage ongoing educational work from local health care workers. Apart from Roger, the other faculty members teaching on the course, coordinated by Athena Tang (an anaesthetist in Kuching), were all based in Malaysia; this project was supported by the Malaysian Association for the Study of Pain. Following an EPM workshop on day one,

the second day consisted of an instructor course to teach some of the participants from the first day's programme. It was particularly rewarding to see the participants increasing in confidence with presentation and other teaching skills as the day progressed. On the third and final day, another EPM workshop was held for a new set of participants, with many of the lectures and sessions run by the new instructors overseen by the more experienced faculty members. It was great to see more and more translation of the basic resources into local languages as the participants engaged with teaching.

Finally, but perhaps most pertinently, I was struck by how readily the EPM course can be adapted to suit the local

setting. For example, a key session in the one-day workshop is devoted to group discussion of local barriers to effective pain management and encourages consideration of how these barriers can be overcome. Furthermore, the actual course materials are designed in a simple format that can be easily modified to suit local practice, to reflect, for example, the availability of certain drugs.

I am particularly grateful to Athena for her hospitality and to Roger for giving me the opportunity to attend the course. The SIG is currently hoping to secure interest towards running further EPM workshops. More information regarding the programme can be found at: <http://www.fpm.anzca.edu.au/fellows/essential-pain-management>

A huge amount of work in the area of improving pain management overseas has come from the field of palliative care; several of our SIG members have considerable experience of educational work in this area. Lou Millington, a SIG committee member, has recently returned from Cameroon and she describes some of her observations and experiences below:

Palliative care is a relatively new medical specialty in many parts of Africa, particularly in francophone countries. The minimal data that is available from French-speaking Africa indicates patchy services in a few countries and non-existent palliative care cover in most.^{2,3} This is coupled with limited access to morphine or no access at all.¹ The need for holistic care in life-limiting illnesses has never been greater in Africa and is set to increase over the next 20 years, due to the increasing incidence of cancer and the burden associated with HIV/AIDS and other chronic non-communicable diseases.⁴

Hospice Africa (soins palliatifs) France (HAF), a registered charity, was conceived with the aim of spreading affordable palliative care in francophone Africa. Cameroon was chosen as the country in which to launch a comprehensive francophone palliative care training course – the first of its kind. It is a bilingual country with palliative care currently available in five units, in both mission and government hospitals, in anglophone and francophone zones. Despite the existence of palliative care services, their provision covers a very small area of the country and oral liquid morphine is only available through the Cameroon Baptist Convention hospitals.⁵

A five-week initiators' course was devised in conjunction with HAF, Hospice Africa Uganda (HAU), L'Alliance Mondiale Contre le Cancer (AMCC) and CBC,

based on that used at HAU. The cost for the five-week residential course was €2,000 per participant excluding flights and some funding was available from HAF and Help the Hospices. The course ran from 2 April to 4 May 2012 and was attended by 14 francophone students from four different countries (Cameroon n = 8; Democratic Republic of Congo n = 3; Rwanda n = 2; Senegal n = 1), consisting of six doctors, four nurses, two nursing assistants and two social workers. The course combined three weeks of lectures with two weeks' practical placements, covering a range of palliative care topics and culminating with a Training of Trainers week.

Follow-up of the 14 students is ongoing, in Cameroon and further afield. The students are in the process of setting up a francophone palliative care network to provide support and resources for francophone palliative care workers and several are working at developing their own palliative care services. We wish them every success with their efforts and HAF aims to continue its support of them in their endeavours. May they continue to have 'fire in the belly' for palliative care for many years to come. For more information related to this work please see the HAF website (<http://www.hospiceafricafrance.com>) or contact Lou Millington via email (lou_milli@yahoo.com).

Other members who are carrying out educational work include Senthil Vijayan (SIG honorary secretary), who is currently setting up his own mentorship programme aimed at supporting those working in pain management in India. He is keen to expand the cohort of pain specialists working with him on this project from the UK. If you are interested in getting involved please contact him directly via email (senthil.vijayan@nhs.net).

Although as I suggested at the start of this piece, challenges to education can be particularly complex in lower-resourced overseas settings, my recent trip also served to emphasise some of the similarities to teaching pain management in the UK. Together with discussions of experiences of our members, this has sparked coordination with the Pain Education SIG to run a joint workshop at the ASM in Bournemouth later this year. During this session, coordinated largely by Emma Briggs (chair of the Pain Education SIG) and Barbara Duncan (SIG committee member), we will aim to focus on how to maximise the efficiency of education strategies in low-resource settings, which we hope will provoke considerable constructive discussion.

Finally, on behalf of the SIG I would like to thank all those who have taken the time to complete the online survey circulated to all members of BPS regarding their overseas experiences. We hope to have some of the data collated in time for discussion at the ASM. Please contact me if you have any further questions regarding the work of the Pain in Developing Countries SIG.

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From the Chair of the Patient Liaison Committee

Antony Chuter



First of all, I am honoured to have been given the opportunity to work with the British Pain Society (BPS). I have lived in chronic pain

for about 20 years, so pain is something I am interested in from a very personal perspective. I got involved in the RCGP and locally in health just a few years ago. I wanted to make a difference for ordinary people then and still do now.

My time in chronic pain over 20 years has taught me many lessons but has also given me opportunities. I became addicted to pethidine for two years and then dihydrocodeine for a further 10 years. I have since got this under control but I know what it is to lose everything you value, including all my hopes and dreams, to a condition and the connected depression. The resulting ripples that the large stone of chronic pain caused in my life and the repercussions continuing into my future were unfathomable at the beginning. I now believe in the line: 'Whatever doesn't kill you makes you stronger.' I still have bouts of depression but I have learned to manage and go with the flow.

My recovery back to life began in 2003 when I found a leaflet for the Expert Patient Programme (EPP), which was run by my local primary care trust (PCT) at the time. I did the course and went on to become a volunteer tutor. Before this I had become agoraphobic, ate one meal every other day and went to bed at 4:00 am most nights. I did not feel like I was living but just existing.

As a volunteer tutor my confidence began to grow. It continued to grow over time and my self-worth increased too. My depression got better as I got busier and I began to have dreams of a different future. I met someone and settled into a relationship for the first time in years.

The PCT used the EPP tutors to act as lay/patient people in certain meetings. Not only did I find that I was wrong in my perception that the NHS was set up for the convenience of the staff; I also discovered that I could make a difference. I talked to my SHA and asked them where their patient involvement was – they were asking all the PCTs so what were they doing; this led to me helping to set up the first patient group in a SHA.

One day while waiting for my general practitioner to call me back, I Googled the letters after his name; I had found the RCGP. I was impressed by their Patient Partnership Group (PPG) as they were the first royal medical college to set up a group and it was not just one that they paid lip service too. The group was involved in almost everything the RCGP did. I emailed to say that I was interested in joining and was pleasantly surprised to find they were recruiting at that time and asked if I was free for an interview the following Tuesday. I am still a member of that group but have just stepped down from a three-year tenure as the chair. In my time as chair, I learned a lot about how organisations like the RCGP work and how to get things done. I also learned how to be more diplomatic – but I can still occasionally put my foot in it.

Work-wise, I was made redundant from the EPP in March 2011 and had a time of adjustment. Previously via my

work at the SHA, I had come into contact with the Connecting for Health (CfH) patient and public involvement lead, Marlene Winfield. Marlene was looking for a lay person to sit on the steering groups for some of the evaluation programs of CfH. I was interested, and still am, in electronic health records and e-prescribing and for a couple of years I attended these meetings. It was there that I kept feeling that just having a lay representative on a steering group will not make the project patient centred or focused. Now I know that not every piece of research needs a lay representative but many do – so I got talking to people. One professor took me up on this and I am now a co-investigator on three projects, with more in the pipeline.

So, to the Patient Liaison Committee at the BPS.

It is an odd feeling to come into a committee as its chair. My experience in the past is one of being elected by my peers. I have always had (I hope) a consultative style to chairing. I like to listen to people and take the consensus of the group. This does not mean that I do not have my own ideas but I do believe that my own ideas should never trump the consensus of any group I am in.

One thing I would like to facilitate is to enhance the work between the BPS and Pain UK. I have a vested interest or a conflict, depending on how you look at things, as I have just become a trustee of Pain UK.

My goal as chair is to leave the committee stronger and with as much influence as it has now. I also want to help the committee and the BPS improve the care of people living in pain and the treatments of pain.



Thoughts of member: Home Run – a personal valediction

Andrew Skinner

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'Home Run' – the term prisoners of war used for a successful escape – was the jokey title I gave an internet discussion about my impending

escape from pain medicine. Looking back more objectively I am not escaping from something I resent, merely planning a gentle decline to retirement, although I am leaving pain medicine a somewhat disappointed man.

I am an anaesthetist and write from the point of view of a pain physician and chiefly to other pain physicians. My pain curriculum vitae goes back to 1983 when I was trained by some of the first-wave, original, pain consultants in York and Merseyside. I have worked closely with about 10 pain consultants and as far as I can tell, both they and the people who referred to me, and to whom I referred, thought I was good at the work, certainly good enough. I was a consultant in Mersey and latterly in Middlesbrough.

Chronic pain medicine is not what I hoped it would be when I started. What I had hoped was that skilful treatments would mean that we could make lots of people a lot better; unfortunately that has not been my experience, nor is it of many pain doctors. Yet we are reluctant to admit as much, even to ourselves.

The *raison d'être* of the original pain clinics was interventions chiefly by way of injections. It was pretty much the whole job when I was training. These simple interventions have been for me, a disappointment. We do certainly make some people considerably better with skilful interventions but we cannot

currently predict whom (and it is certainly a minority so a lot of effort is wasted) and the benefits are almost always short lived. The trouble we have with coming to terms with these injections is that a lot of us like doing them; for some, it is the reason we came into pain medicine and for some it remains the reason they come into pain medicine. This *raison d'être* has become a *sine qua non*. For some of us in the independent sector, they are a lucrative source of income too. We have seen the vigour with which some of these interventions are defended by pain physicians as a whole, but we still lack the evidence that will persuade our commissioners for most of them. Pain doctors of my vintage owe the speciality an apology, because we knew all this but did nothing to gather the evidence and I apologise for my part in this.

Thus, those whose role is to interpret the evidence for commissioners remain unpersuaded that many of these interventions are worthwhile and disinvestment seems the likely result. In places, this disinvestment is being wrongly extrapolated from injections for axial spinal pain to spinal injections for radicular pain – a very different issue. Impurely I wonder if these procedures were not so prominent in independent pain practice, they would have been investigated better and defended with less vigour. Worryingly, learning to do these interventions is often the highest priority for my advanced pain trainees and my managers are keen to keep delivering them as they represent healthy income. Efficacy seems a side issue to a lot of vested interests. We know every failed intervention is a serious iatrogenic harm. All we can do now is hope that we will eventually arrive at a point where we can know in advance whom to

inject and when, but I fear the years of being content with anecdote have forever poisoned the well. The latest addition to the pain literature is openly observational. It is too soon to know where the *Journal of Observational Pain Medicine* will take us, but my fear is a lot of effort will go into work that will not be truly persuasive.

I spend a good deal of my time giving advice about medication. Generally all of this could be wrapped up in a single letter but we cannot come to an accommodation with primary care whereby a good, comprehensive referral – better than the all too common 'this patient has tried lots of medication' – leads to a comprehensive treatment plan from an expert that primary care follows assiduously. I only rarely get updates from primary care about patients whom

I am seeing so I rely on second-hand information via the patient or their carers. We are not blameless in this disorganised dynamic. We often keep patients under review to tinker with medications; we see them frequently and make very ordinary suggestions about changes in medication. We have an epidemic of opioid use, partly dignified by pain clinics' persistence with medication in the face of common sense. Medicating our patients is not the solution for most, partly because we fail to understand the difference between pain and suffering. A lot of this advice to general practitioners (GPs) comes from non-physicians and inexperienced physicians in training. We cannot, on the one hand, claim to be experts for these most difficult patients yet, on the other hand, devolve care to physicians in training or non-physicians. It is irrational; we must be able to do better than this. Non-physicians have a huge role in pain medicine, but it is not being Ersatz physicians in clinic.

Whenever two or three are gathered together in the name of chronic pain, the 'psychological aspects' of the illness are always mentioned. We all recognise the patient's psychological health as paramount to rehabilitation, often the main driver of the painful illness. We have failed to convey this to the rest of the profession. All referrers write from time to time 'I have explained that if you can improve his pain management, his mood will be much improved', which is true for some patients; but it is often written of patients whose mood disorder predates the painful illness by years, perhaps decades. Psychological input is often seen as a bolt-on extra, not part of the bedrock of making people better. Look at the UK chronic pain curriculum and count how few of the competencies relate to psychological health. Consider how little time our trainees spend on this, in contrast to time in theatre learning interventions of doubtful utility. As I write, an event taking place only a few weeks hence, 'Core Competencies in Mental Health for Pain Professionals', still has places available but the programme seems to cover only the more florid mental health issues and looks to leave the issues of the patient's ideation, the harm of failed interventions and of multiple conflicting opinions, the barriers to rehabilitation and such like untouched. These are the things we should be good at; they are things we can actually change, unlike personality disorder, lifelong proneness to depression, addiction and so on. Only physicians have the standing in the patient's eye to address a lot of these issues, yet we fail to train to do so. If we do learn it, it is serendipitous not systematic.

We have been better at rehabilitation – that huge endeavour we casually wrap up in the term 'pain management programmes'. Again this is often seen as a bolt-on, an extra to be deployed when all else has failed – all else being medication, injections and operations – with each failure, a psychological injury and often a physical one too. This sort of intervention is cheap and well evidenced, but we fail to deploy it

when it has the most chance of working – early in the illness. To the physician's shame it is physiotherapy that has taken the lead in this. Google 'Explain Pain': you may have reservations about Explain Pain – you will not be the only person if you have – but it unanswerably fills a void left by pain physicians, a void that seems, when filled, to do the patients a lot of good. The risk is that this type of rehabilitative work will be contracted out of mainstream pain, and done cheaply and badly in the community without the support of pain physicians.

Perhaps the worst failing of the speciality is that we take such polar views. Practitioners tend to be all about interventions or psychological management or rehabilitation or complex implanted devices, but it is a rare pain doctor who has a good balanced view of the place of each (although I have been lucky to work with a



group of doctors who do). Keen pain management doctors think that interventions are complex placebos, interventionalist see themselves as the last defence between the patient and the dustbin of a pain management programme.

There is one final glaring problem with chronic pain medicine in the UK. It stems from the lack of general physicians. The result of this is that more and more patients are coming to pain clinics direct from primary care without a diagnosis. Often we are used as the first doctors who have a second look at a patient about whom the GP is troubled. Since the primary, almost sole, source of pain physicians is from anaesthesia, this is a problem, as our training in general medicine is wanting. Critical care medicine has recognised this in its requirements for medicine in its training programme; we have not. Our trainees, if

lucky, spend short spells in palliative care, in rheumatology, but only rarely in other specialities that are plainly relevant. This is not good enough for critical care and should not be for us. All of us make new diagnoses from time to time; we should be equipped for that, not reliant on good fortune. We need to change our default perception that our physicians will come from anaesthesia. The new faculty has actually seriously damaged pain medicine by reinforcing this position. Again, critical care has overcome this and is the richer for it; we must follow its lead. Without a good general medical training, we cannot do the one thing that helps patients move on: namely telling patients they have gone as far as they can and there is nothing more to do. To me this intervention is the most powerful one we have, often the most liberating for patient and physician alike, but it is only in later years that I have gained the confidence to do so. We need the medical knowledge to do it properly and as everyone else is a super specialist not a generalist, no one else can offer the service. In any case, too often it seems no one else is willing.

There are many things that we have done better in my 30 years as a pain doctor. We have got so much better at cancer pain; we do have multi-professional units (I work in one – a jolly good one too) with a much wider range of treatments; implanted stimulators are much better and better understood; but there is so much more to do. We have not moved on enough from the anti-nociceptive days of my youth.

I may be too critical, both of myself and the speciality as a whole. We do help a lot of patients. Sitting typing this a few days before my last Christmas as a pain doctor, my patients seem finally to have worked out that I am a whisky drinker and the boot of my car testifies eloquently to their gratitude, but only rarely grateful for the type of success I bargained for when I started all those years ago. I think what has dispirited me so much is that our patients and our referrers are still looking for my old type of success and we can change that.



Pain Management Programmes SIG announcement

To do, or not to do, that is the question: Unintended negative consequences in pain management and rehabilitation.

Pain Management Programmes SIG Conference Jersey, UK Channel Islands 26–27 September 2013.

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

The plenary speakers this year are Prof Chris Main, Prof Stephen Morley, Prof Lorimer Moseley, Prof Mick Sullivan and Dr Mick Thacker. The local team and the special interest group (SIG) committee

are excited and proud to announce this line-up. We hope and trust that all professional groups will not miss the opportunity to access these internationally acclaimed figures in pain management, in one single UK-based meeting.

The conference will therefore include the usual fantastic variety of plenary presentations, and the layout has also been modified, based on previous feedback, to provide skills-development sessions, some of which will be repeated to give delegates an opportunity to have some flexibility in the sessions that they attend. There will also be a number of seminars and workshops allowing delegates to contribute their views and to generate discussion with speakers from many areas and clinical backgrounds.

The highlight of any Pain Management Programmes Conference is the opportunity to network and meet others with an interest in pain and its biopsychosocial management and the conference also aims to provide diverse opportunities for people to gather both formally and informally to continue the discussions from each day.

In 2011 the conference was held in Bath and attracted over 200 delegates from across the disciplines involved in pain management. The feedback was extremely positive. The team in Jersey have worked with the local tourist board so that travel and accommodation can be booked at extremely reasonable rates. Preferential rates can also be extended to friends and family accompanying delegates to Jersey, during and after the conference.

BPS Pain Patient Pathways Microsite Now Live!

The British Pain Society is delighted to announce that the Microsite for the Pain Patient Pathways is now live! BPS Members who do not have access to the Map of Medicine portal, may now view the British Pain Society endorsed pathways by accessing the link within the Members section of our website at: http://www.britishpainsociety.org/secure/members_articles_submenu.htm.

There are five pathways in total:

- Initial assessment and early management of pain
 - Spinal Pain
 - Chronic widespread pain, including fibromyalgia
 - Pelvic Pain and
 - Neuropathic Pain
-



CRPS in adults: UK guidelines for diagnosis, referral and management in primary and secondary care

Dr Mick Serpell, Glasgow



Our British Pain Society (BPS) was represented on a multidisciplinary group that developed a comprehensive

guideline on complex regional pain syndrome (CRPS). This guideline required a great amount of work over the period from 2009, to final publication on the website of the Royal College of Physicians in May 2012. Dr Andreas Goebel chaired the 18-member panel, which also included several patient representatives. They are to be congratulated for such a fine effort.

The guideline is an 84-page document and provides an excellent educational review of the condition. An important issue with CRPS is that there are various different disciplines where the patient might initially present with their symptoms. This guideline identifies the different pathways that the patient should travel

along depending on the route of entry. It identifies several different perspectives of health care involvement including: primary care; occupational therapy and physiotherapy; orthopaedic practice; rheumatology; neurology and neurosurgery; dermatology; pain medicine; and rehabilitation medicine.

The guideline contains 16 appendices on various useful aspects, such as the list of references, criteria for making the diagnosis, patient information leaflets, and even which health care sites have expertise or interest to which to refer the patient.

The guideline is freely available at: <http://www.rcplondon.ac.uk/sites/default/files/documents/complex-regional-pain-full-guideline.pdf>

The Painful Truth- New chronic pain report

Following a survey of over a thousand chronic pain patients across Europe, the report unveils significant unmet needs for millions of chronic pain sufferers across Europe and in the UK specifically who, despite trying several treatments and in some cases numerous surgeries, report that they continue to suffer with their debilitating condition and severe pain on a daily basis.

Some of the UK specific findings revealed that:

- **68% of respondents remain in pain for 12 hours a day or more**, despite treatment.
- **A third** of UK sufferers say their healthcare professional was interested or considerate of their condition, but **not very proactive or understanding** of the impact on their lives.
- **Only 1 in 10** patients in the UK is actually **referred on to a specific pain specialist**.
- UK sufferers miss on average, **11 days off work a year** due to their chronic pain.
- Nearly 4 in 10 UK sufferers say chronic pain has **negatively impacted their household income, with an average decrease of 37 – the highest in Europe**.
- **80% of UK sufferers say their marriage or relationship has been affected** by the chronic pain with over half highlighting that opportunities to enjoy activities together and sex/intimacy have been most impacted.



More details could be accessed at <http://www.epresspack.net/mnr/new-survey-finds-chronic-pain-treatments-are-failing-sufferers-across-europe/>

'Octave' analgesia

Arasu Rayen *Birmingham*

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*One good thing about music, when
it hits you, you feel no pain.*

-Bob Marley

I like music. Do you? I can listen to music almost everywhere – while I work on the computer; drive the car; commute in the train; jog; work out in the gym; and also in my injection clinic. Listening to music is a form of entertainment. Music is probably considered as one of the first forms of entertainment that mankind enjoyed. Throughout history it has played an important part in our lives regardless of which corner of the world we live. There is different music for different stages and emotions in our life. Rock music exhibits anger, ballads romance, folk songs the heritage of the country, spiritual songs our feelings about others and the afterlife, and so on.

Music is the art or science of combining vocal or instrumental sounds (or both) to produce beauty of form, harmony and expression of emotion, which is used for artistic, aesthetic, entertainment or ceremonial purposes. Music is ubiquitous; it is there in all social spheres of human life – religion, personal, entertainment,

emotional, and so on. Every day we see many people walking along the side of the road listening to music with their headphones on, not giving any notice to anyone walking next to them.

Music is used in the medical field as a complementary therapy. Recently I had a patient in my injection clinic who specifically requested to play classical music during the procedure. He told me that listening to classical music reduced pain during the procedure by distracting. Was he right? Does music produce analgesia by distraction? Or is music an alternative analgesic in its own right? Was Bob Marley right in saying 'when music hits you, you feel no pain'? Is there any evidence to show that music helps in pain management?

Earlier research

Studies looking at the effect of music in pain management date back to 1960. Gardner showed that the use of music reduced pain in 65% of patients who came for dental surgery.¹ In 25% of patients, there was no need for any anaesthetic during the procedure. Following this publication there were numerous studies looking at the same issue both in clinical practice and at the experimental level. Melzak et al. in 1963 reported that both the music and suggestions had a positive effect of increased tolerance in volunteers for experimental pain.² After publication of the 'gate control' theory and the establishment of the importance of psychology in pain management, there was an exponential growth in experimental research in music and pain management. This also led to a greater

understanding of the mechanism of action of music in pain management.

Mechanism

It is believed that music produces analgesia through three distinct mechanisms:

1. Hearing is a special sensory modality. Listening to music stimulates this special sensory system. This may produce analgesia by 'gate control' (counter-stimulation). Music was also shown to increase the production of different neurotransmitters. Baker suggested that listening to music releases endorphins in the body, which may be part of the reason for pain relief.³ It was also suggested that music might have anti-anxiety properties.⁴ Kumar showed that four weeks of regular music therapy increased the levels of melatonin, epinephrine and encephalins in the blood of 20 war veterans affected with Alzheimer's disease.⁵ Listening to music has also been shown to increase dopamine production in the brain.⁶
2. Music provides distraction (cognitive behavioural therapy).⁷ This may modulate the transmission of pain impulses through the limbic system and sensory part of the cerebral cortex.⁸
3. Music therapy is able to influence pain perception by its positive effect on emotions and memories. It reduces anxiety and depression and motivates people.⁷ Listening to music activates the prefrontal and limbic system of the brain as shown by positron emission tomography (PET) scans.⁹



THE BRITISH PAIN SOCIETY

Pain News

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SAGE

'Octave' analgesia

Music is used in pain management in two forms:

1. Passive music listening
2. Active music therapy

Passive music listening as intervention

This is a form of intervention where the subject or patient listens to the chosen piece of music while they experience pain to assess the effectiveness of the intervention. Some studies that looked at this form of intervention showed that even passive listening to the music relaxes and decreases the overall pain experience in the chronic pain patient.¹⁰ Mites called this form of treatment 'audioanalgesia'. He even equated the use of audioanalgesia to taking 'aspirin through the ears'.¹¹

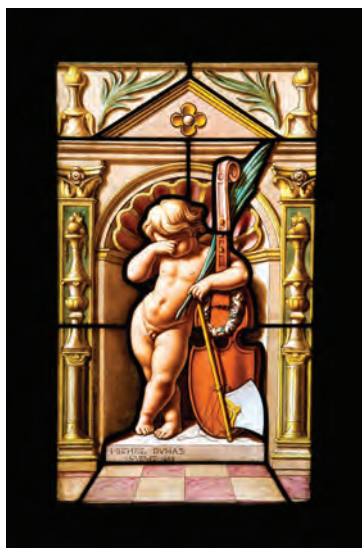
Active music therapy as intervention

Music therapy is a form of complementary treatment delivered by music therapists. It is cognitive behavioural therapy with music. Music therapists are accredited specialists (<http://www.hcpc-uk.org/>) trained in the prescribed use of music and music interventions to improve the physical, emotional and spiritual well-being of patients. They use various methods to achieve these goals: singing, playing instruments, rhythmic-based activities, improvising, listening and composing. Singing improves breath control and reduces anxiety and fear. Playing instruments increases well-being and self-esteem. Improvising and composing improve interpersonal contact and communication. Before embarking on treatment, the music therapist performs a comprehensive assessment including social, cultural, medical and emotional aspects of pain in the patient. As a general rule, both the music therapist and client take an active role in the session by playing and singing and

listening. The music therapist does not teach the client either to sing or to play any instrument. Instead the clients are encouraged to use any accessible percussion and their own voice to express themselves and explore the world around. The music therapist supports and encourages this process.

Literature evidence

Even with the increase in literature, there has been no definitive conclusion about the efficacy of music therapy because of the quality and poor standardisation of the research. Literature review and critical analysis of the available literature



showed that there was lack of randomisation, a reliance on indirect and unreliable pain measurement and a presence of too many uncontrolled variables.¹² Even though the quality of the literature has improved over the years, still there is a lack of very good-quality studies in this field, as illustrated by the recent Cochrane review in 2008.¹³ This evaluated the effect of music on the perception of acute, chronic and cancer pain and the analgesic requirement. The authors included only the randomised controlled trials, which evaluated the effect of

music on pain perception in the adult and paediatric population. In addition to the method of randomisation, demography, concomitant treatments and whether the analysis was based on intention to treat or not, the review also looked at the type of music employed, whether the subjects were allowed to choose the specific music or the type of music, duration of music exposure, how the subjects were exposed (headphones and loudspeakers), whether the subjects were allowed to listen to the same type of music or different types of music, opioid requirement and side effects. Of the studies taken into consideration, only 25% were of acceptable standard for inclusion. The author's conclusion was that the maximal reduction in post-operative pain intensity by music was between 0.9 and 1 on a 0–10 scale. Even though this reduction reaches statistical significance, the clinical importance was unclear. The review also revealed that the reduction in pain intensity did not depend on whether the patients were allowed to choose their music or not. The authors came to the conclusion that the 'numbers needed to treat' for music was five (meaning that five patients needed to be treated with music before one would have at least 50% pain relief). This is similar to the single dose of 325 mg paracetamol. Music also reduced the opioid requirement but very minimally – 1 mg in two hours and 5.7 mg in 24 hours; the clinical significance of this reduction is very minimal. The authors concluded that even though there is some analgesic effect, music should not be considered as a primary method of pain relief.

Oh, one last thing!

A few years ago, I was at the pain management conference, listening to the speaker talking about pain management. At the end of his talk he finished his presentation with a song 'I Live for your

Pain' by Halloween. I have been searching for a good song for MDT pain management. I came across 'Pain' by Three Grace. It begins 'Pain, without love', then it goes on:

*You're sick of feeling numb,
You're not the only one,
I'll take you by the hand,
And I will show you the world that you
can understand.*

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Annual Scientific Meeting 2013

There's still time to book to attend the British Pain Society Annual Scientific Meeting, 16-19 April 2013 at the Bournemouth International Centre (BIC), Bournemouth.

Why you should attend:

- Network with colleagues
- Raise questions, partake in debates and discuss outcomes
- Meet with poster exhibitors and discuss their research
- Meet with technical exhibitors and hear about their products and services
- Discuss your own research

To book your place and to find out more information about this year's meeting, please visit:

<http://www.britishpainsociety.org/2013asm/index.htm>.

New for 2013 – Student rates to attend the BPS Annual Scientific Meeting

This year a special rate has been introduced for students to attend the Annual Scientific Meeting of the British Pain Society. The rate applies to both members and non-members who are full-time undergraduate or postgraduate students. Once you have registered online a letter confirming your full-time student status signed off by your supervisor or administrative department of the university must be sent to the BPS Secretariat in order to confirm your booking.



A new website and discussion groups for the British Pain Society and the use of Monkeys? Results of the consultation of the BPS Council and Membership

Dr Rajesh Munglani, Chair of the Website Development Group and Council Member, British Pain Society

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I hope that many of you took the opportunity to participate in the online survey considering the future of the web presence of the British Pain Society (BPS). The BPS Council was becoming increasingly concerned that the website was not adequately fulfilling the needs of the membership and the secretariat staff who had to maintain it. The special interest groups (SIGs) wanted more interactive sections on the website, including the ability to upload documents and to facilitate discussion between members.

In addition, it was suggested that the application process to become a member of the BPS, renewal of membership and registration for meetings were all rather slow and

cumbersome; this could perhaps be streamlined and automated by a more efficient online process.

The calls from the membership for the setting up of online discussion groups win the most part, driven following the setting up of a group (by myself) for consultants in pain medicine a couple of years ago. This group now has over 350 members and by any standard has proved to be exceedingly popular and helpful both for clinical and related issues.

The BPS Council authorised a working party chaired by myself and ably assisted by a number of individuals who freely gave up their valuable time to meet in London. I reported the setting up of this group and membership in a previous issue of *Pain News* (Autumn 2011, p. 36). We came up with proposals that were examined by the Council and other interested parties. I decided that I would set up a survey to try and gauge the overall opinion of the Council about the website's priorities. I decided to try my hand at setting up a SurveyMonkey and found it exceedingly easy to do. Importantly, it would analyse the

results in a basic fashion and produce some pretty pictures of the findings. I set up an online SurveyMonkey initially to gauge the views of all those Council members who had contributed to the initial document and then created a similar survey for all the members.

The questions asked and the results of the final survey are given in Figure 1. 112 people took part and probably reflects those who are particularly interested in online activity. Accepting the fact that the results will be biased by who took part, we also have to accept that these are exactly the people who will probably use an updated website. We decided that certain things had to happen including ease of maintenance and adaptability of the website by the Secretariat; however we had to brainstorm other items that we need to put to the membership because each extra item would cost extra finance. Putting aside the basic issues like ease of maintenance, it was clear that Council and the membership wanted very similar features as seen below.

The results of the survey are in Figure 1. For convenience the questions are displayed above the graphs.

A new website and discussion groups for the British Pain Society and the use of Monkeys?



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

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18th December 2012

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The British Pain Society has a membership of over 1,400 and is involved in all aspects of pain and its management through the work of the Council, Committees and Working Parties. Further information can be found within this 'About us' section.

News
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IASP Global Year of Visceral Pain
IASP has announced 2012-2013 as the Global Year Against Visceral Pain.

AAGBI Innovation in Pain
The AAGBI invites applications for the 2012 AAGBI Prize for Innovation in Anaesthesia and Critical Care. This prize is open to all UK and Ireland based anaesthetists, intensivists and pain specialists. The emphasis is on new ideas contributing to patient safety, high quality clinical care and improvements in the working environment. Applicants should complete the application form that can be found at the AAGBI website: www.aagbi.org/research/innovation. The closing date for applications is Monday 15 October 2012.

National Pain Summit Final Report
Click here to access the 2011

There are many points to highlight, but what struck most of us on looking at the results of the responses to the first question is that as well as wanting accessibility from slow internet connections and mobile phones, many of you wanted regular email updates from the BPS to its members telling them what is happening in the world of pain. Interestingly, these content-rich email updates are relatively easy and cheap to set up and it does look like the Council may well institute this fairly promptly as it does not require the website to be revamped.

In addition, the Council and members of the BPS desired some form of discussion group activity. There are two ways to have these: one where you have to log in and then see what discussions have taken place; and the other is what is known as 'push e-mail', where as discussions happen, the emails come to your inbox. The latter can mean that your inbox can be rapidly bombarded by dozens of emails if there is a particularly vibrant discussion; however, one can modify this by having a once-daily email or summary of discussion sent.

Setting up of this type of system can be expensive but there is actually completely free software in the form of

Google groups, which has been used successfully by the pain consultants for their own group. I originally set up and run this pain consultant Google group and I also troubleshoot it; so far the system seems to run surprisingly well. However, there are very valid issues that need to be addressed, for example:

Who will moderate the discussion group?

What happens when somebody posts an inflammatory comment?

Do the posts get screened before they are put online or does this happen in real time?

What about legal liability of anything said on the group?

How do you know who everybody is?

Have the email addresses been verified?

How private are the discussions?

These are very important points that had to be addressed when the consultant discussion group was set up. From this experience, I hope that the setting up of the BPS discussion groups will be a much smoother experience. To

address some of these issues, there was a desire expressed to integrate such discussion groups into the website, so that when one logs in to the website as a member, one will automatically be known when one then logs in to the discussion groups. However, this would prove more expensive and leads to the second question (Figure 2).

As it can be seen, there was a strong desire for the discussion groups. If the cost was too high then we would need to use the independent free software to set this up, if we could address the other issues.

Coming back to the financial issue, the BPS like other charities has experienced a reduction in income and therefore has worked hard to improve its efficiency. The President no doubt will inform you of the decisions that have been made, so the question from my point of view was: Is it actually necessary to revamp the BPS website at all? The BPS Council was very keen to revamp the website and Figure 3 shows its views alone.

Interestingly, when the same question was asked of the membership this was the response (Figure 4).

As can be seen, most of you felt that a general revamping of the website could probably wait until finances improved. Accepting that those who took part would generally be interested in online activity, a significant minority did not feel that revamping the website was very important. The significance of this finding will need to be taken on board by the Council, particularly as there will be a cost implication for revamping the website and for maintaining it at a higher level of 'web presence' than currently.

These findings are still being considered by the Council, but it does seem that so long as we institute well-monitored and moderated discussion groups and send out content-rich emails to inform the membership of current issues, then we will have fulfilled two of the main desires of the membership.

A new website and discussion groups for the British Pain Society and the use of Monkeys?

Figure 1

We as the Council have commissioned a sub group to look at redeveloping the British Pain Society website. We have identified a number of features we think are absolute priorities and will be commissioned on the new website regardless, including ease of updating of the website for the Secretariat, calendar of events, council only section and provision on the website of publications from the BPS including the Newsletter and British Pain News. We need to know what other features you would like because every additional feature will involve expense. For explanation if we mention push e-mails that means the e-mails will be delivered actively to your e-mail box otherwise you will have to log in. This is a crucial difference for different types of discussion groups, some of which you need to log in to and others where the discussions will be sent directly to your e-mail box (push emails). Please rank the following items, if you rank something as number one then it will be the highest priority, as you rearrange

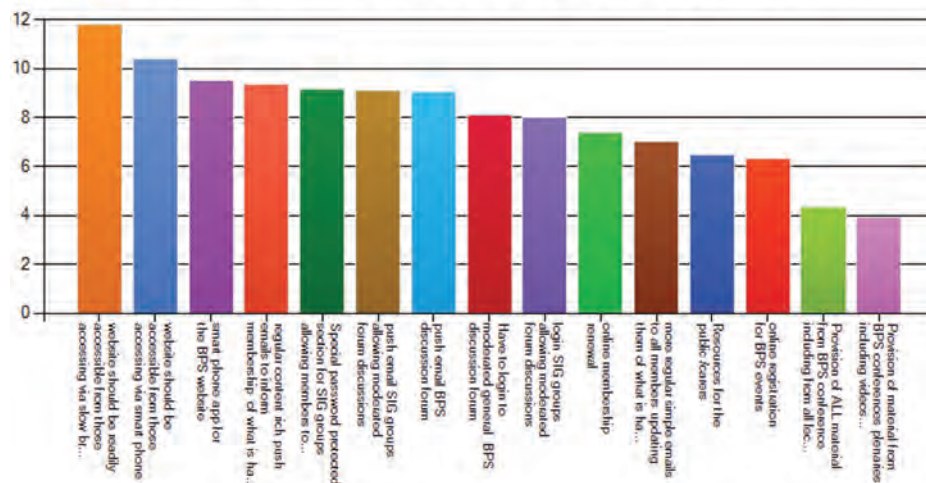
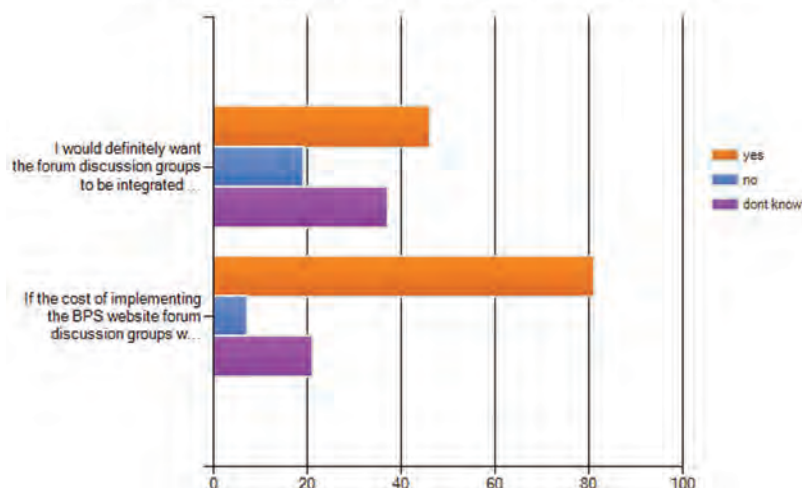


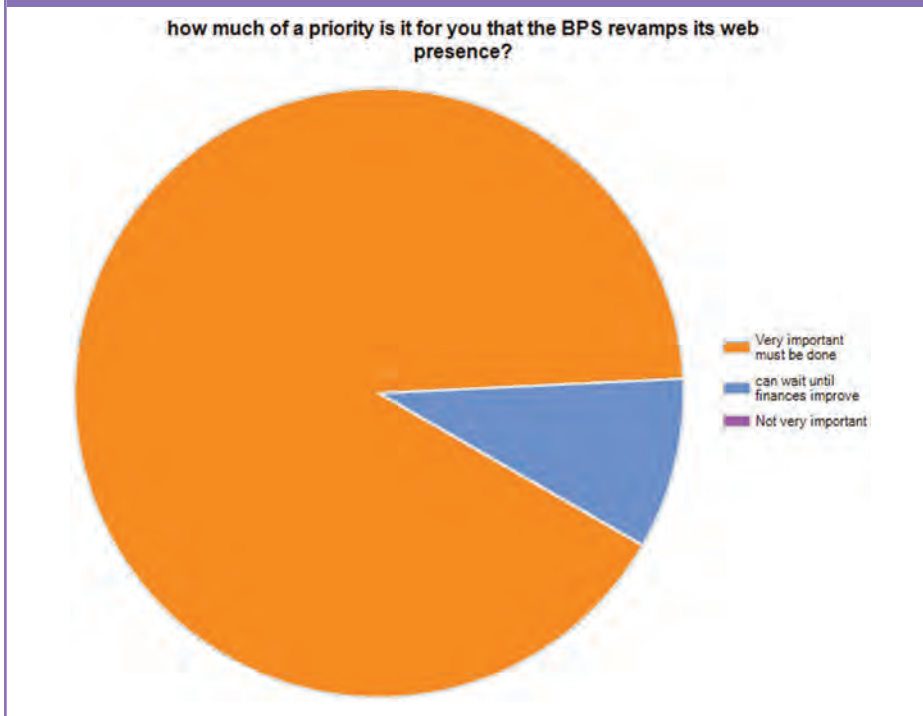
Figure 2

Preamble : If the development of the general BPS and SIG discussion forum could be done free of charge say by utilising free google software, would this be preferable then to having it developed and paid for as part of the BPS website? Please note just because its free doesnt mean we should go for it, implications might include that members would be less likely to login to the website. Also control of identity and membership of discussion groups could be much more easily linked to BPS membership using our own website. However by using google, it does mean if the BPS website went down, the discussion groups would continue. We have posed two questions below



A new website and discussion groups for the British Pain Society and the use of Monkeys?

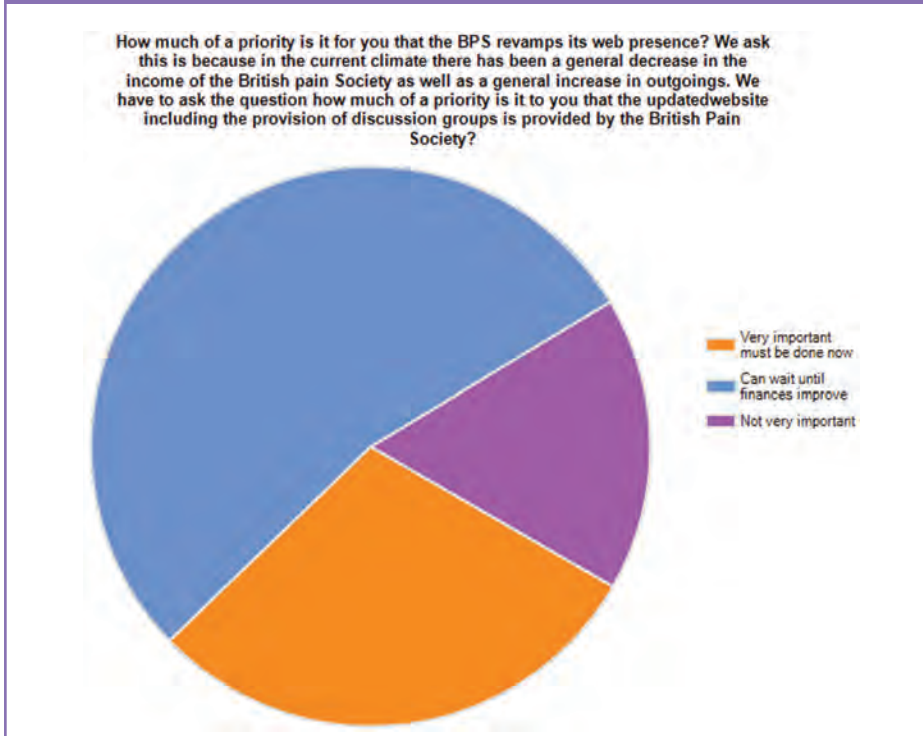
Figure 3



Economically, it is going to make sense to link membership renewal and online registration for the Annual Scientific Meeting, as well as making the website easier to maintain, as we will save a lot of money. I think we will probably end up redeveloping the website in a modular form, but this will be for the technical personnel to tell us how feasible it will be.

Thank you for taking part in the survey, I hope you will notice the benefits of all this activity very soon, and of course we will keep you updated of the developments.

Figure 4





THE BRITISH PAIN SOCIETY

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SAGE

Numbers needed to heal, numbers needed to harm, numbers needed to kill: reflections on opioid therapy and the primary duty of medicine

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I sometimes think that, having been called to practice the healing arts, and in particular the noble art of medicine, I feel like part of a wandering tribe in the desert.

Nothing ever seems to stay the same. While the human body and mind is probably more or less now what it was a few thousand years ago (perhaps a bit fatter from too much cereal consumption and soda pop and resulting in a little more type 2 diabetes and cardiovascular disease – but that is another story), everything else to do with caring for the human condition changes at a frightening pace.

Models of disease process and inferred practice that were considered acceptable and routine a generation or two ago are now considered to be grossly misleading and dangerous. I could mention blood-letting to quench fevers, but a more telling story is the account of how it took many years for the medical profession to accept that the main cause of upper gastrointestinal ulceration was not too much acid but instead a bacterial infection. Between 1984 and 1989, two Australian scientists Warren and Marshall published five papers in highly reputed journals that conclusively showed that it was in fact a

bacterium *Helicobacter pylori* rather than stomach acid that was the cause of gastrointestinal ulceration. Despite this, the medical profession continued for many years to prescribe ineffective antacid drugs and drastic surgery.¹ At one point in 1988, frustrated at the deaf ears and unmoved hearts and minds, Marshall infected himself with the *H. pylori* bacterium and of course promptly developed gastritis. It took approximately another five to 10 years before the medical profession finally came round to believing that the best way to treat stomach ulcers was to provide an antibiotic cocktail. Finally in 2005, Warren and Marshall were awarded the Noble Prize for medicine.

Why did it take so long for people to change in the face of new evidence?

In one commentary on this subject, it is stated that people regarded as experts become used to doing something one way for decades; they do not like to admit that another way involving a paradigm shift might be better. The commentators decided to call the systemic reticence to accepting the obvious change the Warren and Marshall

syndrome.² From my point of view it seems not quite the appropriate catchphrase as Warren and Marshall were the ones who pushed the change rather than inhibited it.

I am also reminded that in 1900, Lord Kelvin – an undergraduate at Peterhouse, Cambridge – was infamously attributed as saying: ‘*There is nothing new to be discovered.... now; All that remains is more and more precise measurement.*’³ This was quoted just, of course, before Einstein published his theories of relativity in 1905 and 1916.⁴

But the concern is that we who regard ourselves as experts, naturally think we know most of what is important to know about a subject; we examine every new idea with a critical mind and hopefully with understanding to realise if something truly new has been discovered. We need to be able to distinguish the useless snake oil from the highly effective tincture of opium that may relieve the suffering of all mankind. However, it does mean on the flip side that we as experts are less likely to accept a novel but possibly true idea if it does not fit the paradigms we have grown up with. The concept that getting rid of a fever by blood-letting, or that

Figure 1

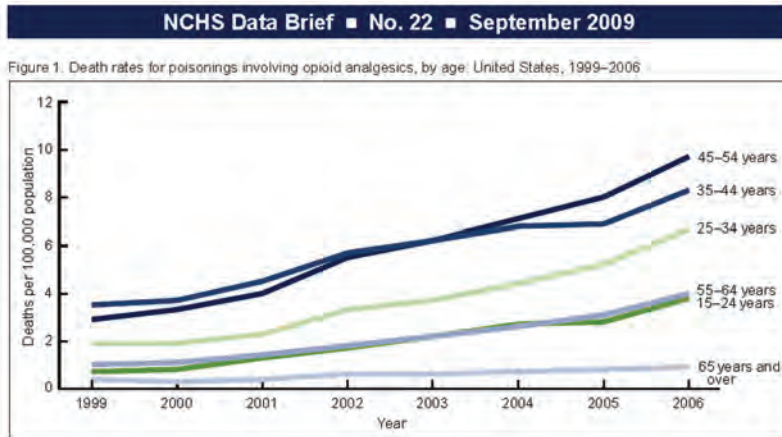
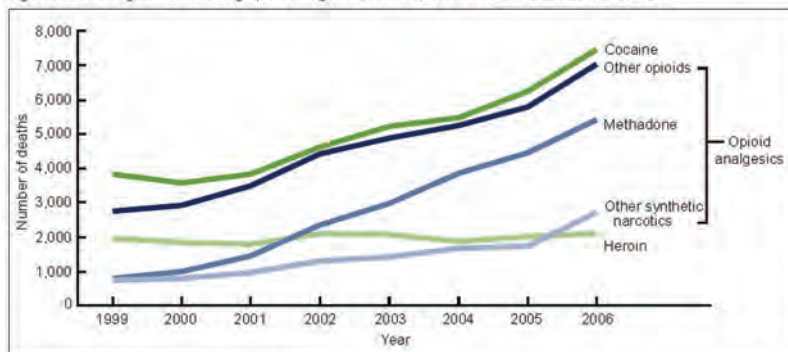


Figure 2

From 1999 through 2006, poisoning deaths involving methadone rose more rapidly than those involving other opioid analgesics, cocaine, or heroin.

Figure 2. Poisoning deaths involving opioid analgesics, cocaine, and heroin: United States, 1999–2006



NOTES: Drug categories are not mutually exclusive. Deaths involving more than one drug category shown in this figure are counted multiple times. Access data table for Figure 2 at http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/Data_Briefs/tb022/tb022.xls.

bacteria rather than stomach acid causes ulceration, can be particularly difficult to shift if the implicit message when we were taught implied that we were being told the absolute and incontrovertible truth.

It has come as quite a shock to many of us in pain medicine that a drug that we had all considered to be relatively safe, now has been shown to be a major cause of morbidity and mortality both for

the individual and society in general. Around 2004, we were just recovering from the COX-2 inhibitor story,^{5,6} thinking that initially these new type of drugs were going to mean that we could provide anti-inflammatory medication and analgesia to our patients without the nasty side effects of stomach erosion, kidney failure and so on, only to find that they dramatically increase the chances of heart attacks and strokes to the point

where the guidance from the medical authorities is now to virtually avoid using any COX-2 inhibitor and indeed to prescribe any nonsteroidal anti-inflammatory drug (NSAID) now in the smallest dose for the shortest period as they all share similar properties. Many of us switched to prescribing the seemingly safer opioids in view of the increasing dangers shown to be associated with anti-inflammatory medication.

However, there was another story that was unfolding, namely that there had also been a fairly aggressive increase in the use of opioids, particularly in the USA with a tenfold rise in opioid consumption in the last 20 years since 1992 and in particular, of the drug Oxycontin, which was aggressively marketed as the extended version of oxycodone on release in 1995. Between 1997 and 2002, the amount of oxycodone use quadrupled.⁷ But even at this time, clouds were looming over the 'safe opioid story', data were already emerging suggesting that the prescription of opioids was anything but benign. The National Centre for Health Statistics published a paper in 2009 reporting an increase in fatal poisonings in the USA between 1999 and 2006.⁸

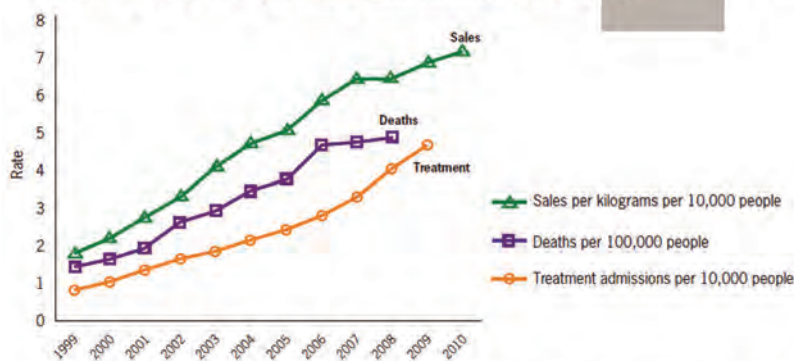
What was worrying was that the increasing death rate was particularly among younger people (see Figure 1). Overall the death rate tripled, particularly among young white males, and this particular study specifically highlighted methadone but also other opioids as a particular drug associated with these deaths.

It was known that states like, for example, Florida had very high death rates that were associated with inappropriate prescribing – three times the rate of prescription of opioids compared to Illinois. As one commentator put it, there was no evidence that the people in Florida suffered more chronic pain than the rest of the USA. Another comment was that enough prescription painkillers were

Numbers needed to heal, numbers needed to harm, numbers needed to kill

Figure 3

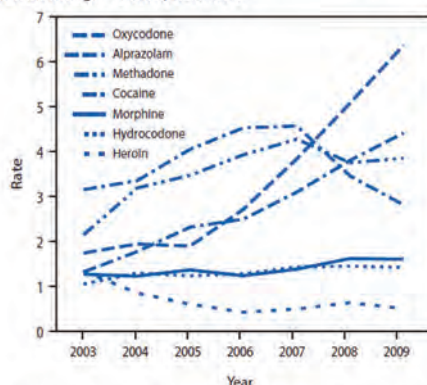
Figure 3. Rates of prescription painkiller sales, deaths and substance abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

Figure 4

FIGURE 4. Annual drug overdose death rates* for selected prescription and illicit drugs — Florida, 2003-2009



* Per 100,000 population. Based on U.S. Census resident population estimates. Available at <http://www.census.gov/popest/states/states.html>.

prescribed in 2010 to medicate every American adult around the clock for a month. In fact, in the same year, 2 million people reported using prescription painkillers non-medically for the first time – nearly 5,500 a day. Although most of these pills were prescribed for a medical purpose, many unfortunately ended up in the hands of people who misused or abused them. It was noted that most prescription painkillers were prescribed

by primary care and internal medicine doctors and dentists, not specialists. Roughly 20% of prescribers prescribe 80% of all prescription painkillers.⁹

The report also noted:

[A]lmost all prescription drugs involved in overdoses come from prescriptions originally. However, once they are prescribed and dispensed, prescription drugs were frequently

diverted to people using them without prescriptions. More than three out of four people who misuse prescription painkillers used drugs prescribed to someone else.

The Centre for Disease Control published a paper in July 2011¹⁰ stating that during 2003–09, death rates increased for all substances except cocaine and heroin. The death rate for prescription drugs increased by 84.2%, from 7.3 to 13.4 per 100,000 population. The greatest increase was observed in the death rate from oxycodone (264.6%), followed by alprazolam (233.8%) and methadone (79.2%). By 2009, the number of deaths involving prescription drugs was four times the number involving illicit drugs.

A further example came from West Virginia when it was noted that there was a 550% increase in unintentional overdose opioid-related mortality between 1999 and 2004. While it seemed initially that the majority of the problem was due to diversion of opioid prescription to mainly young white males – two-thirds in fact, and this was often accompanied by doctor shopping¹¹ until a prescription was obtained – it also became clear that *about one-third of the mortality was actually in those patients who were prescribed the opioid in the first place*. Thus, this phenomenon of a massive rise in the marketing, sales and prescriptions of opioids was not just a problem of diversion that could be seen as a simple (mainly US) sociological problem, but also was the cause of unintended mortality among patients who were being prescribed opioids.

In a Canadian study, where opioids are prescribed on state funding without the financial incentives present in the USA, between 1997 and 2006, patients who were prescribed more than 200 mg of morphine a day were three times more likely to die as a consequence of the prescription.¹² Bonerht found the overall death rate to be in the order of 0.04%

among those given an opioid prescription in a study funded by the Veterans Administration.¹³ The risk was in fact substantially higher with higher doses of morphine above 100 mg, being almost 10 times higher than if one was prescribed up to 20 mg per day; the risk was also substantially increased in those with a history of substance abuse and those on combined regular and *pro re nata* (PRN) prescription. Even accepting the lower overall risk of 0.04%, this worked out at one death in 2,500 patients.

The sharp eyed among you will notice that the figures above do not give any indication over what time frame the risk was present and in fact the authors worked out that the approximate average death rate per 1,000 chronic patient months was approximately one. That is, one patient would die every month for every 1,000 patients taking an opioid prescription. By any accounts this is an extraordinarily high death rate, even higher when one takes into account doses above 100 mg of morphine equivalent, substance abuse and the type of prescription.

This made me think about whether it was worth it. One could argue that if one person died but 999 every month 'thanked God for their doctor and their prescription' for the relief of their suffering, one could argue that providing a quality of life to 999 out of every 1,000 patients per month is not really that bad so long as everyone were aware of the risk. After all, lots of treatments in medicine are risky. The chances of dying on the road every year for each one of those is approximately 1 in 17,000; the chances of an over 75-year-old on an anti-inflammatory developing gastrointestinal haemorrhage is 1% per year according to Bandler.¹⁴

However, what is the evidence that a prescription of opioids is effective for our patients in the first place? One of the studies above suggested that 3% of the American population was taking regular

opioid prescriptions. Presumably this is for severe pain... or is it? Is a complaint of pain a justifiable enough reason to give an opiate prescription? Would we have been negligent if we did not treat the pain and suffering of a fellow human being? It has been argued by Margaret Somerville, professor of law and medicine at McGill University, that the unreasonable failure to provide adequate pain relief constitutes negligence.¹⁵ Should we take patients at face value? If we did, we might be in trouble. In the Grampian Region of Scotland, one study put the incidence of self-reported pain as over 50%.¹⁶ On the face of it, other studies also support the very high incidence of self-reported musculoskeletal pain in the community, with a study from Europe giving rates of up to 50% or so for various pains, particularly with rising age.¹⁷ However, a further analysis in the same paper shows that while the incidence of general complaints of pain may be up to 40%–50% depending on age group studied, the prevalence of clinically significant pain is much lower at about between 3% and 15%.

More importantly, it is crucial to recognise that the perceived pain may be a symptom of another underlying diagnosis, or may certainly be exacerbated by it, in particular depression.¹⁸ Indeed, some authorities believe that many cases of fibromyalgia are generally a manifestation of depression.¹⁹ Failure to recognise that many factors may contribute to the final common presentation of pain is a profound mistake. The commonest error is to prescribe strong opioids in the presence of severe depression, distress and complaints of pain, often on an unrecognised background of past history of significant psychological problems including drug abuse²⁰ and alcohol problems in the vain hope that they will help generally. As one author put it: 'Opioids are being used to treat this undifferentiated state of mental and physical pain.'²¹

The presence of depression or anxiety has to be recognised in such patients and treated independently by pharmacological, psychological or other techniques.²² The largest studies of opioid treatment of chronic pain suggest that particularly in this distressed group of patients, improvements in either pain scores or quality of life are *not* achieved.²³ Becker et al. (in Denmark, with the world's highest rates of opioid prescription and consumption) suggest that those who go on to opioid therapy already had significant comorbidity and were already consuming *five* times the health care resources *prior* to the initiation of opioid therapy, and indeed already are more likely to have had pre-existing drug and alcohol problems.²⁴ Although interestingly, Eriksen and his co-authors reported that addiction rates in their study patients (again in Denmark) were comparable to the general population.²⁵

Yet it is clear that subgroups of (correctly chosen) patients can do well with opioids on a number of measures, including addiction rates of less than 1%^{26–30} and doctors with a little training can instinctively predict who are likely to do well.³¹ On balance, carefully chosen opioid prescriptions in carefully chosen patients are unlikely to cause long-term morbidity and mortality.³² However, we need to recognise that currently the patients who end up on opioids may have severe pre-existing risk factors such as anxiety, depression and addiction problems,³³ and quite simply, these patients need to be recognised and treatments planned more carefully for them.³⁴ These points have been highlighted by the British Pain Society in its opioid prescribing and other guidelines³⁵ and by Joan Hester in the *British Medical Journal*.³⁶

It is also becoming increasingly clear that not all opioids are the same: diversion of opioids from their intended recipients is less likely to take place with sustained release-patch formulation, particularly the newer opioid patch

Numbers needed to heal, numbers needed to harm, numbers needed to kill

medications such as Butrans and Transtec (Buprenorphine patch) or Fentanyl patch (Durogesic patch); problematic addiction problems and dose escalation is less likely particularly with buprenorphine, which incidentally, is used to treat opioid addiction in some countries.^{37–39} However, it is clear that further research is required.⁴⁰

What are the alternatives to prescriptions of analgesics? Talking therapies? Pain management programmes? They are certainly unlikely to harm our patients, but are time intensive and expensive. One study looking at the efficacy of practice-based cognitive behavioural therapy found significant gains in only one out of four to seven patients.⁴¹ A recent view in the *Lancet* by Turk et al.⁴² makes very sobering reading as it states: *'psychological treatment as a whole results in modest benefits in improvement of pain and physical and emotional functioning. ...evidence for the long-term effects is inadequate, and evidence is somewhat contradictory for effects on vocationally relevant outcomes.'* In fact the article is not particularly positive about any pain

treatment including any pharmacological or interventional therapies, stating that very roughly: 'the best evidence for pain reduction averages roughly 30% in about half of treated patients, and these pain reductions do not always occur with concurrent improvement in function.'

Against this modest benefit of active pain therapy, the authors suggest that placebo-based responses range between 10% and 20%. The authors go on to state that this is hardly surprising in view of the complexity of chronic pain; in the absence of a cure we need to maximise pain relief so that patients are able to lead the highest quality of life possible. They also mention managing patient expectation, but even more importantly they go on to state that because of the complexity of pain, the individual tailoring of a treatment to an individual is paramount and this is where future research should lie. We all have patients who have responded dramatically to one particular type of treatment or another. The real issue is how not to do anybody else any harm in the process of selecting the one who benefits. In the absence of a large group affect for any type of pain treatment, individual selection of patients is paramount.

Primum non nocere

First, do no harm, and second, show a degree of humility not only as to the cause of what is troubling our patients, but how much we think we know about the treatment we are providing and how much good it will do. It is not that we get things wrong that is the problem, particularly when everybody else has made the same mistake, but it is a failure not to listen when evidence is there in front of us that we may have got things wrong and we continue to insist on keeping deaf ears, hard hearts and closed minds. If the wandering tribe of Israel had been a little more open perhaps they would not have had to wander around the desert for 40 years.

Conflict of interest

Part of this article was submitted electronically as a letter to the *British Medical Journal*. All mistakes, opinions expressed and misleading statements are entirely the responsibility of the author.

References are not included but can be obtained from the author by email.

Hard work never killed anybody

Dr Alan Roberts GP for 37 years, senior FME 34 years (retired) and medical member of the Tribunal Service

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Hard work never killed anybody

That was the beginning of a statement from Ronald Reagan in 1987...

Hard work never killed anybody, but I figure why take the chance.

It is true of society that some people are work-shy and do not want to work and either feign or exaggerate illness for benefit – but that represents a relatively small number of people. The majority of those on sickness benefit have been stigmatised or believe that their illness is not conducive to work, just because they have a diagnosis.

Diagnosis is *not* disability.

As such, the Department of Works and Pensions (DWP) is looking on a national level at all people on benefit. It gets it right probably 70% of the time, either allowing or rejecting claims. The remainder of the time, the patients appeal against the decision to either get benefit or increase benefit. To put things into perspective, Employment Support Allowance (ESA) is approximately £70 per week and Disability Living Allowance (DLA) is approximately £20–£125 per week depending on the problems. So potentially, full DLA for 40 years is about £250,000 for *one* person.

The number of appeals in 2008–09 was 250,000; in 2009–10, 340,000; in 2010–11, 420,000 – and the expectation for 2014–15 is 625,000.

The reasons for this are that all Incapacity Benefit (IB) is to be migrated to ESA

(1.5 million) and April 2013 will be the start of the migration of all DLA

(1.7 million) to Personal Independence Payments (PIP), at the same time that

the DWP is introducing Universal Credit to replace many benefits.

Although the figures are massive, the government is not doing this solely as a cost-cutting exercise but as a change to society to make work pay and make people believe that they have the potential to work and contribute. I make no comment on the employment situation; I am not a politician. I understand that the thresholds for ESA and PIP will be harder to reach than IB and DLA/AA.

IB was relatively easy to successfully claim in the 1990s and in 2008 the benefit was changed to ESA, which was the first benefit to have descriptors. Descriptors are specific points for specific tasks that the patients can or cannot do. These rules were tightened in 2011 to make it slightly harder to claim benefit: for example, in the 2008 rules, the question was about walking 50 or 200 m; in 2011 it was changed to mobilisation. In other words, a patient under the 2008 rules who had bilateral amputation could not necessarily walk, unless using artificial limbs, but under the new 2011 rules could use a wheelchair with his/her arms and as such lose points.

I will add a website at the end for the descriptors, as there are so many to list, but as a general rule, claimants need 15 points to qualify for ESA. So they may get a 15-pointer or a 9 + 6 pointer or 3 x 6. As you will see, it is all focused on the disability not the diagnosis.

DLA, at present, has two components: mobility and care.

The mobility component has two levels:

High – if the patient cannot physically walk for 50 m.

Low – if the patient needs guidance or supervision, usually for patients with



mental health-type issues, severe learning problems and so on.

The care component has three levels:

Low – attention for up to one hour per day or the main meal test, which is an assessment of whether the patient can make a main meal in the day, *not* that they do not cook because their partner does it.

Middle – in summary is frequent attention to bodily functions or continual supervision to avoid substantial risk or danger, and normally means the carer has to be present – this may be for day *or* night attention.

Highest – as for middle *but* for day *and* night attention (virtually 24 hours and nursing home-type patients, although some families do this in their homes).

In April 2013, DLA is being changed to PIP, which is a new descriptor-based benefit. At the time of writing, I have not had any training so I cannot be specific. However, history shows that the thresholds will be tightened.

The process that the patients have to go through is primarily a paper trail in the DWP process and if they appeal the case is handed over to the Courts and Tribunal Service for review.



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Initially, patients apply to the DWP and they are allowed or rejected on the paper information. If the patient disagrees, he/she can appeal to the DWP to review the decision. This is done by another member of the DWP and might *not* be at the patient's local office; the reviewer of the decision might be in London or Glasgow and will review the same paper/electronic information, but will not see the patient in person.

The reviewer will have the medical report from Atos included with the paperwork, as well as the patient's request. The Atos medical is performed by either a nurse or a doctor who works for Atos and it is based on a computer system called Logic Integrated Medical Assessment (LIMA) – the information is based on drop-down menus and no narrative. They are *not* part of the appeal process, just as we are not part of the original decision.

If the case is disputed by the patient at a DWP or Atos level, and the patient appeals, the whole case is handed over to the Court and Tribunal Service, which is part of the judiciary of the UK.

When the patient attends the tribunal hearing, they can attend alone, with somebody for moral support or somebody to represent them, and make a submission to the court for what they are requesting.

The tribunal is a legal court hearing, albeit on a slightly less formal basis.

There is a judge and doctor for ESA cases and a judge, doctor and disability member for DLA cases. The disability member may be someone with a disability or someone like a nurse, occupational therapist, physiotherapist and so on, trained in disability.

We ask questions to the patient, without any interruptions or prompting from the family, as it is a legal process and the judge transcribes all the answers. If the patient wants anybody else to comment at the end of the questions they are allowed to do so. The questioning is open in nature; we have to encourage the patient to talk and make the whole process conducive to talking. We normally ask the patient to describe their day, how they get about, how they cope and so on, as well as confirmation of diagnoses and medication. Sometimes the situation has changed since the claim, and the appeal may be some six to 12 months later, so we ask about any changes if they are relevant.

The whole process takes about 30–40 minutes and the patient goes outside while the decision is being made. They are called back to receive the verdict from the judge.

We are often the first human face in the whole claim process and most claimants

are grateful for the time to put their case forward and for our time listening, even if their appeal fails. We are not sitting in a clinical way, but an inquisitorial, evidence-gathering way to come to the correct decision. The legal test is the civil 'balance of probabilities', not the criminal 'without a shadow of a doubt'.

There are some specific regulations regarding particular conditions, but there is also a regulation that allows us, with ESA, to say that people are unfit for work when there is no obvious physical disability and that saying they are fit for work would make them worse. As with medicine, every case is different and individual. On average, we allow about 30%–40% of appeals and refuse 60%–70%.

We are human and sometimes we make a view on the paperwork when it is reviewed prior to the sitting, either to the positive or the negative, and when we see and hear the patient in person we sometimes change our mind – *just like in general practice or hospital medicine*.

Some clinicians write long, detailed reports, some write short, vague reports and others have a standard letter that says we do not have the resources to do this 'private' work as it is not part of the National Health Service. I will leave that to your discretion.

Employment Support Allowance and the Pain Team

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I would like to support Drs Jenkins and McGurk's suggestion (*Pain News* 2012; 10: 239) that we get involved with the

reformed welfare system. There are many ways of doing this; one of them is to join the ranks of medical panellists

appointed by the Judicial Appointments Commission (JAC) to hear the appeals raised against the

Department of Works and Pensions (DWP) by those who have had their applications rejected. The current surge in appeals has largely come about as a result of migration from Incapacity Benefit to the replacement benefit, Employment Support Allowance (ESA). Clients who wish to challenge the DWP's decision are allowed to appeal, which may result in an appeal being heard in person, or if they elect not to present, the case is heard on the papers alone. It is well recognised within benefits advice circles that the chances of achieving a successful outcome are much greater if the appellant attends the appeal. The odds improve further if they attend with legal representation. However, the majority who do subsequently appear, do not have the advantage of professional representation and may have great difficulty understanding the documentation they have been given.

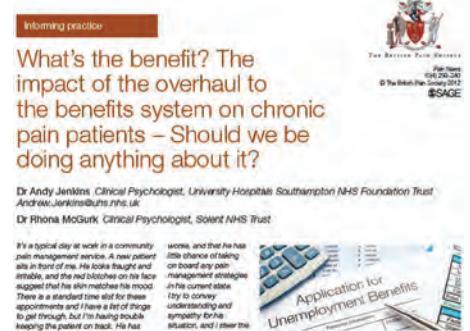
The appeals are heard by a panel made up of a tribunal judge and a medical member. The latter may have come from a variety of backgrounds, but were mostly retired or part-time general practitioners in the past. There is currently a recruitment campaign in progress to increase the number of applicants and also to broaden the range of experience within the panels. I have worked as a part-time medical panellist for the Tribunals Service for about eight years and have found it one of the most rewarding professional activities to engage with. I would urge you to consider applying for one of these roles and if you can get past the administrative jargon that seems to permeate every layer of the civil service, there is a lot to enjoy. There is also a lot to be learned.

It may help to understand the degree of difficulty faced by our clients, to quote from one of the induction manuals for medical panellists giving guidance on how to deal with the terminology used in the appeals process:

The structure of the benefit (ESA) is rather more complicated than most other benefits. Successful applicants for this benefit will be placed in one of two categories. The first is what is known as the work-related activity group. This applies to those claimants who are deemed to have limited capability for work. The second group is the support group where claimants are deemed to have limited capability for work-related activity.

One could read this key advice again and again without gaining any insight into the benefits system at all. Clearly, the welfare reform process has not only created more appeals, it has also added another layer of unhelpful terminology on top of the already complicated Social Security Regulations.

Fortunately, all panellists receive first-class training and continuing education to help them deal with the difficulties raised by the new regulations and emerging case law. The ESA appeals are almost wholly based on medical evidence, in the format of the Work Capability Assessment and any medical reports submitted, together with oral evidence produced by the appellant on the day. The interpretation of medical evidence is a key function of the medical member,



and it is both helpful and rewarding to be able to explain the meaning of terms such as 'impingement of the hip' or 'sequestered lumbar disc' to the tribunal judge in a meaningful way. In this respect, fibromyalgia and chronic fatigue syndrome are just as challenging and common in appeal tribunals as they are in the pain clinic. That kind of experience can usefully inform the appeals process, where disputes often arise from the lack of understanding of the impact that chronic conditions may have on ability and capacity for employment.

The JAC holds regular recruitment exercises through medical journals and increasingly online at <http://www.judiciary.gov.uk>. The money is not great, but the opportunities to widen your professional interests and ensure that members of the public with disability are treated fairly are so much greater. Looking forward, the DWP is now embarking on a similar exercise with Disability Living Allowance, which will soon be transformed into a new benefit called Personal Independence Payment. I can safely say that you will hear a lot more about this process from your patients in the coming years, and that your involvement with it is practically inevitable. Who knows, you might even enjoy it.

Conflict of interest

Dr Wright is a part-time medical member of the First Tier Courts and Tribunal Service, Social Security and Child Support Entitlement Chamber.

Traveling Pain School



THE BRITISH PAIN SOCIETY

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The years leading up to and immediately following India's independence were decidedly tumultuous. A remarkable man, however, was going about

his work with serenity. His pioneering work was to benefit millions around the world in years to come, and inspire many generations of clinicians. His cherished goal was to rehabilitate and restore self-respect among people living in what he called the land of painlessness. India was then home to millions of leprosy sufferers and thousands of leper colonies. The problem with leprosy was painlessness, which left patients unprotected from injuries, often with disastrous consequences. His *Pain: The Gift Nobody Wants* (1993) was an account that was in equal parts fascinating and powerful, and a treasure trove in its entirety. His revolutionary idea was that leprosy attacked the sensory nervous system resulting in patients losing warnings of pain. The resultant tissue abuse and loss of body parts, therefore, was not because of inherent decay brought about by the disease, but entirely due to infection and thereby preventable. The man with the radical idea was Dr Paul Brand. Born to English missionary parents in 1914 at the remote Kolli Hills – the ancient kingdom of the much celebrated philanthropist King Valvil Ori in Southern India – Brand was sent to England for further studies. On his return, following medical training, he joined Christian Medical College & Hospital in Vellore, India, to herald a new chapter in the science of rehabilitation.

As is Brand's story, so is pain medicine: rarely taught in our medical schools. There is, however, much inspiration to be drawn from the former to address the latter. But ours is a nation of idiosyncrasies. While Brand's groundbreaking rehabilitation methods were creating ripples across the world, we were busy legislating against leprosy patients from contesting elections (repealed as recently as 2012), obtaining driving licences or travelling in trains. Similarly, pain clinics figure prominently in the assessment form for accreditation of postgraduate courses by the Medical Council of India (equivalent to the General Medical Council), but pain management is not part of the curriculum in either undergraduate or postgraduate courses. A damning Human Rights Watch report in 2009 said:

Official curricula for undergraduate and postgraduate medical studies do not provide for any specific education on palliative care and pain

management. As a result, the vast majority of medical doctors in India are unfamiliar with even the most basic tenets of palliative care or pain management.

Since then there have been certain cosmetic changes, but nothing to stop one wondering – particularly when in a nihilistic mood – whether we are a nation of flower and fresh air lovers without the sense of smell, à la Wordsworth.

With initiative from the top not forthcoming, the choice of training opportunities in pain medicine in India is limited to private enterprises and a handful of government-run hospitals. Typically run as a two- to four-week programme of observership, the private enterprises tout injections/interventions with alacrity, at the expense of multidisciplinary pain management. Like Kipling who wrote *Mandalay*, without ever setting foot in the Burmese city, the observers too (without any hands-on training and with their wallets





much lighter) go away to set up pain practices. The entrepreneurial ones, who have within them the pomposity of Kipling, thrive well. The majority, however, fall along the wayside, never to practise pain medicine again. This provokes a strange situation in professional meetings where psychosocial aspects of pain often draw the short straw, while the finer points between hydro-discectomy and

ozone-discectomy for low-back pain are discussed in detail. Eerily similar to Kipling's offer to women in *Mandalay*, 'I will teach her not to defile her pretty mouth with chopped tobacco in a cabbage leaf, but to inhale good cigarettes of Egypt's best brand.'

The concept of 'Traveling Pain School' was born out of a compelling need to educate healthcare professionals on the

basic science and clinical aspects of pain management; to create awareness of the benefits of effective multidisciplinary management of pain; and to increase the number of health professionals in our state with special interest in the science and treatment of pain. Andhra Pradesh, our state, is perched proudly atop the Deccan plateau, and is home to 85 million people. Hyderabad, the capital, is a melting pot of cultures. The Indian Society for Study of Pain (equivalent to the British Pain Society) had been quite proactive with its educational programmes in our state. The mandate, when I was elected as its Secretary, was to come up with innovative ideas in pain education and to promote it across the state. There was only a slight hitch – the logistics of reaching out to clinicians (mainly anaesthetists) practising within 106,000 square miles. Distances could be managed, but the anxiety-inducing challenge was to find faculty who were willing to share the ordeal. That eventually turned out to be the easy bit. Hands went up, and it seemed as if people knew these things instinctively – a sharp-elbowed levity to nudge me out of my morbid anxiety. The International Association for the Study of Pain's curriculum for pain education among doctors would suit our purpose very well. We just had to 'Indianise' it. We worked on incorporating India-centred anecdotes in the delivery of lectures to drive home the point effectively. Appropriating others' ideas and tinkering them to suit the local palate has a bit of a history in India. We have done it to the Chinese in the form of Chicken Manchurian (equivalent of Chicken balti).

With an estimated cost of £1,500 per programme and with plans to hold a dozen of them, wherein only multidisciplinary aspects of pain would be emphasised, educational sponsors were hard to come by. A couple of industry sponsors, who placed social responsibility over profit, were agreeable to a restricted grant. It had to be done on a shoestring. We did not expect it to be otherwise. We struggled. We still do. If

Traveling Pain School



the financial support towards our objectives is a trickle, the professional support continues to be a deluge. The Indian Society of Anaesthesiologists (equivalent to the Association of Anaesthetists of Great Britain and Ireland) has endured as our buttress. It has encouraged us to examine what is desirable over exploring what is possible. The selection process of a name for the programme, in comparison, was effortless. Since it involved travelling to the towns and cities in our state to conduct a day-long programme in pain management, it would be eponymous – Traveling Pain School.

Frederick Law Olmsted famously recalled in *Walks and Talks of an American Farmer in England* his chance encounter with a Birkenhead baker that directed him to the enchanting Birkenhead Park, designed by the ever-inventive Joseph Paxton. Six years later, in 1857, it served as his inspiration to design the Central Park in New York. As a trainee in pain medicine in the UK, I have moved around Merseyside. There were no helpful bakers, only senior colleagues to guide me along. There were no enchanting parks, only exalted places of learning. The Traveling Pain School came exactly six years after my time at Merseyside; but it is no Central Park, not on a shoestring anyway. To create a new concept that is meaningful and purposeful – and that could reach

out widely – requires many things to fall into place. Chief among this is formation of a core group that could amalgamate with uncompromising wisdom the different forms of knowledge and skills. Olmsted himself could not have worked on his masterpiece without the draughting skills of the British architect Calvert Vaux. The audience would be primarily anaesthetists, for whom interventions could be of interest. We would have to impart learning of the effectiveness of multidisciplinary treatments, without interventions being too obtrusive. Olmsted's radical design, which won him the contest to landscape Central Park, was to place the cross streets in trenches, below the line of sight, so that park visitors could pass safely above on bridges. Our curriculum was built similarly, where evidence-based interventions would be taught without obstructing the bigger picture that is multidisciplinary management.

'The secret of all victory lies in the organisation of the non-obvious,' said the stoic philosopher and Roman emperor Marcus Aurelius. As a team, we have focused on doing the little things right, without being dreadfully over-systematic. At the outset, each episode of the Pain School would be an informal gathering. There would be eight lectures of 45 minutes each, weaving together the different strands of managing persistent pain into a lucid narrative. The motive

was never to place commercial profit over societal profit; the registration fee was fixed at £2.50 equivalent. A multiple-choice question test was conducted before the start to assess pre-CME knowledge. To avoid being entrenched in habitual patterns, we actively sought candid appraisal of the programme through standardised feedback forms. We have conducted two schools so far and have met 150 clinicians, with plans for a dozen more over the year. The feedback has been overwhelmingly positive. We have tried to restrain ourselves from the temptation of looking at 'what would be?'. But, by the end of the project, thousands of hours would be spent by the faculty in preparing the talks; tens of thousands of miles would be travelled to meet potential pain physicians; more than a 100,000 pages would be given out as printed handouts; and more than 1,000 clinicians would be addressed. Even if we could inspire a small percentage of them to take up managing pain with confidence, it would be a triumphant homecoming. Put simply, a project this size has never been attempted before in our country.

When we started out, our stated goals were to act as a catalyst for bringing together healthcare professionals; to create a supportive network; and to accomplish regional centres for pain service and research. The pilot programme has provided us with much optimism and heart. We still have a considerable distance to go, but the goals no longer seem distant. At a personal level, it made me realise that the notion of travel is a metaphor for living a life, and without confidence travel is misery.

Note

More information about our project is available at <http://www.travelingpainschool.com>, where you can enjoy some old British cartoons. Also, I tweet as @painfreeindia.

Disclaimer

The views expressed are mine and do not necessarily reflect the views of the Indian Society for Study of Pain.

26th & 27th September 2013
Jersey, UK Channel Islands



THE BRITISH PAIN SOCIETY

To do, or not to do, that is the question:
Unintended Negative Consequences in Pain Management and Rehabilitation



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 Jersey have taken the reins and have put together what promises to be a thought provoking and stimulating conference.

The plenary speakers this year are Prof. Chris Main, Prof. Stephen Morley, Prof. Lorimer Moseley, Prof. Mick Sullivan and Dr Mick Thacker. The local team and the SIG committee are excited and proud to announce this line-up. We hope and trust that all professional groups will not miss the opportunity to access these internationally acclaimed figures in Pain Management, in one single UK-based meeting.

The conference therefore includes the usual fantastic variety of plenary presentations, and the layout has also been modified, based on previous feedback, to provide skills-development sessions, some of which will be repeated to give delegates an opportunity to have some flexibility in the sessions they attend. There will also be a number of seminars and workshops allowing delegates to contribute their views and to generate discussion with speakers from many areas and clinical backgrounds.

The highlight of any Pain Management Programmes Conference is the opportunity to network and meet others with an interest in pain and its biopsychosocial management and the conference also aims to provide diverse opportunities for people to gather both formally and informally to continue the discussions from each day.

In 2011 the conference was held in Bath and attracted over 200 delegates from across the disciplines involved in pain management. The feedback was extremely positive. The team in Jersey have worked with the Jersey Conferencing Bureau so that travel and accommodation can be booked at extremely reasonable Rates. Preferential rates can be extended to friends and family accompanying delegates to Jersey, during and after the conference.

http://www.britishpainsociety.org/meet_bps_sigs_meeting.htm

Organised in partnership with JEND (Jersey Employer's Network on Disability)



Trust me – I'm a patient

Paul Dieppe

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The Editor sincerely thanks Peter Wemyss-Gorman for transcribing the Philosophy and Ethics SIG lectures for our newsletter. The next two articles are transcripts of lectures that have a related topic of *Trust*; however, they contrast between relational trust and trust in a medico-legal context.

What is trust? I have found two definitions: 'A firm belief in the reliability, truth, ability of strength of someone or something'; and 'firm reliance on the integrity or character of a person or thing.' Trust matters most when there is uncertainty, when the stakes are high and when there is dependency on another person, and that is absolutely where we are if you are ill, so trust is critical in health care.

Research

I have been involved in research into trust over many years, including with Mike Calnan's and Rosie Rowe's research on trust, which ended up in the publication of a book *Trust Matters in Health Care*.¹

They identified three key issues. The first was the erosion of trust in society, which Onora O'Neill also highlighted in her Reith lectures some years ago.² The second was the dependency of trust relations on the structures and organisation in the health service. The third was the lack of trust between

doctors and managers in the National Health Service, at least in secondary care, which must lead to a dysfunctional organisation. They also found that such literature was mostly



about the trust that the patients are supposed to have in their doctors. The General Medical Council has said: 'trust is a critical component of the doctor-patient partnership. Patients must be able to trust doctors with their lives and health.' Our rhetoric and research are always about the trust

that patients should have in their doctors, rather than the trust (or lack of it) that doctors have in their patients; it is not relational trust. But doctors often do not trust their patients; we say 'You can't believe what people say about giving up smoking or drinking' and we ask ourselves 'Is his pain really as bad as he is making out?'

Rebecca Barnes, Nicola Brennan and I have been working on literature reviews of the trust in health care and have two manuscripts in preparation: 'Trust between doctors and patients – a review of the evidence base' (Brennan et al.) and 'Trust me I'm a patient – an evidence synthesis of qualitative research into consultations for medically unexplained symptoms (MUS)' (Barnes et al.). The reviewed research material mostly comes from the USA, and much of it is quite old and of relatively poor quality. Most research has been undertaken in primary care or oncology and palliative care settings, and it is very 'doctor-centric'.

But the qualitative work that we found provides some interesting insights. There seem to be three main issues for doctors seeing patients with MUS. First, the concern that some patients may be exaggerating their symptoms for some gain such as money – a very common reason for doctors to say that they do not trust patients. Then there is the belief that they are being manipulated by their patients who are exaggerating their symptoms. Third, doctors often struggle with their inability to find congruence between what they believed might be going on and what the patient believed – they cannot find a common narrative to allow them to enter a trusting relationship.

The main issues for the patients were worry that doctors did not believe their description of their symptoms, and/or their severity, and lack of trust in doctors who did not examine and investigate them fully to 'nail the cause', and the related problem of their search for legitimacy.

There is also evidence that if patients do not feel that they can trust the doctor, they behave differently. They do not tell the doctor everything. They are less likely to comply with the suggested treatment and are more likely to look for another healthcare professional, engaging in doctor shopping and seeking help from complementary and alternative medicine (CAM).

Calnan and Rowe¹ described three forms of trust:

1. Forced trust: If you are in a situation where you are very ill and in critical care, you do not have any option – you just have to let people get on with it.
2. Unconditional trust: I still come across this – the 'gosh doctor you're wonderful!' effusion. It really makes

me uncomfortable; I do not know why.

3. Earned trust: In most situations in health care you have to earn trust.

In health care, we need a lot of trust – what you might call 'deep trust'. This contrasts with the concept of instantaneous trust (or distrust). You hear people say: 'As soon as he walked into the consulting room, I knew I could – or couldn't – trust this man.' I find this quite perplexing.

Relational trust

How can we help establish 'deep trust'? Your patient will not trust you if you appear not to believe them and take them seriously, or if they detect incongruous behaviour, such as your saying it is all psychosocial but doing more biomedical tests. Patients pick up our mixed messages. We need to learn from this, especially when dealing with patients with MUS. We do get mixed up – we worry that there may be a cancer that we have missed. People pick up on this and regard it as dishonest, and as a result they do not trust us. They may have lost trust in the medical profession as a result of a series of such encounters when they come to see us; in the pain clinic, we often start in a bad position with people who have 'learned' to distrust the medical profession.

A medical encounter can be an anxiety-inducing situation, and regaining lost trust involves making the patient feel 'safe'. It is important to validate their experiences by taking their responses seriously, conveying that they make sense and are understandable, and to communicate your acceptance. Validation is more than empathy; it has been developed in dialectical behaviour therapy, which

involves 'finding the *kernel of truth* in the interaction'. So if someone is showing strange or exaggerated pain behaviours, there are kernels of truth about that person and what has gone wrong in their lives that may explain why they are in a mess. You need to validate those kernels of truth and work with them.

Conclusion

The best way to find out if you can trust somebody is to trust them.
Ernest Hemingway

We must move on from 'Trust me, I'm a health care professional' to add 'and I will trust you, the patient'.

In the discussion following the meeting, we talked about the different roles, like actors on a stage, that we adopt when dealing with patients. For instance, we may sometimes be guilty of old-fashioned paternalism, which is what some patients seem to want, or at least for us to take control. When we are playing the role of trusting doctor, is it possible to entirely suppress the critical untrusting doctor? A bit of us is trying to connect and believe and care, and another bit of us is wondering if he is exaggerating. The way the patient gets out of their chair in the waiting room or the GP's referral letter may trigger distrust before they have even said anything, and it may be difficult to get back into your trusting role. Using words like manipulation and malingering can make this doubly difficult.

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Medico-legal work – Ethical aspects in pain

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Sadly the legal system does not involve many of the components of care that we have identified in our sessions on the ethics of care, such as compassion, humility, openness, generosity, tenderness and intimacy – we do not even do advocacy, which is the job of the solicitor. The system tends to be male dominated, oppressive, powerful and very much relates to principles, rights and rules. There is very little privacy.

Cases mostly fall into three categories:

1. Personal injury

This is the largest group. Typically it might involve a claimant with a whiplash-type injury and neck pain following a car accident. In the majority of cases that I examine there is misunderstanding and fear regarding the pain and its prognosis, and often high levels of unrecognised distress. It is often the case that a pain expert on either side in such a case is able to provide authoritative reassurance and recommend further reasonable and helpful pain treatment; this might well be considered as 'care'.

2. Clinical negligence

There are increasing numbers of claims arising out of clinical pain practice, such as misdiagnosis or nerve damage from a misdirected injecting needle. Further cases involve pain arising in other medical specialties, such as following 'botched' surgical operations or avoidable wound infections. As well as judging the standard of care delivered, the expert has to assess the claimant's pain condition and how it differs from what would have been otherwise. Some find it difficult to



challenge other clinicians' actions. It must be distressing for the caregivers involved, but behind this is the need to ensure that patients receive appropriate care and we should all take at least some responsibility for the standards of each others' professional practice.

3. Miscellaneous

I have been involved in cases where it has been alleged that testamentary capacity has been affected by drugs so the deceased's will is contested. Also I have been asked to comment on deaths attributed by a coroner's court to therapeutic opioid use or abuse. Occasional criminal cases have involved accusations of fraud arising from proceedings during civil cases for personal

injury, where claimants may have over-egged their pain pudding and subsequently been prosecuted in criminal proceedings.

The process

The solicitor's letter of instruction draws the expert's attention to the parts of the claim requiring comment. Usually I prefer to examine the patient without first having examined the medical records, to get their view of the problem. It is necessary to look at absolutely everything because there is often valuable information in records from occupational health, employment, the Department of Work and Pensions, benefit claim forms, alternative therapy treatment records and so on. There are sometimes dozens of other experts' reports that have accumulated by the time pain specialists become involved. These are most often from orthopaedic surgeons and psychiatrists, who may have concluded that there is 'nothing wrong', so it is a pain problem. There may need to be additional reports from care specialists regarding accommodation – does the house need to be adapted because the claimant cannot use stairs? Finally there is surveillance evidence in many cases, which often causes great anguish to claimants who feel that their privacy has been invaded, but in some cases this provides valuable and relatively objective evidence of physical function outside of the context of medico-legal examination. Having written their reports, experts are often asked 'Part 35' questions. This is like being cross-examined by correspondence. Experts of like discipline are then asked to produce a joint report with the intention of clarifying differences between their often



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contrasting positions. Experts may be asked to participate in a conference with the barrister who is leading the case and providing the solicitor and parties with legal advice. Most cases settle at this stage – only about 5% of personal injury cases and 3% of clinical negligence cases actually get into the courtroom.

A typical personal injury case

A 63-year-old female had fallen and injured her knee when she tripped as she was leaving her work at a supermarket. She was suing the supermarket. She had a long history of depression and was a frequent attendee at her general practitioner's (GP) surgery with a wide variety of pain complaints associated with stress. There were relationship and financial problems and she had a poor work record. There was some reference to abusive relationships throughout her life. There had been one episode of same-side knee pain eight months before the accident, which had been quite significant and took her to the GP, but there were no further problems reported in the knee until the accident. This does raise the possibility that the knee would have become painful again without trauma.

She went to the accident and emergency department soon after the injury. Examination and X-rays showed

no major damage to bone, joint or ligaments, but there were some minor degenerative changes. The GP managed her conservatively but eventually sent her to an orthopaedic specialist who did arthroscopies, joint injections, manipulation under anaesthesia and so on. Over a period of about two years, matters only became worse. There was no sign of complex regional pain syndrome, although there were some possible elements of neuropathic pain. She had a long trial of blocks and medication but nothing seemed to work. When I saw her she was highly distressed and severely disabled with florid pain behaviour. There were inconsistent levels of disability. She staggered about the consulting room holding onto furniture and walked using crutches, but seeing her down the corridor after the consultation, she was walking much more normally and this was confirmed on video surveillance, suggesting exaggeration.

The opinions of the experts in such a case are likely to range from the whole problem being caused by the accident, to insignificant damage from the trauma that has not affected the underlying trajectory of the clinical course. Most often the experts can identify reasonable middle ground for agreement and in this

case, an apparently sensible financial settlement was reached.

Conclusion

The process of medico-legal reporting is presented in stark contrast to the ethics of care. However, the purpose is not care; it is justice, so objectivity must prevail. It is inadvisable to combine the responsibilities of caring for a patient with providing evidence for legal proceedings. I hope that an understanding of the medico-legal processes will assist clinicians in caring for patients in this complex area.

These two talks provided an interesting contrast of perspective on the matter of trust. The relational trust advocated by Paul Dieppe is difficult to maintain in the medico-legal context where objectivity is essential and a degree of suspicion may be necessary. But even in this potentially adversarial situation, it is sometimes possible to explore the reasons for a patient's behaviour with them and show that you understand the complexities and may be able to help them if they will be straight with you, and that you are there as a person to be trusted. This may not be a very high level of trust, but may be enough to help in breaking down barriers and resolving dispute.

Updated guidance now available on "Use of medicines outside of their UK marketing authorisation in pain management and palliative medicine"

September 2012

A consensus document prepared on behalf of the British Pain Society in consultation with the Association for Palliative Medicine of Great Britain and Ireland. Available to download for **free** from the British Pain Society website: http://www.britishpainsociety.org/pub_professional.htm



Delivering pain management seminars in Libya

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A small team of chronic pain experts was invited following a negotiation process by the International Medical Corps (IMC) to offer chronic pain training seminars in post-revolution Libya during April 2012. The IMC is a non-governmental organisation (NGO) established in 1984, delivering humanitarian assistance, health care and training to communities subjected to natural disasters, conflict and poverty in often dangerous, inaccessible and complex environments. The focus of IMC is to save lives, rehabilitate health care systems and help communities return to self-reliance.

Interactive multidisciplinary seminars on pain management

The Pain Team provided biopsychosocial seminars on pain management in three locations across Libya (Benghazi, Misurata and Sirte). Settings included both community rehabilitation centres and acute hospitals. IMC staff in Libya were responsible for logistic arrangements. The eight hour workshops were designed to be culturally sensitive, clinically relevant, and interactive and scientifically evidence based.

The course included the following:

- An introduction by local medical staff regarding current clinical issues in pain management.
- Site-specific aims and objectives.

- A clearly defined explanation of acute and chronic pain.
- An overview of the relevant scientific evidence base relating to the neurophysiology of chronic pain.
- An overview of the relevant scientific evidence base relating to the biopsychosocial approach to pain management.
- A multidisciplinary approach to the prevention and treatment of chronic pain.
- An introduction to biopsychosocial pain assessment and the role of the multidisciplinary team.
- An introduction to practical pain management strategies – this included basic skills in pharmacology, physiotherapy and psychology.

The seminars were attended by 127 healthcare professionals including senior lecturers in physiotherapy, doctors (anaesthetists, orthopaedics, accident and emergency (A&E)), physiatrists (specialists in rehabilitation medicine), physiotherapists, nurses, psychology-trained health professionals, dentists, social workers, speech therapists, prosthetists and technicians.

Clinical presentations

The team was asked to sit in on the interdisciplinary team meetings with patients suffering from complex pain

management issues with the patients being present. The majority of chronic pain patients presented with neuropathic pain following bullet and shrapnel injuries. Patients presenting with chronic pain following road traffic accidents were also common.

Typical chronic pain presentations included patients suffering from nerve pain resulting in avoidance due to the pain, for example avoiding weight bearing and the prolonged use of crutches or splints. The interdisciplinary teams were guided through the assessment process and patients were encouraged to bear weight. Bespoke reactivation programmes were discussed, for example advice on stretches, desensitisation, pacing up walking and management without the use of aids. Active goal-related exercises were encouraged throughout.

A number of patients also presented with histories of post-operative pain. Treatment had included electrotherapy and passive exercises. Fears regarding active reactivation and re-injury were noticed in both practitioners and patients. Discussions with Libyan health professionals included normal healing times, graded reactivation, sports-specific exercises, gym ball work and goal-related creative activities.

It was observed in a number of the presentations that there was a belief that



the pain was predominantly psychological. Patients reported to feel misunderstood and not listened to. The biopsychosocial model was discussed with both practitioners and patients and overall was well received. In some of the regions, it was noted that social workers and psychologically trained staff had been able to be involved with case management and interdisciplinary working.

Children with chronic pain and head injuries following bullet and road traffic injuries were introduced. Discussions with the family, the IMC team and Libyan health professionals included debates about the fine balance between normalising, reactivation and overprotection.

A number of patients, quite often and very sadly children, presented with severe unexploded ordnance (UXO) injuries to their hands. Injuries usually included lost digits. Patients often received skin grafting and surgical management in other countries including Turkey and Czechoslovakia. This patient group often received passive physiotherapy treatment. Functional activities were suggested.

Discussion and recommendations

Chronic pain and psychosocial understanding

The team met numerous people in Libya who described being exposed to severe traumatic events under the rule of the Gaddafi regime and during the revolution that commenced on 17 February 2011 in Benghazi. We have listened to various reports of people (adults and children) suffering from either chronic pain or post-traumatic stress disorder (PTSD) or a combination of both.

The treatment of the chronic pain population can be enhanced by the continuous training and supervision of healthcare professionals (multidisciplinary), while people suffering from PTSD or other mental health problems can benefit from an understanding and the normalisation of their difficulties. The training of professionals in the assessment and treatment of mental health problems is essential and a priority.

There is a significant comorbidity between chronic pain, PTSD, depression and anxiety disorders. We found that

there is a belief under some clinicians and patients that pain is either 'physical' or 'psychological'. This dualism leads to a lack of understanding by clinicians and patients, resulting in patient dissatisfaction and unsatisfactory treatment models impacting upon treatment outcome.

Areas in which the IMC can be of continuing support

Short term (zero to six months):

1. Ongoing training of Libyan health professionals (multidisciplinary) regarding chronic pain assessment and treatment. Training should include the physical/neurological aspects of chronic pain and normalise the psychological components.
2. Ongoing training of Libyan health professionals (multidisciplinary) regarding acute pain assessment and treatment, including the development of post-operative pain management guidelines.
3. Identification of key staff in tertiary education facilities within Libya in order to raise the profile of biopsychosocial pain management. This should reflect the healthcare professionals (doctors, nurses, physiotherapists, social workers and psychologists) who are most likely to engage with patients experiencing pain-related health concerns.
4. Ongoing training of Libyan health professionals (especially psychiatrists, psychologists, doctors, rehabilitation specialists, social workers and nurses) regarding general mental health (prevention, normalisation/de-stigmatisation, assessment and treatment).
5. The continuing support and clinical supervision of health professionals working for the IMC.
6. Awareness of and support for IMC staff being exposed to traumatic

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events and living/working in complex environments.

7. Dissemination of lessons learned within the UK and international societies for pain management in order to generate interest and exposure of the IMC's work.
8. Ensure that translated resources that emphasise adaptive pain management strategies are available within clinical environments.

Mid-term (six to 12 months):

1. Provide support to Libyan health professionals (physiotherapists and rehabilitation specialists) in the introduction and establishment of group-based active exercise programmes.
2. In collaboration with Libyan health professionals and pain specialists, develop culturally relevant information posters and leaflets about the cause and management of chronic pain conditions.
3. Offer enhanced training to Libyan health professionals identified as

having a special interest in pain management. This would serve to promote dissemination of information and develop local expertise.

4. Evaluate the role of digital support networks for both Libyan health professionals and IMC staff. This may facilitate clinical supervision and staff development and provide an opportunity to discuss treatment options with external specialist services.

Long term (12 months and beyond)

1. Enhanced public health awareness campaign around the prevention of chronic pain-related disability and distress.
2. Development of university modules on acute and chronic pain management in line with international standards and evidence-based guidelines.
3. Integrated physical rehabilitation and psychological programmes as part of the IMC's core strategies in emergency and rehabilitation interventions.

4. Development of an extended scope of practice for Libyan physiotherapists in emergency clinics (A&E and fracture clinics) to provide appropriate information and advice on early mobilisation and acute injury management.

The IMC programme in Libya is now in the rehabilitation phase, funded by the EU for a period of three years building on the initial emergency phase. The Pain Team is hoping to follow up the seminars in the near future and believe this model of training could be replicated in other countries.

Acknowledgements

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A survey: dual antiplatelet therapy and interventional techniques for chronic spinal pain

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Background

Interventional techniques are often performed on patients with chronic spinal pain. It is not uncommon to come across patients with spinal pain on dual antiplatelet therapy. As the risk of bleeding is increased significantly with dual antiplatelet therapy, overall risk stratification of interventional techniques for spinal pain is essential in this high-risk group. Since there are no clear established guidelines, most of the time the management of these patients is left to the discretion of the attending pain physician.

Methods

We conducted an electronic survey by sending a questionnaire to all the pain specialists registered with the British Pain Society. Questions included in the survey concerned specialists' practice of managing patients on dual antiplatelet therapy coming for interventional procedures for spinal pain. We also enquired if they had any departmental policy or guidelines in managing these patients.

Results

We received 63 responses in total. Consultants, advanced pain trainees and non-consultant career grade doctors took part in the survey. The responses

revealed some interesting findings about management of the patients on dual antiplatelet therapy coming for interventional techniques:

1. Most (94.8%) of the respondents consider stopping dual antiplatelet therapy before intervention.
2. The majority are concerned about continuing clopidogrel than aspirin.
3. Only 52.6% of the respondents consider speaking to a primary physician before stopping dual antiplatelet therapy.
4. There is no consensus among pain physicians on when to stop clopidogrel before the procedure.
5. There is no consensus among pain physicians on which pain intervention is safe to perform while the patient is on dual antiplatelet therapy.
6. Only 14% of the respondents had a hospital policy on the management of this high-risk group.
7. Most (88%) of the respondents feel that clear guidelines would help in managing these patients safely.

Table 1 shows the responses received for the question on which interventional procedure pain physicians are comfortable in performing while the patient is on dual antiplatelet therapy.



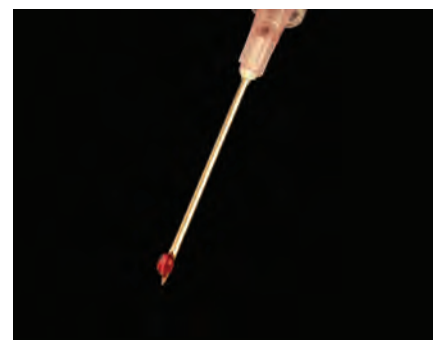
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Discussion

Dual antiplatelet therapy increases the risk of bleeding significantly. Since most of the interventional techniques for spinal pain involve introducing needles into or around the vertebral column, there is always a risk of accidental damage to the blood vessels with the potential risk of increased bleeding causing compression injuries of nerves. Bleeding into a confined space like the spinal canal can result in disastrous cord compression. On the other hand, premature discontinuation of dual antiplatelet therapy, before the recommended minimum duration, could significantly increase the risk of rebound thrombosis resulting in stent occlusion, myocardial infarction or stroke in high-risk patients.^{1,2,3} Balancing these risks is of the utmost importance in managing these patients.

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Table 1. Responses to the question on which interventional procedure pain physicians are comfortable in performing while patient is on dual antiplatelet therapy

Procedure	Yes % (n)	No % (n)	I do not perform this procedure % (n)	Total responses (n)
Cervical epidural	3.4 (2)	78 (46)	18.6 (11)	59
Cervical facet joint injection	13.6 (8)	62.7 (37)	23.7 (14)	59
Cervical nerve root injection	3.4 (2)	67.8 (40)	28.8 (17)	59
Cervical medial branch block	18.6 (11)	59.3 (35)	22.0 (13)	59
Cervical radiofrequency neurotomy	16.9 (10)	50.8 (30)	32.2 (19)	59
Thoracic epidural	3.4 (2)	88.1 (52)	8.5 (5)	59
Thoracic facet joint injection	19.0 (11)	58.6 (34)	22.4 (13)	58
Thoracic medial branch block	23.7 (14)	55.9 (33)	20.3 (12)	59
Thoracic nerve root injection	8.5 (5)	72.9 (43)	18.6 (11)	59
Lumbar epidural	7.0 (4)	91.2 (52)	1.8 (1)	57
Lumbar facet joint injection	33.9 (20)	59.3 (35)	6.8 (4)	59
Lumbar medial branch block	40.7 (24)	54.2 (32)	5.1 (3)	59
Lumbar nerve root injection	11.9 (7)	86.4 (51)	1.7 (1)	59
Lumbar radiofrequency neurotomy	27.1 (16)	61.0 (36)	11.9 (7)	59
Caudal epidural	15.8 (9)	84.2 (48)	0.0 (0)	57
Coccyx injection	48.3 (28)	50.0 (29)	1.7 (1)	58
Sacroiliac joint injection	46.6 (27)	51.7 (30)	1.7 (1)	58

The American Society of Regional Anaesthesia and Pain Medicine (ASRA) and the European Society of Regional Anaesthesia (ESRA) have produced consensus guidelines separately on regional anaesthesia in patients on anticoagulants.^{4,5} In these guidelines, there is an agreement about when or when not to perform central neuraxial blockade and peripheral nerve blocks when the patient is on dual antiplatelet therapy. Unfortunately, these guidelines do not cover most of the procedures done by chronic pain physicians like facet joint injections, medial branch blocks, nerve root blocks and so on.

A literature review by Raj et al. on bleeding risk in interventional pain practice suggested a tool to categorise interventional procedures into low, medium or high risk for bleeding based on the technique involved and patient-related bleeding risk factors.⁶ By far this is the only study that has made an attempt at the risk stratification of interventional techniques in patients with increased risk of bleeding.

This survey clearly identifies that there is no consensus among pain physicians in the UK concerning the safety of interventional procedures in the management of patients on dual antiplatelet therapy. Until clear guidelines are produced with risk stratification of each interventional technique for spinal pain, the safety of this high-risk group continues to be under threat.

Conclusion

- Premature discontinuation of dual antiplatelet therapy is not advisable.
- There is no consensus among pain physicians in the UK on the safety of interventional procedures in patients on dual antiplatelet therapy.
- Risk stratification of each interventional technique for chronic spinal pain is essential in managing this high-risk group.
- Clear guidelines are necessary for the safe management of these patients on dual antiplatelet therapy coming for spinal pain interventions.

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The chronic pain specialist in court: how advances in pain research necessitate pain specialists as expert witnesses



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The 2012 Medico-Legal Pain Conference was held at Peterhouse College in Cambridge in September; this provided another unique opportunity for

legal and medical professionals to discuss the importance of expert witness evidence in court cases involving chronic pain. The important topic of exaggeration and psychological diagnosis in personal injury cases and the role of the pain specialist as an expert witness was discussed.

A vital part of the conference is the provision of space for discussion between the speakers and the audience. Dr Munglani set up this format for the Peterhouse medico-legal conference and commented that he recognised those in the audience were just as much 'experts' as those on the stage – a point he emphasised at both the start and the end of the day. Following one of the lectures, I became involved in what can be described as an 'intense discussion' with one of the highly respected invited speakers, a psychiatrist and an expert well known in medico-legal circles who spoke on the subject of exaggeration.

I made the point that our current understanding of the pain pathway and the concept of the centralisation of pain together with the concomitant changes in the processing of information in the dorsal horn of the spinal cord and the thalamus of the brain could explain many symptoms that present in pain clinics and also in medico-legal claims. Indeed, these are the concepts and explanations that I frequently refer to in my own reports. These suggestions were dismissed as having no substance by some!

Indeed, it was this 'intense discussion' that motivated this article. I believe there is growing evidence providing increasing objective information about the pain pathway and it is our duty as pain specialists to relay this information to the court. This article reviews the neurobiology of pain and the research in this area to support my claims.

The theoretical basis of chronic pain

The gate control theory¹ has been the platform for the understanding and the evolution of modern pain medicine. This theory guides us to a neuro-anatomical model of pain combined with a cognitive-behavioural approach providing an explanation of both pain transmission and perception. Central to this theory is the introduction of a pain-modulating system

in which a neural gate (*substantia-gelatinosa*) within the dorsal horn of the spinal cord can open and close, modulating the perceptions of pain. This gate can be opened by physical factors such as injury, emotional factors such as anxiety and depression, and behavioural factors such as attending to the injury or concentrating on the pain. Equally, it can be closed by analgesic remedies (physical factors both pharmacological and interventional), a good mood (emotional factors), and distraction (behavioural factors). Using this theory as a foundation for rigorous investigations into pain pathways, scientific evidence has amassed over the decades.

Pathophysiology

We accept the idea that peripheral mechanisms may lead to central changes in the spinal cord and brain.

Peripheral mechanism

Tissue injury leads to an inflammatory response with the release of potassium ions, substance P, bradykinin, prostaglandins and other substances. These substances may induce a sensitisation of the peripheral receptors with changes in the response characteristics of primary afferent fibres.²

A-δ and C-fibre innervation of the dorsal horn terminates superficially in laminae I–II with a few connections to



deeper laminae, whereas A- β fibres predominantly terminate in laminae III–VI. Centrally, within the laminae of the dorsal horn, receiving neurones are specific to either A- δ and C-fibre input, to A- β input, or are wide dynamic range neurones receiving input from all three.³

The mechanisms are best understood if we consider what happens in neuropathic pain that arises as injury or irritation of the somatosensory system. Regeneration after nerve injury results in the formation of neuromas and the sprouting of new nerve projections among uninjured neighbouring neurons. Collateral sprouting then leads to altered sensory properties that may be realised as expanded receptive fields. Uncontrolled neuronal firing after experimental nerve injury is largely attributed to increased expression of sodium channels.^{4,5} This mechanism is supported by several lines of evidence, including blockade of neuropathic pain with sodium-channel-blocking local anesthetics.⁶

In addition to sodium channels, expression of voltage-gated calcium channels is also increased following

nerve injury. Calcium entry through voltage-gated calcium channels is necessary for the release of substance P as well as glutamate from injured peripheral nerves. Within the dorsal root ganglion, increased expression of the α -2 delta subunit of voltage-gated calcium channels correlates with the onset and duration of allodynia. Clinical support of the role of this protein in neuropathic pain arises from the analgesic efficacy of α -2 delta voltage-gated calcium-channel antagonists, gabapentin and pregabalin.⁷

Central mechanisms

Sustained painful stimuli result in spinal sensitisation, which is defined as heightened sensitivity of spinal neurons, reduced activation thresholds and enhanced responsiveness to synaptic inputs (i.e. more likely to transmit pain to the brain). This can manifest in expansion of the affected area, increased response to painful inputs and transmission of pain following non-painful stimuli. Central sensitisation is largely mediated by the

N-methyl-D-aspartate (NMDA) receptor. With increased neuronal and NMDA receptor activity, there is hyper-excitability and further up-regulation of the receptors found in the area. This entire process leads to a faulty firing pattern among central nociceptive neurons, explaining the experience of pain despite the absence of any sensory input.^{8–10} Although experimental NMDA-receptor blockade clearly suppresses central sensitisation, analgesic efficacy of NMDA antagonists has been disappointing, likely because of the narrow therapeutic window of available agents.⁷

The spinothalamic pathway has classically been assumed to be the primary pathway for imparting nociceptive information to supraspinal targets, even though multiple other pathways have repeatedly been shown to emanate from nociceptive neurons in the spinal cord and terminate in many diverse targets. The spinoreticular, spinomesencephalic, spinoparabrachial, and spinohypothalamic pathways all transmit nociceptive information cephalad.^{11–13} Direct spinal projections from these cells project to the thalamus, periaqueductal grey (PAG), the parabrachial area frontal cortex and basal ganglia have also been identified.^{14,15}

We accept also the concept of a descending inhibitory pathway as set out, consistent with original gate control theory. The central nervous system (CNS) can alter the afferent nociceptive information that it receives by a descending or modulatory system. This system arises out of several regions of the CNS, including the somatosensory cortex, hypothalamus, PAG, pons, lateral tegmental area and raphe magnus.¹⁶

Descending inhibition largely involves the release of norepinephrine in the dorsal horn from the locus coeruleus, acting at α 2-adenoceptors, to inhibit primary afferent terminals and suppress the firing of projection neurones. Descending facilitatory pathways, primarily involving a serotonergic mechanism, are also

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involved and appear to play a greater role in the development of chronic pain. Thus, in terms of central sensitisation, the spinal cord is an important pain-processing cross-road receiving input from peripheral neurons, interneurons, astrocytes, microglia and descending modulatory controls.¹⁶

Activation of the descending pathways (the PAG-rostral ventromedial medulla) has been shown to reduce pain transmission in animals and humans and is thought to contribute to the analgesic effect of opioids and antidepressants.⁷

Sympathetically maintained pain

The importance of the sympathetic nervous system in neuropathic pain has been demonstrated by analgesia following sympathectomy in animals and humans, and by pain exacerbation through activation of the sympathetic nervous system. Sympathetically maintained pain may be explained by sprouting of sympathetic neurons into the dorsal root ganglia of injured sensory neurons and post-injury sprouting of sympathetic fibres into the dermis.⁷

Evidence

Where is the evidence for the above proposed pathways and mechanisms? The evidence must come from integrating our findings from both animal and human studies.

Animal models for chronic pain have become a fundamental tool with which underlying mechanisms can be systematically studied. Over the last two decades many studies have consistently shown that long-lasting and/or intense states of pain (e.g. when an inflammation is present) lead to the sensitisation of spinal cord neurons as well as to an altered representation of the painful area in the thalamus and the cortex.¹⁷ At minimum, these animal models confirm that chronic pain states are biological entities and not just the imagination of



patients. The challenge has been and is to extrapolate these findings to human models. Nevertheless, our knowledge particularly with developments in neuroimaging is growing.

Pharmacological inferences

Some of our evidence comes from the pharmacological basis of widely accepted treatment strategies applied to pain states and these have been highlighted in the proceeding passages where relevant. It demonstrates that our understanding of the molecular biology and neurochemistry follows the postulated mechanisms.

Brain morphometry

In 2004, the first brain morphometric study showing anatomical evidence for brain atrophy in the chronic back pain patient was published. This result has now been replicated in chronic back pain and other types of chronic pain conditions.¹⁸ In addition, May¹⁹ documents reversible changes in the structure of the brain, specifically the

grey matter, as a response to chronic pain. The brain structures of people experiencing various types of chronic pain have been compared with controls using voxel-based morphometry (VBM), a new technology that statistically compares the volume of white and grey matter in areas of the brain involved in pain processing. Using a more stringent analysis than other VBM studies, via VBM analysis of brain magnetic resonance imaging (MRI) scans, Robinson et al.²⁰ provide evidence for decreased grey matter in a number of pain-related brain areas in people with fibromyalgia syndrome.

Brain neurochemistry

Marked changes in the neurochemical profile of patients with chronic pain have also been observed in specific areas of the brain, such as the thalamus, orbitofrontal cortex and the dorsolateral prefrontal cortex. Such changes have been observed to be more significant when the pain is experienced for longer periods and for more intense sensations of pain.²¹

Neuroimaging

The most exciting evidence to support our current theories on pain mechanisms and central plasticity and reorganisation comes from recent advances in neuroimaging. With the growing use of functional neuroimaging methods such as positron emission tomography (PET), functional magnetic resonance imaging (fMRI), electroencephalography (EEG) and magnetoencephalography (MEG), it is now feasible to obtain objective data that can validate subjective experiences of pain.^{22,23} Furthermore, by relating objective findings to subjective descriptions, we can now gain a neuroanatomical understanding of the role played by mood and attention in the pain experience.^{23,24} Prof Irene Tracey and her team have performed several experiments that have specifically isolated areas central to the pain experience and the transition from acute to chronic pain, including the cortex, brainstem and spinal cord.²⁵

Genetic explanations

The debate over why some people develop chronic pain or pain that is

incongruent to the stimulus or tissue trauma has been particularly hazy until more recently.²⁶ Today, new evidence demonstrates how the brain structure of some people makes them genetically more prone to chronic pain.²⁷ Marked variability in pain thresholds and susceptibility among individuals further highlights the role of heredity in the experience of pain. In particular, single nucleotide polymorphisms, which are likely to be inherited as a group (i.e. haplotypes), have been implicated in pain susceptibility.^{28,29} Catechol-O-methyltransferase (COMT) is among the most widely studied 'pain gene', with data highlighting strong evidence of an association between low COMT and increased pain.³⁰

Conclusion

Later that evening in the lovely gardens and in the Great Hall of Peterhouse, during the champagne reception and dinner, I spoke with several solicitors and barristers who were interested in the exchange in which I had earlier been

involved. I was left in no doubt that many cases of personal injury are still being determined by the power, position and polished performance of individual expert witnesses. Their own personal subjective opinion in complex cases and assertion of exaggeration, functional overlay and secondary gain is still being accepted in the absence of an alternative explanation.

Technological advancements and particular advances in neuroimaging offer the courts new insights into individual experiences of pain. In the coming decades the evidence from neuroimaging tools is likely to play an increasing role in pain neuroscience, clinical decision-making, analgesic drug development and medico-legal issues. In the interests of fairness and justice, I believe, our current understanding, albeit together with all the present gaps in our knowledge of the pain pathway, should be communicated to the courts.

References are not included but can be obtained from the author by email.

Does a diagnosis or understanding of the mechanism of pain mean that we can predict disability?

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I wish to thank those who have taken the trouble to write after the last Peterhouse medico-legal conference held on 13 September 2012 in Cambridge.

The articles by Mr Julian Benson, barrister, Guildhall Chambers, Bristol, and George Couch, medical student, Downing College, Cambridge, in the December 2012 issue of *Pain News*, along with the article by Dr Lourdes Gaspar, Consultant in Pain Medicine, in this issue, highlight the importance and indeed increasing role of pain medicine in the legal world.

There is no doubt that our understanding of pain has increased immensely over the last few decades, the

current insightful article of Dr Gaspar illustrating the neuro biological changes that take place both within the spinal cord and the brain revealed both by neuro anatomical mapping and functional magnetic resonance imaging has contributed much to explaining why certain patients, particularly with genetic tendencies, may end up with more pain than others, despite suffering very similar traumas.

The intense exchange between two well-respected medics that took place at the last conference, one a consultant in pain medicine and the other a consultant psychiatrist, encapsulated the two issues of the day.



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What does it mean medico-legally to be in pain?

It sounds rather a silly question does it not, but perhaps many of you probably do not realise that until very recently chronic pain was listed under the heading of *psychiatry* in the publication that helps court define how much to compensate somebody who suffers from a pain condition after an injury.¹ The fundamental shift in the thinking of the courts in recognising the validity of pain as a robust and recognisable diagnosis along with a definable mechanism underpinning it is something to be welcomed – and in one sense a natural consequence of what has happened in pain medicine generally. Now we have a Faculty of Pain Medicine within the Royal College of Anaesthetists and, of course, specialists in pain medicine from a variety of backgrounds including anaesthetic, psychological, psychiatric as well as nursing and physical therapy are evident.

However, this shift from viewing pain as a purely psychiatric manifestation to recognising that it is a diagnosis with a definable mechanism in its own right will, of course, be accompanied by the tension that accompanies any change.

As Dr Gaspar says, there are still many gaps in understanding of knowledge, but gone are the days that unfortunately I remember as a junior doctor when somebody with a grossly deformed limb of a complex regional pain syndrome

Does a diagnosis or understanding of the mechanism of pain mean that we can predict disability?

would be considered a manifestation of a severe psychiatric condition and their symptoms regarded as a form of Munchausen's or self-mutilation.

Does a diagnosis of pain fundamentally tell us anything about disability?

As will be discussed at the next Peterhouse conference, it may come to us as a surprise that a diagnosis of pain in terms of medico-legal value is relatively small, although complex regional pain syndrome is usually associated with large amounts of compensation compared to, for example, neuropathic pain. The real issue is of quantum, which in this particular case will be defined, for example, as requirement for future care due to ongoing disability and lost opportunity, for example not been able to take up or follow a career that was planned 'but for' the index event.

It is these aspects that are incredibly important in defining the large amounts of compensation that are often associated with these cases.

We all recognise in pain medicine that a diagnosis is not predictive of disability. The 'intense discussion' encapsulated the issue as to whether the validity of a diagnosis of chronic pain would tell us anything about how much care or lost opportunity would be required.

Bogduk, who pioneered the understanding of the generation of spinal pain and also its treatment, talked about the 'dignity of a diagnosis'. I remember my early days of practice in interventional pain medicine in a setting when it was not particularly well accepted and was met by incredulity by some of my colleagues, along with undying thanks from some of my patients in whom I had diagnosed and effectively treated a cause of pain leading them to be pain-free after many years of suffering.

However, sometimes the 'dignity of a diagnosis' may well promote disability. We have all had patients who after being told a diagnosis, have very rapidly settled into the worst-case scenario associated with that diagnosis, usually aided by the internet. Unfortunately, many of us will recognise that this latter tendency seems to be more prevalent when there is a medico-legal case ensuing, along with the diagnosis of pain after injury. In this regard, as well as recognising the validity of a diagnosis of chronic pain along with its neurobiological mechanism, one needs to also recognise that the disability is not simply defined by the diagnosis but is affected by multiple other factors.



It is these latter factors that we often have to modify by the use of social environmental and behavioural/psychological techniques, along with the more conventional drug and other therapies, particularly when we can do no more in reversing the effects of the injury.

Dr Gaspar quotes the work of the eminent scientist Irene Tracy at Oxford who uses functional magnetic resonance imaging. Even her work has recently shown, along with others, that the power of expectation is far greater in terms of predictive affect on the level of function of the effect of a drug that is the pharmacological effect.² The BBC news correspondent did a very good

public-orientated interpretation of this, mentioning: 'A patient's belief that a drug will not work can become a self-fulfilling prophecy, according to researchers.'

One of my favourite quotes is from the Bible from the book of Job who had already understood the work of Irene Tracy: 'that which I greatly feared has come upon me' (Job 3:35). When all is essentially done, it is clear that the mind is very powerful in determining long-term function in chronic pain states, and our role as pain medicine specialists is to remove that fear – such as removing the fear of movement, but also removing the fear of the medico-legal process and fundamentally removing the fear of the diagnosis in whatever way we can within our therapeutic armamentarium and providing control and hopefully returning a quality of life to the patient.

The next 'not-for-profit' Peterhouse medico-legal conference, to be held on 27 September 2013 in Cambridge, will be entitled 'How certain can we be about condition and prognosis?' (see <http://www.rajeshmunglani.com/conference.html>). We have some very eminent and thoughtful speakers coming along, including one of the barristers who was involved in helping move pain from a subsection of psychiatry into its own heading in the legal sense in the Judicial College publication and another barrister who has written about how to minimise the harmful effect of the medico-legal process on patient/claimants. I hope more of you will join in the 'intense discussions' that will undoubtedly occur both throughout the day and during the evening feast.

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Chronic pain as a disease in its own right under the spotlight at Pain Masterclass 2012

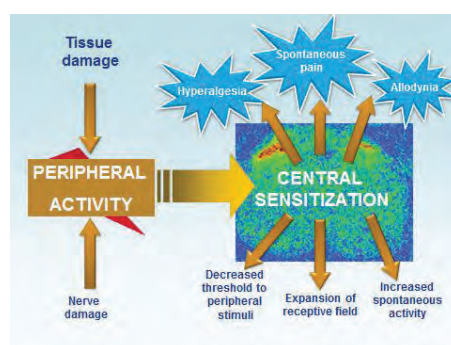
Pain Masterclass is a Lilly sponsored event; Deirdre Elmhirst is a medical writer commissioned by Lilly to prepare this report of the Masterclass 2012

The second Lilly Pain Masterclass was held on 22 November 2012 at the Royal College of Physicians in London and chaired by Dr Beverly Collett, Consultant in Pain Medicine, Leicester and the Chair of the Chronic Pain Policy Coalition (CPPC). This educational meeting, sponsored and organised by Lilly, provided an update on recent developments in the science and the clinical management of chronic pain, together with a stimulating Oxford-style debate on 'Chronic pain, a disease in its own right?'. The opportunity to discuss this controversial topic was enjoyed by the panel of leading international pain experts and approximately 100 delegates, who were mainly consultants in pain medicine and nurses, but also included physiotherapists, general practitioners with a special interest in pain (GPwSIs Pain), psychologists and scientists. The meeting included plenty of Q&A opportunities and audience keypad voting on various issues.

Advances on mechanisms of transition from acute to chronic pain

Professor Tony Dickenson from University College London presented a comprehensive review of the current knowledge on the multiple mechanisms in play at different levels that underlie chronic pain. Many stimuli can trigger pain, with the message being conveyed by peripheral nerves to the spinal cord, where neurons integrate, amplify and

modify the information and pass it on to higher centres. The key event in chronic pain is central sensitisation, which causes functional changes in the spinal cord leading to increased inputs to the brain. Importantly, descending inhibitory and excitatory pathways to the spinal cord 'can turn pain down or switch it up'. Noradrenaline and serotonin are key mediators of these pathways. In chronic pain, the balance appears to be switched to a dominance of excitation.



Imaging the impact of chronic pain on the human nervous system

Professor Irene Tracey, Director of the Oxford Centre for Functional Magnetic Resonance Imaging (fMRI) of the Brain and Head of the Nuffield Division of Anaesthetics at Oxford University, gave a fascinating insight into the power of sophisticated non-invasive brain imaging techniques to tell us about pain, quantify it, and track subtle changes over time. It is important to look for functional

changes. The central nervous system (CNS) is either resilient or vulnerable, and 'patients who feel more pain activate more brain', she said. Chronic pain also produces structural changes in the brain, which correlate with pain intensity and duration. The plasticity of the CNS allows it to change in an adaptive or maladaptive way. Relief from pain depends on patients' expectations, which must be taken into account when discussing therapy with them.

Chronic pain in cancer survivors: Swapping one life for another

Professor Sam Ahmedzai from Sheffield University talked about the increasing number of cancer survivors and the nature of 'survivorship'. Cancer survivors can have chronic pain that arises from both the disease and its treatment. Who manages the pain in cancer survivors? The Sheffield model of supportive care includes a formal needs assessment and action plan. 'We take a holistic approach so that we can get to the heart of what it means to be a cancer survivor,' Professor Ahmedzai said. Such supportive and palliative care can play a major role both during cancer treatment and after treatment in cancer survivors.

Opioids in chronic non-cancer pain: Caring or crippling?

Professor Stephan Schug from Western Australia University, and Director of Pain

Medicine at Royal Perth Hospital, described the problem of opioid overuse, abuse and the 'rising tide of deaths' in the USA and Australia. The problem lies in prescribing opioids for self-reported pain, such as chronic back pain. Opioid treatment of chronic non-cancer pain does not fulfil the outcome goals of pain relief, improved quality of life and better functioning, and can be 'crippling', increasing a patient's need for health care because of problems such as opioid-induced hyperalgesia. However, the small sub-population of patients who derive benefit from opioids should not be denied access to it. Professor Schug outlined the key components of the Prescription Opioid Policy (available at <http://www.ranzcp.org>) developed in Australia:

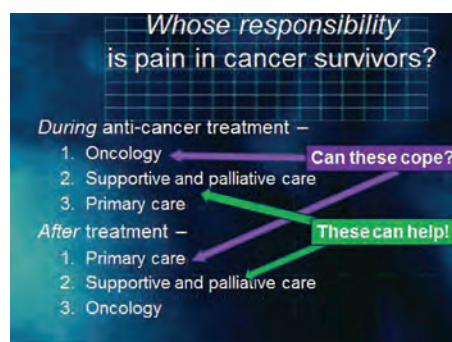
- A pain diagnosis
- Assess risk factors for abuse before initiating opioids
- An opioid trial of limited duration
- Discuss an exit strategy for a failed trial with the patient
- A written treatment contract

Debate: Chronic pain is a disease in its own right

Before the debate, 77% of the audience voted that they agreed with the motion that chronic pain is a disease in its own right. When the audience voted again after hearing the opinions of the four speakers, the results showed a considerable switch in opinion, with 49% now agreeing with the motion.

Proponent 1: Mrs Ann Taylor, Reader in Pain Education and Research at Cardiff University, defined 'disease' as a disorder of structure or function in a human, animal or plant, especially one that produces specific symptoms. A disease can also cause discomfort or distress. She summarised some of the evidence illustrating that chronic pain causes functional and structural changes leading to discomfort and distress, and therefore, should be considered a disease.

Neuroimaging studies have provided objective data that pain affects areas of the brain involved in processing and controlling affect and negative emotions. Pain also distorts cognitive and emotional perception and processing, leading to anxiety, depression and a reduced quality of life. Parts of the brain that normally switch off during rest remain active in people with chronic pain. 'It is like driving a car with your foot constantly on the accelerator,' she said. This widespread impact on brain function can lead to depression, anxiety, sleep disturbance and decision-making problems. In chronic pain, the descending modulatory system that regulates nociceptive processing by facilitating pain signalling to the brain is switched on and maintains a centrally



sensitised state. Normal descending inhibition pathways are also dysfunctional. Structural changes are also seen in the brains of people with chronic pain.

By calling chronic pain a disease, we can improve patient management; they can get a diagnosis, which will help them to accept the problem and use the services currently available for other chronic diseases. It will promote research activity and may lead to innovative approaches to managing chronic pain. The current symptomatic approach has a low effect size. If left unresolved, the neuroplastic changes contributing to pain progression may become irreversible and refractory to treatment.

Opponent 1: Dr Des Spence, a GP from Glasgow and columnist for the

British Medical Journal, outlined the fundamental problem of defining pain as what the patient says it is. Self-reporting is not a reliable way of making a diagnosis. The definition of pain is far too simplistic and does not take into account the broader social aspects. We would not see the tenfold difference across countries in the reported incidence of chronic pain (from 4% of Italian men to 40% of Chilean women) if it were a true condition. Pain is largely cultural and the most common medically unexplained symptom seen in general practice. If chronic pain were classified as a disease, potentially 20% of the population would be diagnosed with chronic pain.

'Chronic pain represents a real danger to society', said Dr Spence, considering the opioid use, abuse and increasing deaths due to opioid overdosing seen in the USA. Although there is far greater use of opioids in the USA, there is a fivefold difference across parts of the UK in the prescribing of painkillers. Chronic pain is the 'golden goose' for pharma companies, especially as medications are used in young people and lifelong. The UK market is worth about half a million pounds. The last decade has seen a 400% increase in the use of opioids in the USA. There are 15,000 deaths per year from unintentional opioid overdose, with no accurate data for Europe. This suggests that for every death, there are 800 people abusing opioids. In the state of Florida, there are more deaths associated with unintentional opioid overdose than with alcohol, heroin and crack cocaine combined. Every day people report chronic pain to their GP and there is widespread drug-seeking behaviour in general practice. We must acknowledge and take responsibility for the problems associated with opioids in the UK. The definition of chronic pain as a disease is a 'house of cards'. If we believe that chronic pain is what a patient says it is, this will lead to more prescribing and more abuse.

Proponent 2: Dr Martin Johnson, a GPwSI Pain and Royal College of General Practitioners Clinical Champion for Pain, provided further arguments as to why chronic pain should be considered a disease in its own right. Chronic pain is the 'universal suffering' and we must have the correct mechanisms in place to prevent under-diagnosis and over-treatment. According to him, chronic pain is increasingly recognised as a disease by relevant international bodies:

- In 2001, Declaration on Pain by the European Federation of IASP Chapters (EFIC).
- In 2004, the International Association for the Study of Pain (IASP) recommended that chronic pain should be diagnosed as a disease in its own right, but added that this should only happen when all signs of the original cause had disappeared or where curative treatment of the initial condition is not possible.
- In March 2010, at the world's first National Pain Summit in Australia.
- On 1 February 2012, Paul Barstow, Health Minister, stated in the House of Commons: 'The Department recognises chronic pain as a long term condition, either in its own right or as a component of other long term conditions.'
- In the recently published Pain Assessment Pathway from the British

Pain Society, now available on Map of Medicine (<http://www.mapofmedicine.com>).

Recognition that chronic pain is a disease will ease its incorporation into disease classification systems and allow its burden on health care systems to be measured. GPs now focus on disease prevention and have incentives like the Quality and Outcomes Framework (QOF). Considering pain in such terms means that we can concentrate on early identification and management. Giving a diagnosis of chronic pain is of great benefit to the patient and stops further unnecessary investigations. In the concluding remarks of the English Pain Summit 2011, Professor Sir Liam Donaldson encouraged us to make pain a 'high street' disease because then will we get equitable access to treatment, care and education for chronic pain.

Opponent 2: Dr Charles Pither, an experienced pain specialist from the Real Health Institute in London, started his rebuttal of the motion by emphasising that we are talking about populations and society. Considering whether pain is a symptom or a disease, he made an analogy with cough and whether we should start calling cough a disease. 'Pain is a symptom and we have lots of painful diseases,' he said. We must not junk the seminal work of past great physicians who translated symptoms into diseases by examining their

pathophysiology. We need to understand the pathophysiology of conditions causing pain to help define and treat them properly. 'The fact that you can measure brain activity when you have pain doesn't make it a disease,' he added.

He continued: labelling chronic pain as a disease is all about politics. Why should we want to label chronic pain as a disease? To get more people into treatment, or to get it treated better? However, according to him, data from the USA on 10 years of therapy for back pain showed a 65% increase in resources spent on people with back pain but absolutely no reduction of pain or disability in society. 'If you think that by labelling chronic pain as a disease you will improve the population of pain – think again,' he warned. The subjective complaints (fatigue, headache, depression and pain) we see in our surgeries cost society so much money. You will not help society by labelling pain as a disease; in fact, you will make it worse. The answer has to be a responsible society, not a society with vested interests that wants more people though their pain clinic doors in the mistaken belief that this is going to change things.

The key presentations from this meeting can be accessed at the Pain Community Centre website from Cardiff University (<http://www.paincommunitycentre.org>).



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First London Pain Forum Winter Symposium 20–25 January 2013, Tignes, France

Submitted by Dr Arun Bhaskar



Pain medicine is a relatively new speciality that has been developing rapidly, incorporating multidisciplinary working with physiotherapists, psychologists and other allied medical specialities. There have been several scientific organisations that hold annual and bi-annual scientific meetings of the highest standards, incorporating basic science, a multidisciplinary approach as well as new technology and developments in the field of pain medicine. However, as the speciality of pain medicine has developed, there has been some dilution of the clinical content

in these meetings and also fewer opportunities for the newly appointed clinicians to have discussions with senior colleagues to share the wealth of experience that they have accumulated over the years. In a period where clinical practice is defined by an evidence-based approach and anything other than a properly conducted randomised controlled clinical trial is not deemed as proper evidence, there was a void in sharing this collective experience to improve the standards in areas where the availability of evidence by randomised controlled trials was far from

straightforward. In recent times, the Google group for pain consultants and the *Journal of Observational Pain Medicine* have been successful in initiating the process of addressing clinical queries and sharing knowledge and experiences among medical professionals practising pain medicine.

However, even before that, Dr Teo Goroszeniuk had the vision of bringing together the pioneers and leading lights in the field of pain medicine and neuromodulation to a small group of pain clinicians to interact in the form of formal lectures and workshops as well as interactive sessions, both formal and informal, to enable free exchange of ideas and to impart education and professional development. The master stroke of a travelling symposium was that small group workshops were carried out while travelling to destinations of historical importance as well as to centres of excellence in pain medicine. This not only facilitated a constant interaction between the delegates and the faculty, but also enabled a seamless and continued flow of clinical experience as well as developing new ideas for collaboration in research and day-to-day clinical practice. The travelling symposia were hugely successful, but were limited by the numbers as well as the timescale involved. The idea of a winter symposium is not new as it has been going on successfully for several years in the form of Doctors' Updates as well as several regional meetings by colleagues in anaesthesia. These meetings have been delivering educational content of very

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high quality, but have been essentially targeted at anaesthetists with very little on offer to a pain clinician. This resulted in the concept of having a winter symposium organised for practising pain consultants and trainees in pain medicine and the first winter symposium on pain under the auspices of the London Pain Forum (LPF) was held on 20–25 January in Tignes, France. This is the report of that scientific meeting.

The first LPF winter symposium came to a close on the evening of 25 January after a week of education not only through formal lectures and presentations but also by sharing ideas and stimulating discussions over breakfast and dinner at the Hotel Village Montana in Tignes, France. The forum provided an opportunity to renew old friendships and also to get to know people who share a passion for expanding the field of pain medicine and neuromodulation. Understandably, the delegates were predominantly from the UK, but there were delegates from Austria, Belgium, the Netherlands, Norway, India, Israel, Australia and the USA. The scientific committee

comprising Dr Goroszenauik, Dr Munglani and Dr Bhaskar had invited delegates via personal communication to deliver topics for presentation and the idea was to involve everyone to participate in the programme and the discussions so that the subjects of interests of individual delegates were discussed. Dr Rajesh Munglani, who is also the editor-in-chief

of the newly launched *Journal of Observational Pain Medicine*, came up with the brilliant idea of offering the opportunity to delegates to publish the various topics presented at the winter symposium in the journal, so that a wider audience would benefit. This was well received by delegates and was widely acknowledged by members of the pain community.

The scientific programme was varied and interesting and although it would be difficult to pen the quality of the lively discussions, some of the highlights of the meeting are mentioned herewith. The meeting opened with a session on cancer pain management and the role of interventions for cancer pain, including percutaneous cordotomy and intrathecal selective sensory neurolysis among others, was discussed at length by Dr Joseph Azzopardi and Dr Arun Bhaskar. Prof Richard Chye, Palliative Care Physician from Sydney, presented the results of a pan-Australian study that revealed that ketamine, a drug used extensively in palliative care practice in the UK, has no added benefit in providing better analgesia in patients with cancer pain. The following day Dr Eric Cosman Jr gave an excellent talk



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on the physics of radiofrequency, explaining the various factors influencing lesion size and characteristics based on some of the recent research findings. Dr Margaret Bone presented her studies on suprascapular thermal radiofrequency ablation for painful shoulder conditions and made a case for early assessment and intervention rather than trying conservative approaches that could lead to continued loss of function. Dr Neal Evans and Dr Ganesan Baranidharan gave updates on the management of sacroiliac joint pain and discogenic pain respectively, adding in practical tips on how to improve outcomes.

The sessions on neuromodulation were particularly interesting, with Dr Baranidharan giving us a flavour of the evolving cutting-edge technology and newer approaches to advances in neuromodulation, while Drs Goroszeniuk and Bhaskar spoke about delivering neuromodulation to the masses by utilising the complex technology by simpler means. Dr Nicholas Padfield, who was also chairing the session, put things into perspective in his own inimitable style during his presentation, by highlighting the importance of choosing the right technology for the right condition, but also taking into consideration the most important factor – the patient.

There were some challenging case discussions, both clinical and medico-legal, with Dr Padfield updating us on capacity and litigation and Prof Alastair Chambers from Aberdeen putting whiplash into perspective as a legal term and medical diagnosis. Prof Wilfred Ilias from the University of Vienna gave a fascinating talk on osteogenic pain and also in a second presentation delivered a critical appraisal of the various claims in the use of pain-modulating nutrients as therapeutic additives, particularly in herbal medicine and nutritional supplements used by people in an effort to prevent developing serious illnesses.



It was quite educational and humbling to hear first hand from senior figures in the field of pain medicine – like Dr James Foster from London, Prof Ilias, Prof Chambers, Dr Olav Wajner from Tiel, the Netherlands, Dr Padfield, Dr David McDowell from Manchester, Dr Henrik Hogstrom from Oslo and Dr Goroszeniuk – their experiences as the speciality has developed over the past 30 years.

Dr Nishkarsh Gupta from the All India Institute of Medical Sciences presented his study proposing the use of intra-peritoneal installation of pethidine in combination with bupivacaine for post-operative analgesia following laparoscopic cholecystectomy, enabling it to be carried out as a short-stay procedure. Dr Bianca Kuehler from Chelsea and Westminster Hospital gave a practical outline of treatment with capsaicin 8% patches and Dr Wajner opened up the controversies surrounding the use of particulate steroids in cervical foraminal injections. Prof Stephanie Davies, from Perth, Australia, spoke to us about the pain assessment systems that are being trialled in Western Australia and how it is being used to link up with

patients in distant towns. The meeting had a fitting finale with Mr Jonathon Hayter, consultant in maxillofacial surgery, giving us an intriguing account of the history of botox and how it has evolved into clinical practice over the last century.

The symposium scientific programme had been awarded 19 continuing medical education (CME) credits by the European Accreditation Council for continuing medical education and 16 continuing professional development (CPD) points from the Royal College of Anaesthetists, London. The format of the meeting was very similar to the ones at the Doctors' Update and the North Thames Anaesthetic Meeting (NTAM) winter meetings, with sessions in the morning and evening and most of the delegates enjoying the day on the slopes, be it learning to ski on nursery slopes, improving techniques on the pistes or having the thrill of taking on the challenges of off-piste skiing. The weather and skiing conditions were perfect, but unlike the disruptions caused by the snow back home in the UK, we were actually enjoying it

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alongside thousands of people on the slopes of Tignes and Val d'Isère. Even the non-skiers were taking on winter activities, like snow walking in the serenity of the French Alps and ice-diving in the frozen waters of Tignes le

Lac. The overwhelming feedback from the delegates was that not only did they enjoy the lectures and discussions that followed, but also had a good time with rest, relaxation and recreation with like-minded people.

The London Pain Forum scientific committee would like to thank Cosman Medicals (Mrs Susan Rhodes and Mr David Rhodes) and Neurotherm (Mr David Drew) for their continuing support. We would also like to express our appreciation to the staff, both administrative and restaurant staff at the Hotel Village Montana, for making our stay very pleasant as well as giving us a daily dining experience of fine French cuisine. Last, but not least, we would also like to express our gratitude to Mr Ciaran Wazir and Dr Malgosia Albin for their tireless efforts in help to organise this symposium and making it a success.

The 2nd London Pain Forum Winter Symposium is going to be held at *Hotel Village Montana* on 18–25 January 2014 in Tignes, France and we would welcome suggestions and ideas for sessions as well as ideas to improve this experience and would encourage you to actively participate in this meeting.

On behalf of the scientific committee
Drs Teo Goroszeniuk,
Rajesh Munglani and Arun Bhaskar



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Living with long-term pain: A guide to self-management

Reviewed by

Arumugam Pitchiah, Pain Fellow,
University Hospital of Wales, Cardiff

The Arthritis Research Group, a well-known medical research charity organisation, has recently launched this electronic self-help guide on managing pain, targeted at people who have tried and tested various other options to manage their long-term musculoskeletal pain without much success. The guide was written, based on the results of the Active Listening Campaign conducted by the research organisation, where patients suffering with arthritis provided feedback and information about their problems and practical issues. The book has contributions from several reputed senior clinicians with vast experience in the specialty from across the country.

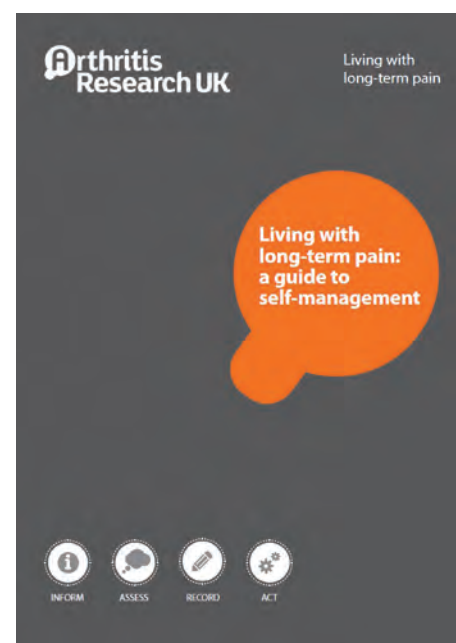
The public has open access to this guide and it is available for free download on the organisation's website. The guide, which has a total of 102 pages, may at first glance appear to be overwhelming for anyone, especially for the patient in pain. It becomes obvious on scrolling through the pages that it is well formatted, clearly presented and also encourages the reader to use it as an interactive diary or workbook. Throughout the guide, the narration directly addresses the patient, which would keep the reader engaged thereby encouraging them to adopt the changes suggested.

The book is divided into six sections with a case study prior to the first section that aims at getting the patient to

empathise and relate to their own issues in order to encourage 'active participation' in the interactive sections that follow. The first section focuses on the introduction to long-term pain, the mechanisms involved and the types of pain. This has been described in plain, easy language in a very coherent manner and has completely avoided medical jargon.

The second section is all about the patient and is fully interactive. This section has questionnaires about the usefulness of a treatment or change adapted by the patient to treat the pain and encourages them to write it down in the designated sections, *akin* to the Brief Pain Inventory. The questions dwell more on the thoughts, emotions and time spent on thinking and performing activities to relieve the pain. The questionnaire pages are repeated with the intention of motivating the reader to form a 'diary-keeping' habit.

The subsequent sections furnish details about the various treatment options and the role played by different specialists. The roles of the general practitioner (GP), physiotherapist, occupational therapist, podiatrist, rheumatologist, pain specialist and so on, in terms of offering specific services and providing referrals to specialists with respect to arthritis and its related issues are explained elaborately. This is probably one of the highlights of this document, as this information is usually quite unclear among patients, as witnessed in clinical practice, which either gives them a sense of having reached a dead end prior to exploring all the options, or prompts them to request repeated consultations with their GP or the specialist to enquire about different treatment options.



The section on specific therapies summarises physical, psychological and pharmacological options in a concise manner. The World Health Organisation ladder approach for the use of medications and the rationale for its use are explained in the format of a well-designed table. The details on cognitive behavioural therapy and mindfulness-based exercise are quite crisp and easy to comprehend.

The last couple of sections inform the patient about the various research projects conducted in relation to arthritis-related pain by the organisation and explains their purpose and outcome. The details of websites and addresses of various societies and organisations that provide more information on arthritis and other related conditions are provided in the last few pages.

The authors explicitly state that the aim of this guide is to assist the patient

in adopting a proactive approach in managing their pain and also emphasise throughout that the locus of the control of pain management is not external. This is a good read for health professionals too as it clearly demonstrates the use of simple language for explaining complex concepts and process, a very valuable

tool in the clinics especially for trainees in the specialty.

There are similar books written by various specialists out in the market, but this guide stands out among them and should definitely be recommended as it is free, published by a well-known organisation and is completely practical in approach. Even though this book is

available as an electronic copy, the pages on pain fatigue diary and the questionnaires will probably need to be printed by the patient to be more effective. This guide may also be used to educate patients in monitoring and managing pain, so it would probably be useful to have a paper copy of this book in the pain clinic.

Book reviews

Andrew Davies. Oxford Pain Management Library: Cancer-Related Breakthrough Pain, 2nd edition.

Oxford: Oxford University Press, 2012, ISBN 978-0-19-965697-4

Reviewed by Dr Joan Hester, London

The second edition of *Cancer-Related Breakthrough Pain* has been completely rewritten to reflect the changes in clinical practice that have occurred over the last five years. A recent definition of breakthrough pain is 'a transient exacerbation of pain that occurs either spontaneously or in relation to a specific predictable or unpredictable trigger, despite relatively stable and adequately controlled background pain' (Davies et al. 2009). The prevalence of breakthrough pain in cancer is well explained with useful summaries of relevant studies. The aetiology of breakthrough pain is less well described, with classification of visceral pain as a type of nociceptive pain. The possible mechanisms of breakthrough pain remain unclear and there is no description of the central processing of pain or the possible role of descending inhibitory or facilitatory mechanisms, although psychosocial factors and coping mechanisms are mentioned.

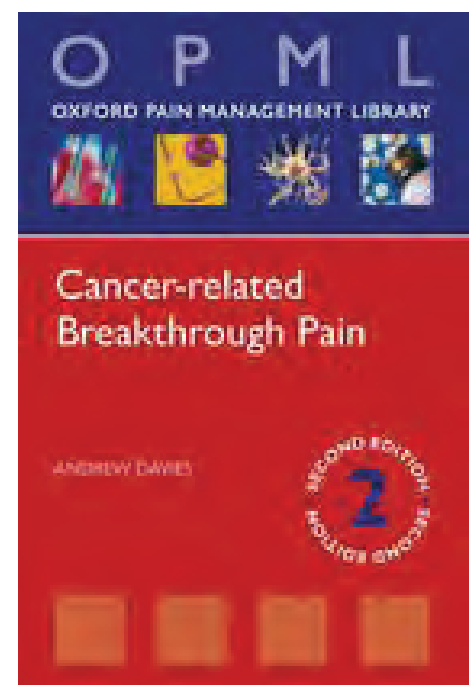
The diurnal variation, or chronobiology, of breakthrough pain is an interesting feature, discussed in chapter 2.

Assessment of breakthrough pain is accompanied by a useful diagnostic algorithm, and the importance of frequent reassessment is also clearly explained in chapter 3. Some useful case studies are given throughout the booklet.

The remainder of the booklet gives a detailed explanation of the management of breakthrough pain, with an emphasis on the use of short-acting and ultra-short-acting opioids. This is a useful resource and a nice summary of the opioids currently available with reference to the literature. Routes of delivery – oral, rectal, nasal, sublingual, transmucosal, inhaled, subcutaneous, intramuscular and intravenous – are discussed with the acceptability of each route for mild, moderate and severe pain. It seems that there is no relationship between the effective dose of background medication and the most effective dose of rescue medication, contrary to conventional teaching; individual responses vary widely. It is recommended that patients with difficulty in controlling pain are referred to a specialist with an interest in cancer breakthrough pain.

Oral, transmucosal, nasal and sublingual preparations of fentanyl are discussed in detail, with useful insights into the pharmacokinetics of these agents. Long-term side effects such as

addiction, hormonal effects and dental decay are not mentioned, nor is how to withdraw cancer survivors from using these preparations – a very difficult task in my experience. The author does not advocate the use of breakthrough analgesics for non-cancer pain, although procedural pain is mentioned. The use of non-opioid analgesics for breakthrough pain is briefly described in chapter 8, including nitrous oxide, but there is no mention of intestinal obstruction (pneumothorax is mentioned) as a contraindication.



The final chapter briefly describes 'other therapeutic interventions', including transcutaneous electrical nerve stimulation, acupuncture and 'anaesthetic strategies', a somewhat inaccurate term that presumably means that the intervention is performed by an anaesthetist; 'specialised pain management techniques' would now be

a more accurate descriptor. The author mentions a study (Zech, 1995) that showed that 'only' 11% of cancer patients could benefit from an interventional technique; 11% is a significant number of patients. I feel that this chapter is rather inadequate and does not stress the potential advantages of interventions versus increasing doses

of opioids, particularly for movement-related pain.

Overall, this is a useful booklet for a detailed description of the pharmacokinetics and clinical use of short-acting opioid analgesics for breakthrough pain related to cancer and would be very helpful for those working in a palliative care setting.

Book reviews

Andrew Souter, Roman Gregg and Sam Chong. *Back Pain: Oxford Pain Management Library*

Oxford: Oxford University Press, 2012, ISBN 978-0-19-960977-2

Reviewed by Dr Neil Collighan,
East Kent Hospitals University
Foundation NHS Trust

This book is a further addition to the Oxford Pain Management Library and deals specifically with back pain. This is a concise book with the aim of providing a brief reference to all people who may have involvement in the treatment of back pain at any level. It tries to provide referenced evidence to support the views within but has a healthy unbiased overview as a final chapter to complement this. A good example of this is references to the 2009 NICE – *Early management of persistent non-specific low back pain* – guidelines within the main body of text, which is then followed by an intelligent appraisal of the guidelines' weaknesses in the final summary chapter.

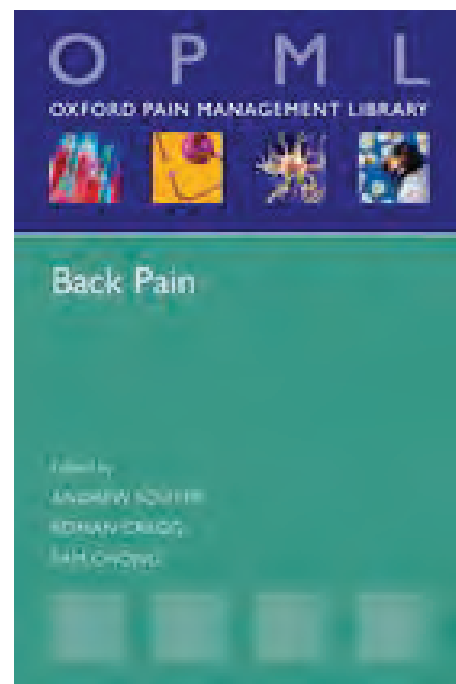
The book comprises 14 chapters starting with epidemiology and then moves on to early assessment, anatomy and physiology and investigation. There are then four chapters on physical therapy covering physiotherapy, manipulative therapy, acupuncture and

transcutaneous electrical nerve stimulation (TENS) (briefly). Following this are the psychological therapies and finally the more interventional approaches up to and including surgery. The final two chapters cover more long-term sequelae post treatment and ongoing management. There is then a well-constructed closing 15th chapter providing a well-balanced overview of back pain management and its future.

The individual chapters are of varying complexity and content but all cover the salient points and are well written to match the required brief. From the previous chapters, I had hoped for more from the TENS chapter considering the references given, but apart from this I have no complaints. The other chapters assume minimal initial knowledge whereas this chapter could have provided more basic information about the TENS machine itself, pad placement and so on.

It is unfair though to allow one small point to cloud the overall opinion that this is a good basic text on back pain. The two particular standout chapters are those on acupuncture and the role of surgery in back pain and sciatica. These give a very full and candid overview of these therapies with good supportive tables, evidence and figures.

The whole text covers the biopsychosocial approach to pain management and encourages the appropriate multidisciplinary approach with a movement towards patient



self-management strategies. I think it would be best suited to those who require an initial brief précis and overview on back pain management. Hopefully this would then inspire a more in-depth search for further knowledge. It would suit all disciplines that see back pain patients, be it in primary care or at all levels in secondary care providers.

In summary, the book provides a good starting point and hopefully will interest the reader to further investigate the incredibly complex and multidisciplinary management of back pain.

Mindfulness as a self-management tool for chronic pain

Vidyamala Burch and Anjali Chatterjee
info@breathworks.co.uk

People living with chronic pain experience limited options as to how to address their symptomology and maintain a sense of well-being. Mindfulness offers an approach to pain management that seeks to educate people suffering with chronic pain about the subconscious patterns that frequently develop in reaction to their suffering. Learning to cultivate 'moment by moment non-judgemental awareness' is the key to mindfulness for chronic pain and the stress that characteristically exists alongside it.

So what is mindfulness in relation to health? The rationale for mindfulness for chronic pain is simple: *awareness equates with choice*. Choice means empowerment for the individual, and this empowerment leads to a more meaningful and satisfying life.

In 1981, Dr Jon Kabat-Zinn (USA) introduced mindfulness as part of a stress clinic programme and this led to the development of mindfulness-based stress reduction (MBSR). In 2001, Vidyamala Burch established Breathworks to further develop this work to meet the needs of people with chronic pain and illness. Experiencing chronic pain and paralysis herself, Burch based the initial courses on her own experience of the sound efficacy of mindfulness to manage her pain. Burch and her colleagues have since established Breathworks as an international provider of mindfulness courses, teacher training and research development.



Breathworks and the Mindfulness for Health Programme: Applying mindfulness to chronic pain and illness

The programme is offered in different formats to best meet the needs of our mobile global population. Whether it is face to face, online or using another method of delivery, each works on the premise that mindfulness can help to resolve the tendency in individual sufferers for the experience of chronic pain to dominate, making them feel overwhelmed by this aspect of their lives.

Often leading to the feeling of being caught and trapped in subsequent negative mental states, the individual can ultimately experience themselves as frustrated, weary and disempowered in relation to their own life. Using the World Health Organisation definition of pain, the mindfulness 'moment by moment' awareness introduces the notion that the individual can instead perceive their pain in a more accurate way that enables them to discern clearly their physical, cognitive and emotional pain. They are then able to



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choose how to respond to their present moment experience of pain rather than remaining caught in a net of fear about their past and future painful experiences. By undercutting these automatic reactions, *individuals can learn to distinguish between the actual experience of pain and their reactions to that experience*. Breathworks has termed this respectively as primary and secondary suffering.

Primary and secondary suffering

Primary suffering is the stressor: suffering based on the unpleasant sensation of a part of the body in pain. Secondary suffering stems from resistance to that unpleasant sensation. It manifests as physical, mental or emotional reactions such as tensing up or thinking: 'I don't want this to be happening to me.' The practice of mindfulness skills facilitates a space between primary suffering and the normal automatic reactions of secondary suffering so that gradually the experienced pain is less overwhelming and becomes more manageable. Typically we can see that

secondary suffering falls into two extremes of blocking (avoiding) and drowning (becoming overwhelmed).

When living with chronic pain, people often cycle between these two poles in an attempt to run away from what is painful or unpleasant until they become exhausted, perhaps losing perspective and becoming low in mood. Over a decade of the programme, experience has shown that mindfulness practice can significantly lessen these extreme reactions to suffering over time. We typically see these changes emerging after week four to five of the eight-week programme offered through Breathworks.

The five-step process of mindfulness

Using a five-step process, the Breathworks programme guides course participants through mindfulness skills rooted firmly in the development of non-judgemental awareness. This emphasis on what we term 'Kindly Awareness' is distinctly part of the Breathworks approach. Kindly Awareness seeks to meet some of the negative self-judgement and social isolation that often accompanies the health career

of people with chronic pain. Awareness of the breath, meditation, pacing and mindful movement are introduced throughout the programme. Each method is explored as to how it can help break the cycle of reactivity to pain through both accepting one's primary suffering and reducing the resistance at the root of secondary suffering.

Step one: Awareness

This involves using practices such as breath awareness and body scanning, which involves bringing detailed attention to sensations in the body from head to toe.

Step two: Move towards the unpleasant

The key to overcoming the resistance underpinning secondary suffering is to 'turn towards' the unpleasant experience and see that primary suffering is a process and not a static, permanent 'thing'. People living with chronic pain can find that what has been dominating their lives is never the same from one moment to the next. Gradually, the density of pain is teased apart and becomes just one aspect of the flow of life.

Step three: Seek out the pleasant

Habitually resisting the unpleasant can harden sensitivity and awareness, numbing the ability to appreciate pleasure or beauty. There is always something pleasant in our experience if we know how to look for it. It is important to recognise and enjoy these experiences as a counterbalance to the unpleasant side of life.

Step four: Broaden awareness to gain perspective

This step introduces a wide-angle perspective to cultivate stability so that habits of resisting the unpleasant and clinging to the pleasant are undermined. One's experience of pain can also be a route to empathy with others as one

PRIMARY SUFFERING

Basic Unpleasant sensations
MINDFULNESS HELPS ACCEPT



RESISTANCE



SECONDARY SUFFERING

Mental, emotional & physical reactions
MINDFULNESS HELPS REDUCE / OVERCOME

BLOCKING	DROWNING
<ul style="list-style-type: none"> • hardening against unpleasant sensations • restlessness • inability to 'stop' • feeling driven • addictions of all kinds, e.g. <ul style="list-style-type: none"> * food * cigarettes * alcohol * recreational drugs * excessive talking * excessive working • emotionally brittle and edgy • anxiety • anger and irritability • denial • being 'in head', not body • overly controlling 	<ul style="list-style-type: none"> • feeling overwhelmed by unpleasant sensations • exhaustion • physical inactivity and loss of function, weakening of muscles etc • giving up • lack of interest - vagueness • being emotionally dull and passive • depression • self-pity and victim mentality • tendency to catastrophise and loss of perspective • dominated by physical experience • loss of initiative <ul style="list-style-type: none"> * withdrawal * isolation

broad and stable moment-by-moment awareness, one is able to break out of a reactive cycle and live with choice and initiative, no matter what primary suffering is present. This is what it means to live mindfully.

The Breathworks programme in action: Applications in Wigan

In 2009–10, Breathworks ran a series of Living Well with Pain and Illness courses in Wigan borough, for people out of work with a long-term health condition, and focused in the areas of greatest social deprivation. Commissioned as a pilot project by Wigan Borough Partnership as part of its 'What Makes Wigan Work' initiative, the programme aimed to help people to manage their condition, improve their quality of life, and help those that felt ready to move towards greater activity including volunteering, training and employment. Wigan borough has one of the highest claimant counts for Incapacity Benefit in the country, with several thousand people in the borough unable to work due to ill health. Almost 4,000 people claim Incapacity Benefit due to musculoskeletal pain alone. In many cases, there is only a limited amount that can be done with conventional medical treatment; people can find themselves needing to find the best way to manage their long-term condition of chronic pain or ill health with often only limited support. Mindfulness approaches are not well known in the borough, despite the strong research support for their usefulness.¹ However, with a gradual build-up of referrals and recommendations, 42 people joined the programme. Participants came with a range of conditions including arthritis, neuropathic pain, multiple sclerosis, brain damage, stress and myalgic encephalomyelitis. They undertook the Breathworks mindfulness programme involving weekly teaching sessions and daily practice over two months. The results were extremely encouraging. One participant, Cheryl Taylor of Hindley

Reproduced from 'Living Well with Pain and Illness – the mindful way to free yourself from suffering' by Vidyamala Burch pub Piatkus, Nov 08

realises that everyone suffers in one way or another. This helps overcome tendencies towards self-absorption and can give pain a very different meaning.

Step five: Choice - learn to respond rather than react

This step is the behavioural outcome of the previous four steps. On the basis of a

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Green, has not been able to work due to 18 years of chronic spinal and neck pain. Her pain had been progressively worse leaving her 'at the end of her tether'. She reported: 'The course has helped me learn to live with my pain, but really live with it. I'm more contented – with the pain. I would just like to say thank you very much for giving me my life back.' She now runs a parents and toddlers' craft session at her local school. Another participant with severe neuropathic pain who had been taking maximum dosage of analgesia and antidepressants and

was unable to work for 10 years reported:

I have learned to accept my pain and see it as a small aspect of a much greater experience. I don't get angry if the pain suddenly gets worse. I see a future and I'm in control of my life again. It has been a "eureka moment" for me. I have the tools to deal with my problems.

A further participant, a young man recovering from leukaemia and living with

rheumatoid arthritis, reported: 'I no longer feel so isolated. My fears have been reduced due to the methodology of Breathworks.' He now volunteers with the Leukaemia Support Society. Such positive course outcomes are leading Breathworks to further develop networking opportunities within the health and social services and towards funding for similar programmes to continue the significant positive impact on the quality of life and activity of people living with severe health limitations.

For further information go to <http://www.breathworks-mindfulness.org.uk> or email info@breathworks.co.uk

References

- 1 National Institute for Health and Clinical Excellence (NICE). *Depression: The NICE Guideline on the Treatment and Management of Depression in Adults*. London: The British Psychological Society and The Royal College of Psychiatrists, 2009. Available online at <http://www.nice.org.uk/nicemedia/live/12329/45896/45896.pdf> (Last accessed 28 January 2013)
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- 3 Kabat-Zinn J. *Wherever You Go, There You Are: Mindfulness Meditation in Everyday Life*. London: Piatkus, 2004
- 4 Segal Z, Williams J, and Teasdale J. *Mindfulness-Based Cognitive Therapy for Depression*. New York: Guilford Press, 2002

End stuff

Letter to the Editor



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Editor,

Thank you for publishing a very interesting edition of *Pain News* this month. I was particularly interested in the articles on long term follow up of patients on opioid therapy, hence my frustration at the lack of references and contact details for the authors of this paper.

I would be very grateful if you could supply me with either so that I can learn more about what follow up they undertook into long term medical complications and what evidence they based this on. It is very pertinent to my pain population.

Dr Isobel Rice
Isobel.Rice@iow.nhs.uk

Response from the Editor:

The Editor conveys his sincere apologies as the references were missed due to the space limitations. However, the author's emails are:

Louise.Jeynes@wsh.nhs.uk
chrisrgwaters@aol.com

The Editor conveys his thanks to Dr Rice for her kind feedback.

End stuff

Erratum

Dr Louise Jeynes has pointed an error in her article in the previous issue on the article on Opioids in our December issue; in page, it was mentioned "*a high DIRE score is associated with high risk*" but should have read "***a low DIRE score is associated with a high risk***". *Pain News* requests our readers to note this significant correction.



PAIN PATHWAYS AND COMMISSIONING ROADSHOWS

SAVE THE DATE!

- **Monday 11 March in London**
- **Thursday 2 May in Bristol**
- **Monday 13 May in Manchester**
- **Thursday 23 May in Birmingham**
- **Further dates to be added**

‘Implementing the BPS pathways and preparing for the commissioning agenda’

Programme

- Welcome and Introduction
- The National Pain Audit
- The challenge of commissioning pain services/presenting evidence based practice in commissioning
- Writing directives and plotting pathways/implementation of BPS pathways
- Presenting evidence and submitting proposals to commissioners
- National Specialised Pain Services

Further details including registration, venue and speakers will be released shortly. To receive more information about the above dates and future regional road shows please send your contact details to: rsusgaardvigon@britishpainsociety.org

10th to 13th June 2013
Launde Abbey, near Leicester



Changing the Culture of Pain Medicine



How can we restore an ethic of care to its place as the wellspring of pain medicine?

How can we reintegrate scientific biomedicine with care, compassion and healing of the whole person?

How can we cope with financial, managerial and political pressures which can make this difficult?

How can we use education to promote values-based practice?

How can we exploit the potential of journalism and the social media for changing attitudes and culture?

http://www.britishpainsociety.org/meet_bps_sigs_meeting.htm

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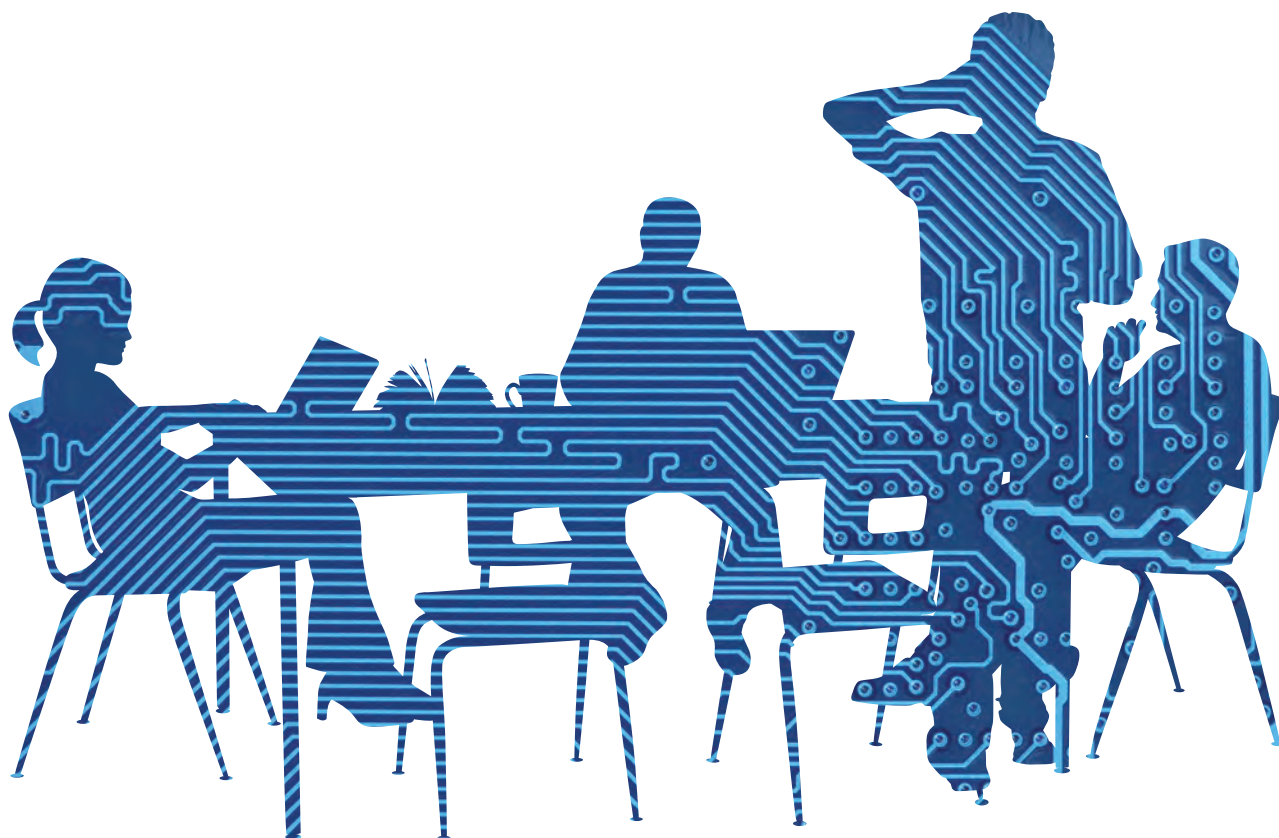
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