SEPTEMBER 2013 VOLUME 11 ISSUE 3

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

The British Pain Society

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CYMBALTA® (DULOXETINE) ABBREVIATED PRESCRIBING INFORMATION Presentation Hard gastro-resistant capsules, 30mg or 60mg of duloxetine. Also contains sucrose. **Uses** Treatment of major depressive disorder. Treatment of generalised anxiety disorder. Treatment of diabetic peripheral neuropathic pain (DPNP) in adults. **Dosage and Administration** *Major Depressive Disorder* Starting and maintenance dose is 60mg once daily, with or without food. Dosages up to a maximum dose of 120mg per day have been evaluated from a safety perspective in clinical trials. However, there is no clinical evidence suggesting that patients not responding to the initial recommended dose may benefit from dose up-titrations. Therapeutic response is usually seen after 2-4 weeks. After establishing response, it is recommended to continue treatment for several months, in order to avoid relapse. In patients responding to duloxetine, and with a history of repeated episodes of major depression, further long-term treatment at 60 to 120mg/day could be considered. *Generalised Anxiety Disorder* The recommended starting dose in patients with generalised anxiety disorder is 30mg once daily, with or without food. In patients with insufficient response the dose should be increased to 60mg, which is the usual maintenance dose in most patients. In patients with co-morbid major depressive disorder, the starting and maintenance dose is 60mg once daily. Doses up to 120mg per day have been shown to be efficacious and have been evaluated from a safety perspective in clinical trials. In patients with insufficient response to 60mg, escalation up to 90mg or 120mg may therefore be considered. After consolidation of the response, it is recommended to continue treatment for several months, in order to avoid relapse. *Diabetic Peripheral Neuropathic Pain* Starting and maintenance dose is 60mg daily, with or without food. Doses above 60mg/day, up to a maximum dose of 120mg/day in evenly divided doses, have been evaluated from a safety perspective. Some patients that respond insufficiently to 60mg may benefit from a higher dose. The medicinal response should be evaluated after 2 months treatment. Additional response after this time is unlikely. The therapeutic benefit should regularly be reassessed. Abrupt discontinuation should be avoided. When stopping treatment with Cymbalta the dose should be gradually reduced over at least one to two weeks to reduce the risk of withdrawal reactions. If intolerable symptoms occur following a decrease in the dose or upon discontinuation of treatment, then resuming the previously prescribed dose may be considered. Subsequently, continue decreasing the dose, but at a more gradual rate. **Contra-indications** Hypersensitivity to any of the components. Combination with MAOIs. Liver disease resulting in hepatic impairment. Use with potent inhibitors of CYP1A2, eg, fluvoxamine, ciprofloxacin, enoxacin. Severe renal impairment (creatinine clearance <30ml/min). Should be used in pregnancy only if the potential benefit justifies the potential risk to the foetus. Breast-feeding is not recommended. Initiation in patients with uncontrolled hypertension that could expose patients to a potential risk of hypertensive crisis. **Precautions** Do not use in children and adolescents under the age of 18. No dosage adjustment is recommended for elderly patients solely on the basis of age. However, as with any medicine, caution should be exercised. Data on the use of Cymbalta in elderly patients with generalised anxiety disorder are limited. Use with caution in patients with a history of mania, bipolar disorder, or seizures. As with other serotonergic agents, serotonin syndrome, a potentially life-threatening condition, may occur with duloxetine treatment, particularly with concomitant use of other serotonergic agents, as described under 'Interactions' (below). Caution in patients with increased intra-ocular pressure or those at risk of acute narrow-angle glaucoma. Duloxetine has been associated with an increase in blood pressure and clinically significant hypertension in some patients. In patients with known hypertension and/or other cardiac disease, blood pressure monitoring is recommended as appropriate, especially during the first month of treatment. Use with caution in patients whose conditions could be compromised by an increased heart rate or by an increase in blood pressure. For patients who experience a sustained increase in blood pressure while receiving duloxetine, consider either dose reduction or gradual discontinuation. Caution in patients taking anticoagulants or products known to affect platelet function, and those with bleeding tendencies. Hyponatraemia has been reported rarely, predominantly in the elderly. Caution is required in patients at increased risk for hyponatraemia, such as elderly, cirrhotic, or dehydrated patients, or patients treated with diuretics. Hyponatraemia may be due to a syndrome of inappropriate anti-diuretic hormone secretion (SIADH). Adverse reactions may be more common during concomitant use of Cymbalta and herbal preparations containing St John's Wort. Monitor for suicidal thoughts, especially during first weeks of therapy, dose changes, and in patients under 25 years old. Since treatment may be associated with sedation and dizziness, patients should be cautioned about their ability to drive a car or operate hazardous machinery. Cases of akathisia/psychomotor restlessness have been reported for duloxetine. Duloxetine is used under different trademarks in several indications (major depressive disorder, generalised anxiety disorder, stress urinary incontinence, and diabetic neuropathic pain). The use of more than one of these products concomitantly should be avoided. Cases of liver injury, including severe elevations of liver enzymes (>10-times upper limit of normal), hepatitis, and jaundice have been reported with duloxetine. Most of them occurred during the first months of treatment. Duloxetine should be used with caution in patients with substantial alcohol use or with other drugs associated with hepatic injury. Capsules contain sucrose. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption, or sucrose-isomaltase insufficiency should not take this medicine. **Interactions** Caution is advised when taken in combination with other centrally acting medicinal products or substances, including alcohol and sedative medicinal products; exercise caution when using in combination with antidepressants. In rare cases, serotonin syndrome has been reported in patients using SSRIs/SNRIs concomitantly with serotonergic agents. Caution is advisable if duloxetine is used concomitantly with serotonergic agents like SSRIs/SNRIs, tricyclics, MAOIs like moclobemide and linezolid, St John's Wort, antipsychotics, triptans, tramadol, pethidine, and tryptophan. Undesirable effects may be more common during use with herbal preparations containing St John's Wort. *Effects on other drugs:* Caution is advised if co-administered with products that are predominantly metabolised by CYP2D6 (risperidone, tricyclic antidepressants [TCAs], such as nortriptyline, amitriptyline, and imipramine) particularly if they have a narrow therapeutic index (such as flecainide, propafenone, and metoprolol). **Undesirable Effects** The majority of common adverse reactions were mild to moderate, usually starting early in therapy, and most tended to subside as therapy continued. Those observed from spontaneous reporting and in placebo-controlled clinical trials in depression, generalised anxiety disorder, and diabetic neuropathic pain at a rate of $\geq 1/100$, or where the event is clinically relevant, are: *Very common* ($\geq 1/10$)*:* Headache, somnolence, nausea, dry mouth. *Common* ($\geq 1/100$ *and* $< 1/10$)*:* Weight decrease, palpitations, dizziness, lethargy, tremor, paraesthesia, blurred vision, tinnitus, yawning, constipation, diarrhoea, abdominal pain, vomiting, dyspepsia, flatulence, sweating increased, rash, musculoskeletal pain, muscle spasm, dysuria, urinary frequency, ejaculation disorder, ejaculation delayed, decreased appetite, blood pressure increased, flushing, falls, fatigue, erectile dysfunction, insomnia, agitation, libido decreased, anxiety, orgasm abnormal, abnormal dreams. Clinical trial and spontaneous reports of anaphylactic reaction, hyperglycaemia (reported especially in diabetic patients), mania, hyponatraemia, SIADH, hallucinations, dyskinesia, serotonin syndrome, extra-pyramidal symptoms, convulsions, akathisia, psychomotor restlessness, glaucoma, mydriasis, syncope, tachycardia, supra-ventricular arrhythmia (mainly atrial fibrillation), hypertension, hypertensive crisis, epistaxis, gastritis, haematochezia, gastro-intestinal haemorrhage, hepatic failure, hepatitis, acute liver injury, angioneurotic oedema, Stevens-Johnson syndrome, trismus, and gynaecological haemorrhage have been made. Cases of suicidal ideation and suicidal behaviours have been reported during duloxetine therapy or early after treatment discontinuation. Cases of aggression and anger have been reported, particularly early in treatment or after treatment discontinuation. Cases of convulsion and tinnitus have been reported after treatment discontinuation. Discontinuation of duloxetine (particularly abrupt) commonly leads to withdrawal symptoms. Dizziness, sensory disturbances (including paraesthesia), sleep disturbances (including insomnia and intense dreams), fatigue, agitation or anxiety, nausea and/or vomiting, tremor, headache, irritability, diarrhoea, hyperhydrosis, and vertigo are the most commonly reported reactions. The heart rate-corrected QT interval in duloxetine-treated patients did not differ from that seen in placebo-treated patients. No clinically significant differences were observed for QT, PR, QRS, or QTcB measurements between duloxetine-treated and placebo-treated patients. In clinical trials in patients with DPNP, small but statistically significant increases in fasting blood glucose were observed in duloxetine-treated patients compared to placebo at 12 weeks. At 52 weeks there was a small increase in fasting blood glucose and in total cholesterol in duloxetine-treated patients compared with a slight decrease in the routine care group. There was also an increase in HbA_{1c} in both groups, but the mean increase was 0.3% greater in the duloxetine-treated group. *For full details of these and other side-effects, please see the Summary of Product Characteristics, which is available at http://www.medicines.org.uk/emc/.* **Overdose** Cases of overdoses, alone or in combination with other drugs, with duloxetine doses of 5400mg have been reported. Some fatalities have occurred, primarily with mixed overdoses, but also with duloxetine alone at a dose of approximately 1000mg. Signs and symptoms of overdose (duloxetine alone or in combination with other medicinal products) included somnolence, coma, serotonin syndrome, seizures, vomiting, and tachycardia. **Legal Category** POM **Marketing Authorisation Numbers** EU/1/04/296/001, EU/1/04/296/002 **Basic NHS Cost** £22.40 per pack of 28 X 30mg capsules. £27.72 per pack of 28 X 60mg capsules. **Date of Preparation or Last Review** July 2013 **Full Prescribing Information is Available From** Eli Lilly and Company Limited, Lilly House, Priestley Road, Basingstoke, Hampshire, RG24 9NL Telephone: Basingstoke (01256) 315 000 E-mail: ukmedinfo@lilly.com Website: www.lillypro.co.uk CYMBALTA® (duloxetine) is a registered trademark of Eli Lilly and Company.

● UKCYM01679b July 2013

References:

1. Goldstein DJ, Lu Y, Detke MJ, et al. Duloxetine vs placebo in patients with painful diabetic neuropathy. Pain 2005;116:109-18.
2. Hall JA et al. Poster presented at the 25th American Pain Society Meeting; 2006; May 3-6; San Antonio, USA.
3. Lilly. Cymbalta [EU] Summary of Product Characteristics, July 2013.
4. British Pain Society, Pain Assessment and Management Pathways: Neuropathic Pain. Available at http://bps.mapofmedicine.com/evidence/bps/index.html Acccessed 6/6/13

Adverse events should be reported. Reporting forms and further information can be found at: www.mhra.gov.uk/yellowcard.
Adverse events and product complaints should also be reported to Lilly: please call Lilly UK on 01256 315 000.

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

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PAIN NEWS

contents

PAIN NEWS SEPTEMBER 2013

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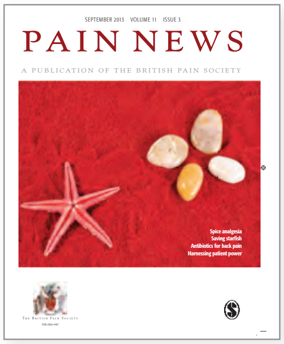
SEPTEMBER 2013 VOLUME 11 ISSUE 3
PAIN NEWS
A PUBLICATION OF THE BRITISH PAIN SOCIETY
Spice analgesia
Saving starfish
Antibiotics for back pain
Harnessing patient power
THE BRITISH PAIN SOCIETY

The editor welcomes contributions including letters, short clinical reports and news of interest to members, including notice of meetings.
Next submission deadline : 11th October 2013

Material should be sent to:

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Regulars

News

Professional perspectives

Informing practice

Book reviews

End stuff

THE BRITISH PAIN SOCIETY

British Pain Society Calendar of Events

2013

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

Visceral Pain (29th Study Day)
Tuesday 19th November
Churchill House, London

Clinical Information SIG Meeting
Monday 25th November
Churchill House, London

2014

Primary & Community Care SIG Meeting
Friday 17th January
Churchill House, London

Topic TBC (30th Study Day)
Monday 10th February
Churchill House, London

Annual Scientific Meeting
Tuesday 29th April to Thursday 1st May
Manchester Central, Manchester

Philosophy & Ethics SIG Annual Conference
Rydal Hall, Ambleside, Cumbria
Monday 30th June – Thursday 3rd July

Topic TBC (31st Study Day)
Tuesday 25th March
Churchill House, London

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

Qdem
pharmaceuticals

You should only switch from OxyContin if you have a good reason. Here's the good reason.

Longtec® is the smart way to prescribe prolonged release oxycodone.
It's a straight swap for OxyContin® – same formulation, same quality, same level of pain care[1] – but with one important difference, the price is 20% lower.[2]
And because generic reimbursement won't match that price, there's also a good reason to prescribe them by brand name.
So, for severe pain, write *Longtec*.

Tablets shown actual size

Brand quality
Generic prices

Longtec

Prolonged release oxycodone hydrochloride tablets

Longtec® tablets contain an opioid analgesic.

Longtec® (oxycodone hydrochloride) 5 mg, 10 mg, 20 mg, 40 mg, 80 mg prolonged release tablets. **PRESCRIBING INFORMATION. United Kingdom. Please read the Summary of Product Characteristics (SPC) before prescribing. Indications:** Moderate to severe pain in patients with cancer or post operative pain. Severe pain requiring the use of a strong opioid. **Dosage & administration:** Tablets must be swallowed whole, and not broken, chewed or crushed. *Elderly and adults over 18 years:* Take tablets at 12-hourly intervals. Dosage is dependent on the severity of pain and the patient's previous history of analgesic requirements. Not intended for use as a prn analgesic. Usual starting dose for opioid naïve patients, or patients presenting with severe pain uncontrolled by weaker opioids: 10 mg, 12-hourly. Some patients may benefit from a starting dose of 5 mg to minimise the incidence of side-effects. Opioid naïve patients with mild to moderate renal and/or mild hepatic impairment may be started on 5 mg, 12-hourly and titrated to pain relief. Any dose increases should be made, where possible, in 25%–50% increments. When transferring from morphine, the following ratio should be used as guidance: 10 mg oral oxycodone is equivalent to 20 mg oral morphine. Opioids are not firstline therapy in non-malignant pain, nor are they recommended as the only treatment. The need for continued treatment in non-malignant pain should be assessed at regular intervals. *Children under 18 years:* Not recommended. **Contra-indications:** Respiratory depression, head injury, paralytic ileus, acute abdomen, delayed gastric emptying, chronic obstructive airways disease, cor pulmonale, severe bronchial asthma, hypercarbia, known sensitivity to oxycodone or any of the constituents, moderate to severe hepatic impairment, severe renal impairment, chronic constipation, concurrent administration of monoamine oxidase inhibitors or within two weeks of discontinuation of their use, galactose intolerance, lactase deficiency, glucose-galactose malabsorption, any situation where opioids are contraindicated, pre-operative use or use during the first 24 hours post operatively, pregnancy. **Precautions and warnings:** Hypothyroidism, opioid dependent patients, raised intracranial pressure, hypotension, hypovolaemia, toxic psychosis, diseases of the biliary tract, pancreatitis, inflammatory bowel disorders, prostatic hypertrophy, adrenocortical insufficiency, alcoholism, delirium tremens, chronic renal and hepatic disease, severe pulmonary disease, debilitated patients, elderly and infirm patients, history of alcohol and/or drug abuse. Do not use where there is a possibility of paralytic ileus occurring and if this is suspected or occurs during use discontinue immediately. Patients about to undergo additional pain relieving procedures (e.g. surgery, plexus blockade) should not receive ***Longtec*** tablets for 12 hours prior to the intervention. ***Longtec*** 80 mg tablets should not be used in opioid naïve patients. ***Longtec*** tablets should be used with caution following abdominal surgery, and not used until normal bowel function returns. ***Longtec*** tablets have a similar abuse profile to other strong opioids. ***Longtec*** tablets must be swallowed whole and not broken, chewed or crushed which leads to a rapid release and absorption of a potentially fatal dose of oxycodone. Concomitant use of alcohol and ***Longtec*** tablets may increase the undesirable effects of ***Longtec*** tablets; concomitant use should be avoided. **Interactions: *Longtec*** tablets, like other opioids, potentiate the effects of transquilisers, anaesthetics, hypnotics, antidepressants, sedatives, phenothiazines, neuroleptic drugs, other opioids, muscle relaxants and antihypertensives. Monoamine oxidase inhibitors are known to interact with narcotic analgesics, producing CNS excitation or depression with hypertensive or hypotensive crisis. Inhibitors of CYP3A4 or CYP2D6 may inhibit the metabolism of oxycodone. Alcohol may enhance the pharmacodynamic effects of ***Longtec*** tablets; concomitant use should be avoided. **Pregnancy and lactation:** Not recommended. **Side-effects:** Common (≥ 1%): constipation, nausea, vomiting, dry mouth, anorexia, dyspepsia, abdominal pain, diarrhoea, headache, confusional state, asthenic conditions, dizziness, sedation, anxiety, abnormal dreams, nervousness, insomnia, thinking abnormal, somnolence, bronchospasm, dyspnoea, cough decreased, rash, pruritus, hyperhidrosis, chills. Uncommon (≤ 1%): but potentially serious: anaphylactic reaction, anaphylactoid reaction, hypersensitivity, biliary colic, cholestasis, ileus, gastritis, dysphagia, dental caries, hallucinations, depression, dysphoria, affect lability, mood altered, restlessness, agitation, euphoria, disorientation, amnesia, vision abnormal, vertigo, drug tolerance, drug dependence, drug withdrawal syndrome, paraesthesia, speech disorder, convulsions, urinary retention, ureteral spasm, libido decreased, supraventricular tachycardia, hypotension, orthostatic hypotension, respiratory depression, syncope, oedema, oedema peripheral, increased hepatic enzymes, exfoliative dermatitis, urticaria, amenorrhoea, erectile dysfunction. Overdose may produce respiratory depression, pin-point pupils, hypotension and hallucinations. Circulatory failure and somnolence progressing to stupor or deepening coma, skeletal muscle flaccidity, bradycardia and death may occur in more severe cases. The effects of overdosage will be potentiated by the simultaneous ingestion of alcohol or other psychotropic drugs. Please refer to the SPC for a full list of side-effects. Tolerance and dependence may occur. It may be advisable to taper the dose when stopping treatment to prevent withdrawal symptoms. **Legal category:** CD (Sch2) POM. **Package quantities and price:** 5 mg – £10.00 (28 tablets), 10 mg – £19.99 (56 tablets), 20 mg – £39.98 (56 tablets), 40 mg – £79.98 (56 tablets), 80 mg – £159.98 (56 tablets). **Marketing Authorisation numbers:** PL 40431/0001-0005. **Marketing Authorisation holder:** Qdem Pharmaceuticals Limited, Cambridge Science Park, Milton Road, Cambridge CB4 0AB, UK. Tel: 01223 426929. For medical information enquiries, please contact medicalinformationukQdem@qdem.co.uk **Date effective:** February 2013. ® LONGTEC, OxyContin and QDEM are registered trade marks. © 2013 Qdem Pharmaceuticals Limited. **UK/Qdem-13001 PI approved January 2013. References: 1.** UKPAR Longtec 5, 10, 20, 40 and 80 mg Film-coated prolonged release tablets PL 16950/0145-9. [Accessed July 2013]. http://www.mhra.gov.uk/home/groups/l-unit1/documents/websiteresources/con014571.pdf **2.** MIMS. July 2013.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.
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SAGE

Can antibiotics cure back pain?

Thanthullu Vasu

> *"If politics is the art of the possible, research is surely the art of the soluble.*
> *Both are immensely practical-minded affairs"*
>
> *- Sir Peter Medawar, Noble prize winner - 1960*

I am neither a politician nor do I know much about it, but can write about a few recent researches in our field of pain management that have created intense deliberations. The altercation was so extreme and some eminent scientists believed that one of these innovations could even be a Nobel Prize winner while the other group was pessimistic of the conduct of research itself! As I wish to review them critically, I declare that the views represented are that of my own and do not represent that of the British Pain Society or the Council.

Albert HA, Lambert P et al. Eur Spine J (2013) 22: 690-6

The first research that I wish to elaborate is that of the use of antibiotics for back pain. Two recent articles in European Spine Journal were the basis for these discussions. Based on these researches, newspapers quoted that 40% of back pain could be treated easily and no wonder, they made headline news in many sections[1]. This first part of the study was conducted by the Spine Centre for Southern Denmark with collaboration from School of Life and Health Sciences at Birmingham, UK.

The first research is to prove that the disc material removed from patients who had surgery with changes in MRI scan (modic changes) had infection with bacteria[2]. It is interesting to note that 6% of general population and 40% of low back pain have modic changes on MRI scan. In the patients having back surgery with modic changes, 43% of patients had positive anaerobic growth on microbial culture tests. Out of these, 80% had modic changes with anaerobic growth. However, none of those with aerobic bacteria developed modic changes and 44% with negative cultures still developed modic changes. All these 61 patients had MRI scan proven changes and had review with MRI scan at 1-2 years post surgery. ***The research concluded that the intervertebral discs infected with anaerobic bacteria are more likely to develop modic type 1 changes in the adjacent vertebrae.***

Questions that were deliberated

> *"There are three kinds of lies: lies, damned lies and statistics"*
>
> *- Attribtued to Benjamin Disraeli, Creator of modern Conservative Party, 1846*

The questions that immediately came to my mind with regards to this research were:

- Nearly half (44%) of negative cultures also developed modic changes, how can this be interpreted? Further, 6% of general population have modic changes on MRI as quoted by the researchers.
- If none of the aerobic infections developed modic changes, can the critics interpret that the aerobic infections are a treatment for back pain, though this could be totally absurd? Statistics could be represented in many ways, but I agree that the logical interpretation in a clinically useful manner is the way forward.
- The authors say that the relative risk of anaerobic infection causing modic changes to that of aerobic infection causing modic changes is ***infinity***; however, those with an elementary knowledge of mathematics clearly know that anything divided by zero will give infinity! So, is this a sensible way to interpret the numbers?
- This is not the first study to predict the relation between modic changes and infection; further, previous research[3] has shown that modic changes are dynamic markers of the normal age-related degenerative changes; these lesions can convert from one type to another with time and occasionally superimposed stress can cause reverse conversion back to type I changes.
- Why does the study have less females (only 27% were female), while this is not true in the clinical presentation in this population?

Despite all these facts, this was the study which gave more reasons to do their final clinical study which was the highlight of the media recently.

> *"Research is what I'm doing when I don't know what I'm doing"*
>
> *- Wernher Von Braun, credited as Father of Rocket Science*

Albert HB, Sorensen JS et al. Eur Spine J (2013) 22: 697-707

This was the clinical study done from the researchers in Southern Denmark[4], which proved that 100 days of antibiotic treatment improved outcome in chronic low back pain with one year follow-up. The researchers termed this as Modic Antibiotic Spine Therapy (MAST). 162 patients were randomised to either 100 days of amoxicillin-clavulanate (500 mg /125 mg) three times a day or placebo. Two more randomised groups were included with double the dose of antibiotic or placebo also. The results were so impressive that in the study group the disease-specific disability-RMDQ (Roland Morris Disability Questionnaire) score fell from 15 to 11 in 100 days and down to 5.7 in one year! On the other hand, in placebo group, it fell from 15 to 14 at both 100 days and one year (meaning no change at all). Leg pain score fell from 5.3 to 1.4 in antibiotic group, while it worsened from 4.0 to 4.3 in the placebo group. Lumbar pain score did not change at all in the placebo group with 6.3 even before and at 100 days and one year! Doubling the dose of antibiotics was found to be more efficacious, showing a dose-response relationship. However, the authors quoted that there was no statistical significance.

Few questions that might arise after reading this interesting research include:

- How could the control/placebo group have no response at all? Most of the other pain trials yield a placebo response of around 20-30% in pain research.
- We have come a far way from managing pain in a biological manner, appreciating the social and psychological factors. This research needs to be proved conclusively with fear that the progress already made could be really jeopardised.
- We had a study of intradiscal injection of methylene blue some time ago[5] (again from the same journal that published this antibiotic study). The results were unbelievably in favour of this dye being injected into the disc (87% disappearance of pain or marked alleviation of pain). However, further studies were not able to replicate the same long-term results or outcome[6]. Some clinicians say that the excitement that this antibiotic study has provoked mimics that of methylene blue trial; considering the past, one cannot be blamed for being sceptical and worried.

- If this study is replicated to be true, is there a concern for antibiotic resistance as few critics have already argued? There have been worries of colitis and Clostridium difficile in susceptible patients with use of amoxicillin. The Centre for Disease Control has regarded antibiotic resistance as one of the top concerns facing the health care system.
- In another similar trial by same group[7], nearly 10% of patients stopped antibiotic treatment due to diarrhoea. In this study, though nearly 15% of antibiotic group dropped out of the study, side-effects to antibiotic was the cause only in less than 5%.
- All research participants were educated for 1.5 hours before the trial with regards to modic changes and how they cause pain; they were educated why *they should **not** do exercise* during the treatment period. This is ***against*** most pain clinic interventions in our country, where keeping active and coping strategies form the basic priniciples.
- Interestingly, even the leg pain was significantly reduced in the antibiotic group; the authors claim various reasons for this improvement in radiculopathy, including reduction in irritation chemicals around nerve roots.
- Nearly three out of four patients had disturbed sleep at night due to pain before treatment in both groups; antibiotic treatment reduced this to around 30% whereas it was still 61% in the placebo group.

Socioeconomic implications

The study investigated patients with MRI scan before and after the antibiotic therapy; an experienced radiologist was also needed to code the modic findings as the study only included type I modic changes. Low back pain is estimated to affect around one-third of the UK adult population each year; one in 15 will consult their GP about their back pain[8], which is 2.6 million per year in the United Kingdom. If this study is true, then are we going to afford all these sufferers a MRI scan investigation to look for modic changes? The newspapers[1] quoted that half a million sufferers could avoid major surgery by taking antibiotics!

Ethics of research

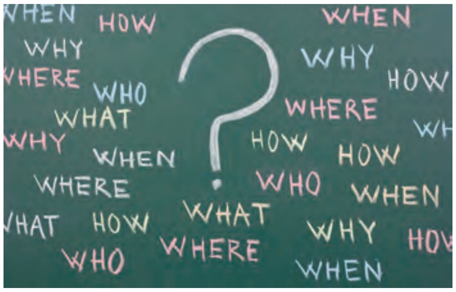
> *Science cannot stop while ethics catches up – and nobody should expect scientists to do all the thinking for the country"*
>
> *- Elvin Stackman, American Plant Pathologist*

Some critics of this research have raised an ethical question that the authors have not disclosed their interests in this study. The Primary authors run the MAST academy, which runs teaching courses and examination to certify a practitioner in MAST treatment. However, their website clearly mentions that this company is run in UK as a ***not-for-profit*** company[9].

What should we do now?

> *"Politics cannot be a science,*
>
> *because in politics theory and practice cannot be separated,*
>
> *and the sciences depend upon the separation"*
>
> *- W H Auden, Poet and Writer*

With regards to evidence-based medicine, we give huge importance to randomised controlled trials, next only to meta-analyses. As this research was hugely popularised in public domain including various newspapers and media, many members of our Society have mentioned that patients are requesting for antibiotics for the treatment of back pain. Most of the health care professionals in the field of pain management in United Kingdom have been trained on a multidisciplinary biopsychosocial way of managing back pain. Though the aim is not to deprive patients of an effective biological treatment, many feel that it is too early to make decisions on this treatment modality. The hype raised by media certainly does not help the health care professionals who manage these unfortunate sufferers. Having trained ethically with the Hippocratic Oath of "*Do No Harm*", many health care professionals have questioned this and have difficulty when the requests have come. Clearly, more research is needed to prove this fact; may be this could be a Nobel Prize winner like the discovery of Helicobacter Pylori as the cause of the gastric ulcer. However, having faced similar dilemmas in past[5], including that of the methylene blue study, we are sceptical and want to wait. In case of the Helicobacter, the further studies clearly replicated the findings. Many of us sincerely hope for this sort of replication of research.



Long time ago, when I started Pain Management, I got fascinated by the various new pain receptors and their modulators in the treatment of pain. As a young person, I was excited hearing the discovery of these new receptors. However, clinically we have not succeeded as much as we could have hoped for! Still we have not had any new drugs that could change the scenario - should I be blamed for being pessimistic or should we listen to well proven fact of managing in a biopsychosocial model? It was interesting to read recent article by Prof Andrew Moore in BMJ[10] about the need to expect analgesic failure and ways of pursuing analgesic success. As he mentions, though it might be news for others, pain clinicians know that most analgesic medications work well only in a small percentage of people!

I understand that policy statements are being prepared by spinal surgeons and other stakeholders involved with regards to the use of antibiotics for back pain. This was discussed in the British Pain Society Council meeting in June 2013 and I am sure that you would have received a statement from our President by email even before this newsletter reaches you. The Council of our Society receives many requests for comments, opinions and views similar to this problem; our Council Members and the Executives spend their valuable time to respond to many of these vital problems and their efforts needs to be sincerely appreciated.

Albrecht PJ, Hou Q et al. Pain Med 2013 Jun; 14(6): 895-915

> *"If we knew what it was we were doing,*
>
> *It would not be called research, would it?"*
>
> *- Albert Einstein*

This research[11], though not gained much popularity in the public domain as the previous one, still definitely caused interesting discussions among the pain fraternity and raised significant hope in patients suffering with fibromyalgia. The authors have shown that there is peripheral neuropathology among the innervations of the arteriole-venule (AV) shunts in the skin of patients with fibromyalgia. Skin biopsies taken from 24 female fibromyalgia patients showed that there was increased innervation in the AV shunts in fibromyalgia patients. The authors postulate that this causes severe pain and tenderness in the hands of these patients; more importantly, they say that this could affect thermoregulation to skeletal muscle causing increased metabolic demand and widespread deep pain and fatigue. This study was a collaboration of a company – Integrated Tissue Dynamics, USA and Albany Medical College, USA. This research, no doubt, is an important one

considering the various postulates of pathogenesis of fibromyalgia.

Unfortunately, the concerns that arise are:

- The study only looked at skin AV shunts; but the theory postulated of the metabolic demand was not the part of study neither proven.
- Through various media releases, from one of the authors (Rice FL) who is the President of the Integrated Tissue Dynamics, this was promoted as a major breakthrough[12] and raised huge hopes in these sufferers. In fact, his press release titled "Women with Fibromyalgia have a **real** pathology…" goes in detail to explain parts of a car and what happens when the thermostat in the engine has a problem- he quotes that this is a simple problem to sort out. On similar note, he equates that the thermostat in skin (AV shunts) have a problem in fibromyalgia. Obviously, this should raise unnecessary expectation in these patient groups. Readers will be aware of the huge problems that surrounded the discovery of a virus as a cause in fibromyalgia in the recent past[13].

Research ethics

Academic research should always be interpreted with a clinical sense and knowledge. The National Health Research Authority with its National Research Ethics Service has made huge changes in the way ethics application is granted before it starts and during the process. However, my view is that the above research examples may have flaws in the way how they were disseminated to the clinicians and the public. The MAST study should have awaited more trials before it was publicised internationally to give huge hype to the patients; similarly the fibromyalgia study is an interpretation of the finding that has given huge hope to these patients. This puts clinicians who are in the forefront of the delivery of pain management services in difficulty; I only hope that these researches are translated into clinical practice in a timely manner for the benefit of our patients!

Chronic pain is more complex than what we as clinicians and commissioners understand; some short term funding plans are made based on quick fix solutions, but they don't realise that chronic pain has an effect not only on patient but on their families, friends and the whole Society. Recent paper from Aberdeen[14] has clearly proved the significant association between reported chronic pain and all-cause mortality (risk of 1.32 times); the authors found that even after adjustment for socio-demographic factors and long-term illness, severe chronic pain remained significantly associated with all-cause mortality (risk of 1.49 times) and all circulatory system disease deaths (risk of 1.68 times). It is clear from this study that this risk is independent of socio-demographic factors; this study concludes that severe chronic pain is a serious health problem in primary care and is associated with increased risk of death, particularly from heart disease and respiratory disease. This is a crossed-linkage study done in patients recruited by Aberdeen Pain Group in 1996, who were surveyed after ten years; this epidemiological study once again proves the need for national datasets in chronic pain management; this type of studies are very vital to influence and facilitate discussions with commissioners and those who fund the treatment modalities. Though the study did not aim to find the cause why this happens, further studies[15] have revealed few links between chronic pain and lifestyle factors like smoking, sleep disturbances and low physical activity that could lead to increased mortality.

Well done Andy- Wimbledon after 77 years!

Not only has Scotland given us the pride in Wimbledon, but the Scottish have done immense work in our field of pain management also. The Scottish Intercollegiate Guidelines Network (SIGN) are developing a guideline for the management of chronic pain; the Scottish Parliament held a debate on 29th May 2013 on ensuring access to high quality sustainable services for people living with chronic pain (more details available on http://www.knowledge.scot.nhs.uk/pain.aspx). We all remember that the Scottish Government appointed the first Czar or senior doctor to spearhead improving care for chronic pain in 2009; Dr Pete MacKenzie who started this effort was followed by Dr Stephen Gilbert. Dr Gilbert, the National Lead Clinician for chronic pain healthcare improvement in Scotland has kindly written an update for this issue of our newsletter. This gave the opportunity to receive updates from Northern Ireland by Dr Pamela Bell and from Wales by Dr Rhian Lewis and her team. I hope to have regular updates from all our nations as well as different regions regularly in our newsletter. Of course, we learn from each other regarding how to progress with the difficulties we face in this present financial situation and these updates will help us significantly. If you have any regional news, please do not hesitate to contact either me or the Secretariat; we are always willing to support the work you are doing by publishing to a wider audience.

SIG updates

I thank the SIG chairs for their updates regularly; Pain in Older Adults, Pain in Developing Countries and the Pain

Education SIG have given interesting updates from their groups; Patient Liaison Committee should also be thanked for their timely update of their meeting and activities. Thanks to Jenny at the Secretariat, SIGs have agreed on a timetable for regular updates to all the wider membership, though we encourage more regular updates in each issue of our newsletter. There is so much of hard work going on in every aspect of our Society and I feel that members need to be aware of all these activities; this might also encourage members to fully participate in all activities of our Society.

Saving starfish

> *"Act as if what you do makes a difference; it does"*
>
> *- William James*

Big results could be achieved by small changes; I was amazed by the feedback of the Philosophy and Ethics SIG meeting from Betsan Corkhill. I did attend this meeting at Launde Abbey and learnt a lot from others; however, Betsan has done a great job by writing such eloquently about the meeting for this issue of our newsletter. In the present NHS climate where frustration and dissatisfaction is prevalent, the story of a child saving starfish gives us the glimmer of optimism and the motivation to do small changes.

Interesting articles

Dr Rayen has researched a lot about use of curry as analgesia in this issue; coming from Birmingham, when he promised me a treat of curry, my understanding was different! However, I am sure you will all enjoy the variety of interesting pain topics he could find and write for us! When I asked Dr Arun Bhaskar to write about his poster of Opioid from the ASM, little did I realise that he will give us an interesting article on the experience of how he changed his surgeons and GPs! As usual, Dr Peter Wemyss-Gorman gives us interesting transcripts from the Philosophy and Ethics SIG and I thank him sincerely.

Do you want to become Editor / Associate?

You should have already received email advert for these posts from the Secretariat. The adverts are also published in this issue of our newsletter (P151-152). Considering the ever-expanding work of the Council of our Society and the increasing interest of our members to publish, we have planned for two Associate Editor posts to help the Editor. All these three posts start from next March, but the new appointed Editor/ Associates will have opportunity to observe two Editorial meetings and follow one whole issue in preparation before taking their task. I really enjoyed this role till now and am impressed with the interest of the wider membership in the newsletter. If this is of interest to you, please apply or if you want more details don't hesitate to contact me at vasubangor@gmail.com or phone the Secretariat at 020 7269 7844. The Editor will have the opportunity to be co-opted to the Council and can also be part of the Communications Committee of the Society. Three out of four Editorial meetings will be held via teleconference and one meeting will be held in Churchill House. The last date for these applications is Friday 20th September 2013.

I thank you all for the feedback and interest in our newsletter. If you want to share any interesting news/ facts to our members, please write to us and we are happy to publicise through *Pain News*. Now, enjoy reading this issue of our newsletter,

Thanthullu Vasu
Bangor, North Wales

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The British Pain Society

Pain News
11(3) 137–138

SAGE

From the President

Dr William Campbell

At the time of writing, some months will have passed since the Annual Scientific Meeting (ASM) in Bournemouth. The Secretariat has been exceptionally busy since then. By the time that you read this, the office of our Society will have moved about 10 metres from its current location but remains on the Third Floor of Churchill House. The computer systems will have been updated, and we continue to explore how best to improve the British Pain Society (BPS) website.

Our Communications and Events Officer, Rikke Susgaard-Vigon went on maternity leave in July, and we wish her well over the coming months. During Rikke's year of absence, her office activities will be carried out by Dina Alumuli – a warm welcome to the BPS office team Dina!

Commissioning

Although this may not sound like an exciting topic, it is essential that you or your clinical lead makes contact with your Trusts Contract Manager, if you have not already done so. This applies to all disciplines and is essential to ensure that your activity in managing pain continues to be recognised within your Trust and by the Commissioners in your area as an essential service. Engaging with the Health and Wellbeing Board is also a desirable move on your behalf, to ensure that pain remains on their agenda. In addition, ensure that you are working towards best patient care via the Map of Medicine; see microsite at http://www.britishpainsociety.org. Pain management requires multidisciplinary management in a timely fashion, and Commissioners need to be made aware of this, as our patients are much more likely to develop co-morbidities if this is ignored, resulting in time off work and potential breakdown of family units as well, http://www.nationalpainaudit.org/media/files/NationalPainAudit-2012.pdf

Many patients will require secondary care in hospital, especially the more complex cases, so it is important to gradually build up the pain service in your area, as per the pathways, rather than to radically dismantle and reassemble in a completely different fashion.

Your feedback after the ASM

Following the ASM in Bournemouth, we asked all those who attended, as well as non-attenders, to complete a form indicating which parts of the meeting were desirable as well as those parts that could be improved upon. Due to the very large amount of information gathered and ultimately collated by the secretariat, we hope to improve the delivery of future events. On 18 June 2013, we had a meeting of both the Special Interest Group (SIG) Chairmen, and on the same day, Professor Gary Macfarlane led a meeting to plan next year's ASM. The SIG Chairs meeting was attended by Gary for some time after we had discussed possible ways of improving the future meetings. There is every likelihood of some considerable change in ASM delivery, not only within the educational programme but also the social activities!

National Institute for Health and Clinical Excellence (NICE)

In early June, several of us met with Professor Mark Baker, Director, Centre for Clinical Practice, NICE. NICE is developing a library of Quality Standards in various areas of health care including pain. In addition, they are planning a complete rewrite of guidance on the management of low back pain, with the old CG88 due for replacement over the next few years. The old CG88 only included randomised controlled trials, but the new document should take all types of graded evidence. Currently, there are many guidance documents available, including NICE guidance. Commissioners

Dr William Campbell

will follow the NICE guidance in preference to all others. Of course, pain issues arise in many of the NICE guidance documents, and in the past, Dr Sam Eldabe and Dr Rajesh Munglani have reviewed the draft NICE documents and submitted expert pain opinion and evidence where needed. Dr Tim Johnson, supported by Dr Austin Leach, has now taken on this task. We are very grateful for the hours of work that they put into these activities.

The BPS publications process was inspected by a group from NICE and following a gap analysis recently, a further meeting is planned in late July, to determine whether our publications can be NICE accredited. This of course would include the Pain Patient Pathways, which have generated considerable interest internationally, and the International Society for the Study of Pain (IASP) is exploring how they may have links with the pathways via the Map of Medicine.

Roadshows on pain pathways, National Pain Audit and Commissioning

These Roadshows supported by the Association of British Pharmaceutical Industry Pain Initiative (APBI PI) have been delivered in Bristol, Manchester, Birmingham and Edinburgh. A further presentation was delivered in London, and a further two are due to take place in Newcastle and Belfast. On behalf of us all, I am very grateful to the dedicated speakers who have given their time to deliver the appropriate presentations at these events, and Professor Richard Langford who secured the funding for these.

Annual patient seminar

On 12 June 2013, Mr Antony Chuter, Chair of the Patient Liaison Committee (PLC), ran a very well-organised annual patient seminar day in Churchill house. This was attended by a wide range of patient representatives and health-care professionals, indicating weaknesses and strengths in our current health-care delivery and how we can move forward for the benefit of all. I am sure the PLC will expand on this for all or our benefit.

eLearning pain

This project has come on very well this year, with a reorganisation of the content modules and all authors in place. The e-Pain Project Executive wish to express their thanks to the module leaders:

Lesley Colvin
Ian Goodall
Paul Farquahar-Smith
Richard Howard
John Hughes
Roger Knaggs
Jane Quinlan
Mark Rockett
Pat Schofield
Rob Searle
Cathy Stannard
Stephen Ward
Paul Wilkinson

We thank them for their tremendous efforts over the past months in driving this project ahead, as we were getting behind our Department of Health agreed timeframe. Their hard work, together with that of the very many authors, has now ensured that we are now back on target for completion in a timely manner.

Post-herpetic neuralgia surveillance project

Public Health England (PHE) wishes to determine the benefit of a herpes zoster vaccination programme in the over 70-year-olds. PHE wishes to contact all pain clinics in England using a card system to determine the benefit of this vaccination from this autumn onwards. The project will be administered by PHE Colindale. They are looking for your support in this project and may already have been in contact with you prior to you reading this.

Low-back pain

The British Orthopaedic Association forwarded a draft consultation commissioning guide for low back pain. It was decided to coordinate a ‘pain’ response, including the BPS. Dr John Goddard coordinated responses from three bodies – the BPS (responses collected by Manohar Sharma), the Faculty of Pain Medicine (responses collected by Stephen Ward) and Specialised Pain Services Clinical Reference Group (via Neil Colligan). This was a major task and extremely well referenced. It is a tribute to those who contributed so much. A further draft document on radicular pain is currently being considered.

Finally, our Council has an additional co-opted member Ann Taylor, who will have an important role Project Facilitator - Problematic Pain. This will, of course, be in addition to her many other activities in pain education and problematic pain, the later activity being primarily for the Faculty of Pain Medicine.

From the Honorary Secretary

Dr Martin Johnson

THE BRITISH PAIN SOCIETY

Pain News
11(3) 139–140

SAGE

Summer is here at last, and I am late preparing this report because I just had to watch THE match – well done Andy!

Turning away from the great Scot to the complexities of the English NHS! Do you really understand all the layers and associations of the new system (I cannot believe that we have got rid of some bureaucracy!) - if you are not confused, well done! If you are as confused as me, The King's Fund have just released some resources to coincide with the 65th anniversary of the NHS. This includes a wonderfully simple but informative video clip that explains all - www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england

May I draw your attention to the release of some more guidance? Many of us have to deal with complex issues surrounding prisoners with pain. Early July has seen the launch of a substantive document from Public Health England "Managing persistent pain in secure settings" - a guide for professionals working in custody settings, to support best practice in diagnosing, assessing and managing the symptoms of persistent pain among prisoners. The document was written in association with the BPS, FPM & RCGP and the working group was co-chaired by Cathy Stannard. You can find a copy of the guidance at the following link www.nta.nhs.uk/news-2013-persistent-pain.aspx

Membership

According to the database (thanks Ken), we now have 1391 members - a partial breakdown of these figures shows 673 anaesthestists, 220 nurses, 95 psychologists, 77 physiotherapists, 21 GP's plus everyone else (no insult intended if your group is not specifically mentioned). Looking at the figures for this time last year, this amounts to a decrease of 4.9%, mainly from the anaesthetists and nurses section. Drilling into the reasons, it appears to be mainly due to the posts not being continued, retirements etc. I have yet to see any negative comments about BPS membership – anecdotally I heard some comments about the BPS not supporting its membership. All I know is that many people are working flat out to develop and support the world of pain management, with many great successes (as reported in previous editions of *Pain News*). If you think there are other things that we should be doing, please please don't remain silent – let us know!

ASM

A perfect example of what we can do when we get feedback is regarding the ASM – we asked for feedback after Bournemouth and we certainly received it – all 54 pages! I realise that, again, not everyone approved of having to give feedback to get your certificate but firstly we have only ever got limited feedback in the past and secondly feedback can be used as part of your reflective commentary for your CPD. Overall we are getting a lot of things right but your feedback will help us fine tune it to make the next ASM really reflective of your needs and opinions. Of course, we can't make everyone happy – some say there is too much science others say there is too much clinical etc. The secretariat and Gary have worked really hard to produce a new balanced programme. Gary will present this elsewhere in this edition of *Pain News* along with further details of the survey.

Contributing Members

As the Honorary Secretary, one of my primary responsibilities is to promote membership of the BPS – only by more of us working together, we will solve many of the issues that confront us in pain management. Looking at the existing application form, it would appear that the only way to become a member is applying for ordinary or international membership. If you look further into the regulations (including the Memorandum

& Article's), then you will see two further ways to become a member – Contributing & Associate membership. These two categories are about as clear as mud! Working with Jenny and Ken in the Secretariat, we have proposed a series of amendments to Council – some of which will need to go through the next AGM; the idea being to clarify this whole area. BUT in the meantime – if you work in the field of pain but are either not a health care professional or you do not practice as a health care professional, you may be entitled to join the BPS as a Contributing Member – this may appeal for example to many of our members of our patient groups or individual members of companies that we work with such as pharmaceutical or device companies. Hopefully by the time you read this, the membership application form will be tidied up and we would have advertised this membership category.

As I finish this column, England have just won the first Ashes Test match – Wimbledon to Trent Bridge – you can see how long I have been writing it!

THE BRITISH PAIN SOCIETY

SAVE THE DATE

IPM SIG Annual Scientific Meeting, 18th October 2013
Churchill House, 35 Red Lion Square
London WC1R 4SG

Topics including:

Post surgical abdominal wall pain
Low back pain: Update on diagnosis and management
Outcomes and developments in Interventional Pain
Current concepts in managing Chronic Pancreatitis

Invitations for articles for *Pain News*

Have you ever considered writing an article for *Pain News*? Do you have a topic that you would like to share with the membership?

Then contact Dr Thanthullu Vasu, Editor of *Pain News* at: newsletter@britishpainsociety.org

We would love to hear your ideas!


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News

The British Pain Society

Pain News
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SAGE

What's happening with chronic pain in Scotland?

Steve Gilbert *National Lead Clinician on Chronic Pain with Healthcare Improvement Scotland*

The Scottish position

The issue of chronic pain and how services should be delivered are currently very much in the spotlight in Scotland. Public, parliamentary and clinical interest has been building over the last decade, and reports such as the McEwen Report (2004),[1] a Best Practice Statement on Chronic Pain[2] and the Getting Relevant Information on Pain Services (GRIPS) report (2007),[3] together with patient petitions and the formation of a Cross Party Working Group and parliamentary debates, have all contributed to the current position. In response, Scotland has been developing a model for chronic pain and more recently actively supporting its widespread implementation.

Our approach

The Scottish Service Model for Chronic Pain (SSMCP)[4] covers community, primary, secondary and tertiary care settings and is predicated on a biopsychosocial approach. It recognises that most people with chronic pain are managed in community and primary care settings, that many can and want to self manage and that only the minority require very specialist care. The need for access to secondary/tertiary care specialist pain services is not overlooked within the model and their importance fully understood. In 2011, Healthcare Improvement Scotland (HIS) carried out further work finding that although there had been improvements in the number and extent of pain management services since 2005, including a presence in every Health Board, variation still existed and, particularly, the availability of multidisciplinary pain management programmes (PMPs). The audit also found little pain management being actively delivered in primary care. The referral rate to secondary care services was only 0.3% versus an estimated 5%–10% incidence of chronic pain.[5]

I was appointed National Clinical Lead for Chronic Pain in 2010, taking over the role from Dr Pete Mackenzie, the very first national lead who unfortunately had to retire due to ill health. Pete did a great job in kicking off the development of the model work that the team at HIS has been taking since then. I work two days a week, which, together with my normal pain sessions at the hospital, makes for a lot of pain in my week! I've been told I even talk about it in my sleep!

Working with the project team, I coordinate the national work overseen by the National Chronic Pain Steering Group, which has wide ranging clinical and patient representatives. Our approach has been to encourage the development of Service Improvement Groups (SIGs) in every health board who will provide a co-ordinated approach to implementing the SSMCP locally. Last year, the team was 'swelled' by an additional three facilitators working one day a week each to assist with the work. All are senior physiotherapists: John McLennan from National Health Service (NHS) Lothian, Linda Sparks from NHS Greater Glasgow and Clyde and Norma Turvill from NHS Forth Valley. Our priorities for this year focus on longer term sustainability and include the following:

1. Supporting the development of SIGs and the SSMCP in every health board in Scotland;
2. Establishing a national network for SIGs;
3. Producing information and resources for the public, service users and health-care providers to replace the current information at http://www.knowledge.scot.nhs.uk/pain.aspx

4. Gaining baseline data for SIGs as they move forward, including information about local service configuration, uptake, patient pathways, experience and outcomes.

When the SIG approach was first suggested as a way forward, there was a degree of scepticism from clinicians who were hoping for big pots of money to use locally. Scotland, however, has a good track record of utilising the Managed Clinical Network or SIG approach for a range of conditions, hence our reason for adopting such an approach. SIGs bring together all stakeholders involved in providing services across an area from all sectors including patients and provides the structure to review how the service is provided. Despite this initial scepticism, great examples are starting to emerge in a number of areas: NHS Ayrshire & Arran, NHS Dumfries & Galloway and NHS Greater Glasgow & Clyde to name a few. Glasgow, one of the first, set up their SIG in 2009 systematically looking at care pathways, data collection, education, information and equity of services. They've made many improvements and joined up cerebral palsy (CP) services across Glasgow compared to their previous traditional, very individual approaches. The Scottish Government Health and Care Directorate has provided £100,000 pump priming funding over two years for each NHS Board to help with establishing their SIG.

Light at the end of the tunnel? – hope it's not a train coming!

During my first year in post, I went on a tour of pain services around Scotland to establish current practice and share the good work they were doing as well as better understand the challenges they were facing. We've used this learning to shape our thinking and approach. What we've learned is that local situations vary due to a range of circumstances including geography, clinical capacity and capability, resource and so on. The model therefore must be flexible enough to accommodate these differences but also offer national solutions to some of the generic issues. Providing advice and information for the public and patients is a prime example of this. Our solution was to design Web-based resources at a population level linking with other national information providers (NHS Inform and musculoskeletal (MSK) services).[6] We also ran a community pharmacy poster campaign in collaboration with Pain Association Scotland, Pain Concern and the Royal Pharmaceutical Society.[7] Supporting clinician education is another key strand to our work, and we're working closely with NHS Education Scotland (NES), the main education provider in Scotland.

Other key highlights from our recent work

- All Boards in Scotland have signed up to developing a local SIG, but this is just the start of the journey with much still to do! Nearly all have submitted plans for their local service improvement with most already out of the starting blocks.
- Pain Association Scotland, a voluntary group that provides self-management training, and support groups have been able to establish local groups, with Health Board support.
- General practitioners (GPs) and community pharmacists are involved in the SIGs and contributing to the development of the pathways for pain assessment and management.
- In parallel to the work on improving chronic pain currently underway in Scotland, there is a similar national initiative for improving the management of MSK conditions. As many people with chronic pain also have MSK problems, close alignment between these streams of work is important. MSK services will be subject to a national target this year that all patients referred to Allied Health Professions (AHP) services will be seen within four weeks. A similar target for psychology services is also being introduced (18 weeks) by the end of 2014; both will represent a significant improvement in access to these services for people with chronic pain.
- Chronic pain service development will be part of Local Delivery Plans for NHS Boards from 2014. This is good news as the spotlight will be on these services, which is challenging, but also very helpful!
- Most recently, we have been examining the case for an intensive National PMP. This has been the subject of much external interest as currently a small number of patients are referred to the Bath residential PMP due to lack of a Scottish option. A consultation paper has been written and is currently out for views with a decision expected later this year.
- We have also been working on coordinating guidelines for referral and management for specialised interventional techniques, such as Spinal Cord Stimulation and so on.
- SIGN, the Scottish Intercollegiate Guideline Network (a part of HIS), has developed a SIGN Guideline for the management of chronic pain, which is also currently undergoing peer review and is due for publication in December this year. This concentrates on the assessment and management of chronic pain in primary care and has been welcomed by the Royal College of General Practitioners in Edinburgh as well as NES as a useful tool to provide pain management education to GPs and other primary care staff.
- The Scottish Pain Research Community (SPaRC) has held three successful meetings highlighting the diverse range of research being carried out around Scotland. The research subgroup of the Steering group has been successful in obtaining a Chief Scientific Officer grant to carry out research on opiate prescribing in Scotland.

- A national meeting will be held in December 2013 to launch the SIGN Guideline and SIG Network and share good practice and followed up by a further meeting in March 2014 to build on progress.

When will we be there?

We are fortunate in Scotland to have a relatively small pain management community which is proactive and well known. We rely on these networks on achieving better collaboration and communication, and I'm confident that we can achieve much together.

There is still a long way to go till the SSMCP is fully implemented throughout Scotland and real improvements realised. I'm clear however that the SSMCP and its biopsychosocial approach is the right way for Scotland and will deliver better services. After all, there's much at stake for our patients.

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News

Advancing the pain agenda in Northern Ireland

Dr Pamela F Bell *Chair, Pain Alliance of Northern Ireland*

Sometimes the task of ensuring that the long-term pain agenda is not forgotten in the (slow) rush to 'Transform Your Care' in Northern Ireland seems Herculean! Although it is impossible to argue with the basic tenet that health-care costs need to be contained and that people benefit from being actively engaged in managing their own health (including receiving support for self-management), which is something that most of us have believed for a very long time and for which there is a growing body of evidence, my heart sinks when confronted with the 'it's not a priority' response from commissioners.

Indeed, long-term pain does not appear in the list of five priorities for the five Integrated Care Partnerships which are being set up across the province, these priorities being given to the frail elderly, respiratory conditions, end-of-life (palliative) care, diabetes and stroke. That long-term pain is a distressing symptom for a significant number of people with diabetes and stroke and is more prevalent (and perhaps more difficult to assess and manage) in the frail elderly has received little consideration.

At the Northern Ireland Assembly, there has been some support from the members of the Health Committee, across all political parties, who continue to ask questions of the Minister for Health, Social Care and Public Safety regarding progress on the Chronic Pain Road Map. This seven-point plan includes several things that are within the gift of the Minister, including the establishment of a Lead Clinician (of Tsar) to promote development of services for those with long-term pain across primary and secondary care and with voluntary sector organisations contributing in supporting self-management. Regrettably, responses from the Minister are increasingly anodyne.

When asked whether tackling chronic pain will receive specific attention in future Local Commissioning Plans and what measures his Department has implemented to ensure that tackling the suffering of patients and chronic pain remain a priority, he responded,

> *The provision of services to patients suffering from chronic pain is an operational matter, the responsibility for which lies with each Health and Social Care Trust.*
>
> *Pain management services are delivered in each HSC Trust area, with the Belfast Trust delivering specialist pain management services and procedures.*
>
> *In April 2012, I launched 'Living with Long Term Conditions', my Department's Policy Framework to provide strategic direction for the reform and modernisation of services for adults with long term conditions. The Policy Framework is designed to be relevant across a wide range of long term conditions, including chronic pain. The Framework focuses on six key areas of care including supporting self management, medicines management and improving care and services.*
>
> *My Department has endorsed a number of National Institute for Health and Clinical Excellence (NICE) technology appraisals and clinical guidelines, relating to chronic pain management, as applicable for implementation in Northern Ireland. As any new or updated Technology Appraisals or Clinical Guidelines relating to chronic pain management are published by NICE in the future, these will be locally reviewed and, where appropriate, endorsed by my Department for implementation within health and social care in Northern Ireland.*
>
> *Each of the local commissioning groups with a local elective orthopaedic service has prioritised the development of a musculoskeletal pathway within their local commissioning plans and processes. This is intended to improve the care pathway for a wide range of patients including those with chronic pain.*

In an attempt to bring some focus to what might be achieved, we selected a group of patients with long-term pain secondary to moderate-to-severe endometriosis to highlight the specific difficulties that they encounter in using health services, including chronic pain services. There were several reasons for choosing this group, not least a core group of highly articulate young women who were prepared to meet members of the Assembly Health Committee and to engage actively with the media. First, all had very powerful stories of the impact that pain (and infertility) had had on their lives. Second, none of the Pain Clinics in Northern Ireland has a specialist pelvic pain service, and there is only one gynaecologist who deals with those with moderate-to-severe endometriosis. Third, there was a growing feeling that dealing with long-term pain in the round was just too big an issue and putting the spotlight on a single condition might provide a template for future service development.

Following a breakfast meeting with the Health Committee where the pain, gynaecological and fertility issues were presented by the consultants, and the stories of the patients shared, the Chair of the Health Committee, Sue Ramsey MLA, invited us to prepare an Assembly Motion as follows:

> *That this Assembly calls on the Minister of Health, Social Services and Public Safety to initiate and expedite an inquiry into the urgent need for an integrated endometriosis service to address the severe suffering experienced by women with this condition across Northern Ireland.*

This motion was signed by every member of the Health Committee, in itself an unusual occurrence, and on the day of the debate (which coincided with the visit of President Obama to Belfast), every political party put forward at least one speaker in support of the motion. The Minister responded by recognising the pain and distress that endometriosis can cause, but felt that since it is a common condition (affecting 1 in 10 women of child-bearing age), it should be managed by General Practitioners. He rather overlooked the point that the moderate-to-severe form of the condition which affects 1 in 100 requires the input of specialists at an early stage to minimise the risk of development of long-term pain and to improve the rate of conception and successful pregnancy for these women.

Perhaps not the most satisfactory outcome and certainly not an undertaking to establish an endometriosis centre or a specialist pelvic pain clinic; however, we have received the robust assurances of the Chair of the Health Committee that she will not let the issue drop and will raise it again in the next session of the Assembly.

Despite the Obama visit, there was a welcome print and broadcast media interest in the issue, so pain continues to receive coverage.

On a much more positive note, the Survey of Patient Experience of Pain Services being conducted by the Patient and Client Council is progressing well, and we hope to present the preliminary results at a meeting with the Commissioners and Transforming Your Care Implementation Leads on 10 September. This is a joint meeting between the Pain Alliance of Northern Ireland, the British and Northern Ireland Pain Societies, the Patient and Client Council, the Northern Ireland Confederation of Health and Social Care Organisations and the Long Term Conditions Alliance Northern Ireland.

I hope to report on this in the next issue of *Pain News*.

News from Welsh Pain Society

The British Pain Society

Pain News
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Dr Rhian Lewis, Bangor and Dr Mark Turtle, Carmarthen

Over the last twelve months, there have been considerable developments in Wales. The Welsh Pain Society has continued to be a forum for clinicians to get together and discuss clinical and administrative issues, as we all struggle to manage increasing demand with a shrinking health budget. Despite encountering some recent difficulties, the Welsh Pain Society has addressed our means of representation and accountability, has almost completed the process of modernising our constitution as well as the means whereby we agree the policies and looking forward for another interesting Annual Scientific Meeting on 18th October 2013.

Current officers of the Welsh Pain Society are:

Chair	Dr Mark Turtle, Carmarthen
Vice Chair	Dr Rhian Lewis, Bangor & Dr Rob Davies, Cwm Taf, Llantrisant
Secretary	Dr Tzvetanka Stoilova, Newport Gwent
Treasurer	Sherrill Snoellgrove, Swansea

Annual Scientific Meeting

The next Welsh Pain Society Annual Scientific Meeting will be held in Llandeilo on the 18th October 2013; there are thought-provoking interesting talks, including a "patient perspective" by Mr Simon Weston, "establishing relationships in a sea of anxiety" by Professor Baldwin from Southampton, "Placebos and objective goals" by Michael Lee from the Clinical Neurosciences Department in Oxford and "Headache" by Paul Davies, Consultant Neurologist in Northampton.

Welsh Pain Society

Annual Scientific Meeting
Friday 18th October 2013

Registration fees for health professionals	
Medically qualified non WPS members	£100
Medically qualified WPS members	£80
Non medically qualified non WPS members	£40
Non medically qualified WPS members	£25

Venue
The Plough Inn, Rhosmaen, Llandeilo
info@ploughrhosmaen.com
Telephone: 01558 823431
Fax: 01558 823969

Please book your accommodation directly with the hotel.
Rooms available per night : double £90.00, single £70.00. N.B. there is limited availability at this rate
(please quote "pain meeting" when booking your room).
There are various other hotels/accommodation options in the Llandeilo area. Staff at The Plough will help with your arrangements if required.

Annual Society Dinner – Thursday 17th October
The annual dinner will be held at The Plough Inn on the evening of Thursday 18th November at 7.00 for 7.30 @ £35 per head (3 course meal with wine - soft drinks extra).

Please note : Current annual WPS Membership is £10.00
contact Treasurer: Sherrill Snellgrove S.R.Snelgrove@swansea.ac.uk
or Secretary: Tveta Stoilova Tzvetanka.Stoilova@wales.nhs.uk

Please send your completed registration form along with a cheque made out to "*The Welsh Pain Society*" to
Hannah Goldsworthy
Secretary Department of Anaesthetics, Intensive Care and Pain Medicine,
Glangwili General Hospital
Carmarthen SA31 2AF

Alternatively, email a completed registration form & pay by BACS
(Welsh Pain Society : sort code 40.16.23 : account no. 61240757)

Further information Hannah Goldsworthy / Joyce Rees / Mark Turtle
01267 227111 Hannah.goldsworthy@wales.nhs.uk

There are the usual poster presentations and a panel discussion of community Pain Clinic developments. Information can be obtained from the Welshpainsociety.org.uk.

Further details can be obtained from Dr Stoilova -Tzvetanka.Stoilova@wales.nhs.uk

The Welsh Pain Society is able to help Professionals who do not have access to finances for study leave to attend the meeting.

National Specialist Advisory Group

The National Specialist Advisory Group for Pain in Wales was set up in November 2012. We have successfully worked with the combined Welsh Board of the Royal College of Anaesthetists and the National Specialist Advisory Group to form a Pain Medicine Sub-group, which is multidisciplinary and constituted by health professionals elected by their peers and meets twice a year. This will be the sole statutory mechanism of communication with the Welsh Assembly Government. The officers of this group include:

Chair	Dr Rhian Lewis
Vice Chair	Dr Rob Davies
Secretary	Dr Sonia Wartan

There are two representatives from each Health Board in Wales – one from a medical and the other from a non-medical pain specialty. We are also working closely with the Welsh Government and the new Minister for Health and Social Services, Mr Mark Drakeford AM, who has invited us to join with him in working to improve the services for patients in Wales. We have planned a series of audit projects to objectively identify where deficiencies lie and work on the first of these, which we hope will set out what is currently provided, is at an advanced stage. Developments within the community along with measures to ensure that pain suffers constitute the core of service, are both items that will continue to be a major focus, although progress on them as yet has been disappointingly slow. We optimistically anticipate, however, that we will be in a position to report substantial progress in due course!

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More updates of NSAG

Dr Ann Taylor *Cardiff University*

As mentioned earlier, the National Services/Specialist Advisory Group which advices the Chief Medical Officer has recently sent round a survey / questionnaire to chronic pain services in every Health Board to get data on what is currently being offered. This is in response to the National Leadership and Innovation Agency for Healthcare's survey, which stated that Health Boards' were 98% compliant with the Chronic Pain Directives. The survey was seen to be flawed and pain services do not feel that it is an accurate description with what is available. The hope is that this will prove where gaps are in the provision of services and will bring extra funding to expand. At the very least, they are hoping they can use the information to liaise with the Welsh Government.

There is also increased engagement with Welsh Government through the Welsh APBI Pain Subgroup, who are working with pain clinicians and academics to develop questions that Assembly Members can use to challenge the Health Minister and there is also a Welsh Government political debate on pain services in the offing. Again the hope is to put pain on the political map.

There are still issues around the provision of services for the most debilitated and complex patients, where local services cannot provide for them. For example, some of the Health Boards can no longer directly refer to patients to the Inpatient Pain Management Programme but have to be managed by the local service. They need to go through a number of obstacles to get access and that is not always straight forward. The concern is that this facility will come under threat if it does not get enough referrals but even more that patients needing the more intensive input might miss out, fall out of the 'system' and suffer as a result.

There are also issues of high opioid use in Wales. The All Wales Medicines Strategy Group is undertaking work this year to look at opioid use, focus primarily on tramadol.

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Pain education and the Faculty of Pain Medicine

Shyam Balasubramanian *Coventry*
Sanjeeva Gupta *Bradford*

The Faculty of Pain Medicine of the Royal College of Anaesthetists and the British Pain Society promote education in pain medicine. Education for both primary and secondary care clinicians is a very important factor in facilitating seamless flow of care for patients with chronic pain. The Royal College of Anaesthetists organises different education programmes for continuing medical education for doctors interested in pain management.

Educational events

The Faculty of Pain Medicine runs biannual study days themed around specific areas of pain medicine, which covers issues as wide ranging as cancer and neuropathic pain to medico-legal issues. The Faculty also conducts FFPMRCA Examination Tutorial series.

The Faculty holds its Annual Meeting in November each year. As well as a useful-updates day, it is an opportunity for pain medicine doctors to get together with other members of the Faculty and the Faculty Board. Apart from lectures by highly regarded speakers, there is also a Faculty update, trainee publication prize award and the Patrick Wall Lecture followed by the award of the Patrick Wall medal.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

This year, the Annual Meeting is held on 22 November, and the topics include the following:

Persistent post-surgical pain: *Dr Robert Searle, Cornwall*

Pain management in primary care: *Professor Blair Smith, Dundee*

Medico-legal issues in chronic pain management: *Dr K Markham, Surrey*

Patrick Wall Lecture: *Professor Martin Koltzenburg, London*

Debate: 'Opioids have a role in functional pain syndrome': *For: Dr T Vasu, Bangor; Against: Dr A Rayen, Birmingham*

Whiplash injury: *Dr S Kapur, Dudley*

Cancer pain management – basic principles and interventions: *Dr J Antrobus, Warwick*

The events provide a forum for networking with peers and experts in the field, as well as making an important contribution to your continuing professional development (CPD). More detail on event registration is available at: http://www.rcoa.ac.uk/node/12425

News

The British Pain Society

Pain News
11(3) 149–150
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Pain Patient Pathways and Commissioning Roadshows – Feedback and Evaluation

Dr Andrew Nicolaou *Chair of the Pathways implementation and Dissemination Workstreams*

The Pain Patient Pathways and Commissioning Roadshows have been part of a number of initiatives to help promote the implementation and dissemination of BPS pain pathways. Their publication on Maps of Medicine toward the end of 2012 had been eagerly anticipated, and since then they have been well received. As you will know, the pathways have been a very important project for the BPS for some time and I believe they are a huge credit to our Society. Part of the project was to underpin a commissioning strategy. This was identified at an early stage as being a hugely important area. Before the pathways were ready to release, we held meetings at the 2012 ASM in Liverpool and at Churchill House in September specifically around commissioning and these were well attended.

The aim of the meetings – dubbed roadshows, was to support the pain pathways and inform our commissioning strategy. So far, the roadshows have been held in Bristol, Birmingham, Manchester and Edinburgh; Belfast is well advanced in preparation for its meeting. The whole process has been cost neutral to the BPS and all meetings have been free. Funding secured from the ABPI pain pharma group heralded a new era of collaboration and cooperation with industry that has been entirely unrestricted. With further specific unrestricted industry support, a number of the meetings have been enhanced with audiovisual recording / Webinar format for those unable to attend.

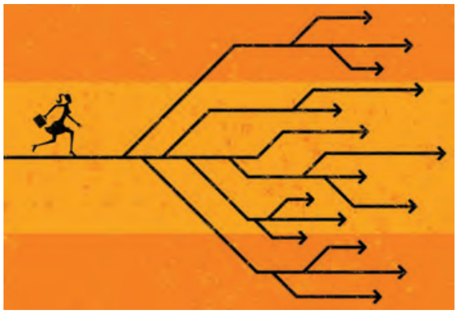
We need to deliver the latest and most up-to-date material in the context of an ever changing NHS. It seemed that new developments were springing up every week as we put together the programme – Clinical Senates, debates about Section 75 rules etc. Considerable elements around commissioning were (and some still are) far from finalised, and much of how this was actually going to fit together was unclear (and again, some still is).

We put together a programme around the National Pain Audit and Health Survey of England setting the scene and highlighting the significant variability of pain services around the country. Following this the format was generally around:

- the challenge of commissioning pain services / presenting evidence based best practice in commissioning
- writing directives and plotting pathways/implementation of BPS pathways
- presenting evidence and submitting proposals to commissioners
- National specialist pain services

Where possible, there were regional variations around the format, and we deliberately aimed to give as much time as possible to Q&A and debate – being mindful there was a lot of content to deliver.

I am pleased to report the roadshow feedback has been favourable and I feel this is a reflection of all the hard work put in by many to make them happen. The meetings had good attendance and were interactive, with good debates. Many appreciated the goalposts were moving around the commissioning process, with areas still to be decided/ evolving and there was much information to take in. Speaking to a number of those attending the meeting, it was clear that many attendees had differing levels of knowledge around commissioning, some much more knowledgeable than others – but all seemed to realise its importance and relevance. Even if this was just to start a conversation and engage with local stakeholders. Others were already further down the path with service reviews and local area needs assessments already underway- however they were very much in a minority. The message appears to be getting through that engagement is necessary and that there is no white knight able to appear to solve any concerns or issues. The pain pathways seemed well used and their uptake demonstrating their clinical utility and relevance - 'they speak for themselves' was often heard.



What was also clear from the feedback was the need for more support around the 'business' side of commissioning, especially around specifics such as writing business cases, outlining good service models and in particular costings. Some attendees also felt the presence of commissioners to take part would be valuable, and I do know that a number of them had been invited as audience to the roadshows. There was also mention of the differing relevance of some of the material to those in the community and primary and secondary care – however this is inevitable and overall the content was appreciated. Actual examples of commissioning of pain services, whether exemplary or where this was less than ideal, was requested by a number of delegates.

As we conclude the implementation and dissemination phase of the pain patient pathways, we need to look ahead to the next phase. More needs to be done and is being done. Hosting commissioning examples on the web has been discussed before and is being further considered. Good examples plus examples where this has unfortunately not gone favourably would be most informative. Some of this knowledge is known to some already but there is obvious value in sharing this more widely. Clearly there will be time and resource requirements to do this – and to keep it up-to-date. Regarding more support materials for commissioning, we have a major document due for publication this summer joint with the RCGP. Work towards this commissioning materials document has been on-going for some time, with a wide group, across all stakeholders, contributing. The document is representative of the needs of community, primary care and hospital care and has commissioner involvement. In particular, the 'business' side has been specifically addressed.

The merits of further collaboration across all stakeholders such as the BPS with the Faculty of Pain Medicine, CPPC, RCGP and with equal emphasis given to the needs of our members –whether in the community or primary care or in secondary care, are obvious. This is a huge area we are dealing with and still evolving. We have not even touched other areas - derivative work generated by the pathway / commissioning agenda process such as NICE accreditation for the pathways, their upkeep and possible pain patient pathway expansion, work around problematic pain etc. The next phase is clearly a matter of debate for the BPS Council.

I am grateful for the expertise of all of those involved in putting together the roadshows and also in their actual delivery across the country. Particular mention goes to Andrew Baranowski and Ann Taylor for their help with the initial material used and, with Richard Langford, for their valued guidance; also to Jenny Nicholas and Rikke Susgaard-Vigon and the rest of our busy, long suffering BPS Secretariat. I also thank the Implementation and Dissemination Group Workstream leads: Ollie Hart, supported by Martin Johnson, for the Commissioning Workstream, Martin Johnson, for the Primary Workstream, Nick Allcock for the BPS Membership Workstream and Antony Chuter, supported by Ann Taylor for the Patient Workstream.

News

Declaration of the Philosophy and Ethics SIG meeting: "*Changing the Culture of Pain Medicine*"

Dr Peter Wemyss-Gorman

At our meeting in June 2013 at Launde Abbey, the Philosophy and Ethics SIG discussed the imperative for a change in the culture of pain medicine. In particular, we identified two requirements: firstly a more effectively integrated approach to the multidisciplinary management of chronic pain, and secondly prioritisation of the needs of the patient over the interests of the profession and all other managerial, financial and political considerations.

We hope all the members of the BPS will want to share the challenges of realising this ambition.

Call for Editor of *PAIN NEWS* the official newsletter of the British Pain Society

The British Pain Society is looking for a new editor for *Pain News*! This prestigious role is of great importance to the Society and its members. *Pain News* provides a great opportunity for Council to update members about its work and for members to express their views on relevant and pertinent issues. Each past editor has made an enormous contribution and improvements in design and content, but there is still plenty of scope for innovation.

Have you an interest in journalism? Do you want to support the activities of the Society? Read on, as this may be an opportunity for you....

JOB DESCRIPTION

Term of office: Three years.

Key Responsibilities

- The production of *Pain News* on a quarterly basis (March, June, September, December).
- As Editor (and therefore a co-opted member of the BPS Council), attend meetings of the Council at the offices of the BPS in London (normally four times a year).
- Lead quarterly editorial meetings (one at the BPS, three via tele-conference)
- Attend the Society's !nnual Scientific Meeting (three day event held in the UK) and other public functions hosted by the BPS as agreed with the President.
- Participate as an active member of the Communications Committee and actively liaise with the Editor of the *British Journal of Pain*.
- Develop the skills of two Associate Editors (to be appointed).

Specific Duties

- Commission copy for regular input (e.g. from executive officers), for specific articles, occasional updates of BPS activity (e.g. SIGs), etc.
- Approve content and quality of copy (in liaison with the Communication Committee Chair as appropriate).
- Edit and produce copy ready for publication (including tables and suggestions for supporting graphics).
- Provide an editorial for each issue.
- Proof-read and check for corrections.
- Work with the Secretariat and publishers, to ensure advertising revenue to ensure break-even on production costs.
- Work with the two Associate Editors to streamline the production of newsletter.

Skills

- Experience of publishing as an author (essential) and of being a peer reviewer (desirable)
- Exceptional communication skills; written and verbal.
- Proof-reading experience.
- Ability to work to tight deadlines.
- Excellent IT skills.

TO APPLY

If you want to discuss more about this post, please contact the Secretariat at 020 7269 7844 or email the Editor at vasubangor@gmail.com

If you are interested in this post, please submit the following information to Jenny Nicholas at the details provided below by **Friday 20th September 2013**:

- Short CV
- List of publications
- Details of editorial experience
- Personal statement of no more than 250 words to support your application; this may include new directions for the publication, other supporting information etc.

Jenny Nicholas, Secretariat Manager, The British Pain Society, 3rd Floor, Churchill House, 35 Red Lion Square, London WC1R 4SG or by email at jennynicholas@britishpainsociety.org

Call for Associate Editors of *PAIN NEWS*

The British Pain Society is looking for ***two*** associate editors for *Pain News*! This is a new role introduced to support the new Editor. As a multidisciplinary Society, we would like to encourage members from all disciplines to join the *Pain News* team.

Do you want to develop your writing, commissioning and editing skills whilst gaining experience of working alongside our publisher SAGE? The post holder(s) will support the new Editor to develop the content and direction of *Pain News*. In addition to working with contributors and the editorial team, you will deputise for the Editor in their absence and attend the Council and Communications Committee meetings as required.

The term of office is three years.

TO APPLY

If you want to learn more about this post, please contact the Secretariat at 020 7269 7844 or email the current Editor (Dr Thanthullu Vasu) at vasubangor@gmail.com.

If you are interested in this post, please submit the following information to Jenny Nicholas at the details provided below by **Friday 20th September 2013**:

- Short CV
- List of publications
- Details of any previous editorial experience
- Personal statement of no more than 250 words to support your application; this may include new directions for the publication, other supporting information etc.

Jenny Nicholas, Secretariat Manager, The British Pain Society, 3rd Floor, Churchill House, 35 Red Lion Square, London WC1R 4SG or by email at jennynicholas@britishpainsociety.org

News

Pain in older adults: Events

The British Pain Society

Pain News
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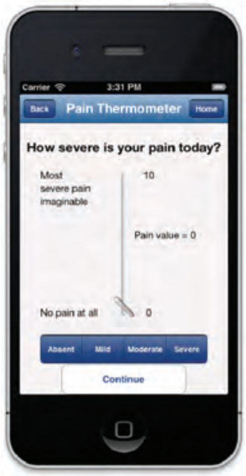
SAGE

Pat Schofield *Chair of Pain in the Older People SIG*
p.a.schofield@greenwich.ac.uk

We have seen a number of events occurring with the Pain in the Older People Special Interest Group (POP SIG) in the last year. Following on from our workshop at the Annual Scientific Meeting (ASM), we introduced the theme of technology for managing pain in older adults. We had two very interesting presentations. The Technology to Support Older People (TOPS) study presented by Dr Alasdair Mort is a study being carried out in remote and rural parts of the United Kingdom to determine whether the introduction of technology can impact upon personal and social interaction of older adults with health and social care providers. The second presentation was given by Lucas Hawkes-Frost from the South East Coast Ambulance Service (SECAmb). This group has been evaluating the use of the iPhone/Android pain app for the assessment of pain in adults with dementia. The pain assessment app, follows the guidelines on the assessment of pain (2007) developed by the British Pain Society and the British Geriatric Society. It incorporates the Abbey pain scale, and takes the user through a series of questions, for which the user selects the most appropriate answer from a set of answers displayed on the device screen. The flow of the questions asked in the pain app varies depending on the answer to questions provided at each stage. As the application steps through each question, a pain profile is built in the background for the patient being assessed. If the user is unsure how to answer a question, then additional guidance is provided at each stage. At the end of the assessment, the application provides feedback to the user on the steps they should take next. An example screen shot of the app is shown below.



When the application was used a total of 92 times in the initial 4-month period, all patients reportedly suffered from dementia; all of them were at a stage of their dementia in which they were no longer able to communicate verbally. Each of the 92 patient contacts had been initially assessed using traditional methods to help identify the presence of pain. When conventional methods of pain assessment, including use of numerical scoring, visual analogue scales and so on, proved inconclusive, the pain assessment app was considered to be useful.

Of these 92 patient contacts, 35 incidences were highlighted as sufficiently positive in terms of behavioural suggestions of pain to provide paramedics with the additional confidence to believe that the empirical use of analgesia would be appropriate.

Feedback was provided from users in the form of narrative in terms of the user perceptions of the usefulness of the tool as well as insights that users have regarding other applications for the tool.

Feedback included statements from a number of key individuals, including the following:

> *"The app provided me with the confidence to give pain relief proactively – when the patient wasn't able to describe their pain. I think this is a really great tool to help clinicians when they are dealing with these [advanced dementia] patients".*
>
> *"As a Clinical Supervisor, the pain app is such a welcome addition to the tools that we already have on the clinical desk, especially when dealing with calls from crews..."*
>
> *"I showed a patient's wife, who is also his carer, how to download the app. She was so relieved to have a tool to help her tell what was going on with this man who was living with her, who wasn't her husband anymore".*

KT-EQUAL

A collaboration between the University of Bath (Professor Chris Eccleston) and the University of Greenwich (Professor Pat Schofield) resulted in an event held in Greenwich in May of this year. The event was designed to consider the use of technology for older adults with dementia. Presentations were given by Professor Peter Passmore and Dr Beverly Collett, and this was followed by a debate, chaired by Angela Rippon. It provided the opportunity to launch the iPhone/Android app and the Dementia Carers website for pain assessment along with the National Management guidelines. The event was well attended with representatives from health-care professional, academics, researchers, carers and funders.

The second event was held in Kent and was a falls conference. This

Dementia Carers website

Observing and talking about pain behaviors

An on-line resource for family members of persons with Alzheimer's disease and other dementias

Welcome!

We produced these resources because people with dementia often experience pain that is undetected and under-treated. This does not happen because family and healthcare providers do not care. It happens because people with dementia are often not able to clearly voice that they have pain. Often they express their pain in ways that we do not usually think of as indicating pain. For example, people with dementia who are in pain may rock back and forth, or they may withdraw from people around them. Often these actions do not get interpreted as indicating pain. Family and healthcare providers sometimes feel powerless to help because they do not know what the

coincided with the visit of Professor Suzanne Leveille from University of Massachusetts, who is responsible for the MOBILIZE Boston study – one of the largest epidemiological studies related to falls and chronic pain. This coincided with the national falls campaign and was well attended with staff from all over Kent.

So, there are lots of interesting innovations happening in the field of pain and ageing; it is an area definitely on the government agenda, especially around dementia and falls.

Finally, the EOPIC (Engaging with Older People in developing and designing Interventions for the management of Chronic pain) team will be contacting you soon to take part in an evaluation of the materials developed during this 4-year Medical Research Council (MRC)-funded programme of research. Please take part in our focus groups. Thanks in anticipation of your support.

Pictures from the KT-EQUAL event

News

The British Pain Society

Pain News
11(3) 155

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Update from the Pain in Developing Countries Special Interest Group

Clare Roques *Chair, Pain in Developing Countries SIG*

clareroques@hotmail.co.uk

The Pain in Developing Countries SIG appears to be flourishing, reflected both in the projects being undertaken by the group, and in the steadily increasing membership numbers. The SIG workshop at the BPS ASM in Bournemouth, held jointly with the Education SIG, was a great success, featuring an interactive format facilitating excellent engagement between the speakers and the participants. Emma Briggs, Chair of the BPS Pain Education SIG began the session by presenting a short background on the principles of maximising the impact of education; and Catherine D'Souza, a registrar in palliative care, with considerable experience of teaching overseas, most notably in Africa, described many of the specific difficulties encountered when working abroad in resource-poor countries. Following this introduction the two speakers led an engaging interactive session with discussion of several case studies and suggested solutions to the problems raised. Plans are well underway for next year's workshop for the ASM in Manchester, which is planned to be a joint venture with the Philosophy and Ethics SIG.

As many of you will recall we sent out a survey to the whole of the BPS membership last year and we are very grateful to the society for supporting and assisting in administering the questionnaire. One of our committee members, Kaly Snell, coordinated some of this work and describes the results below:

The aims were to help produce a resource pool. In particular, a list of organisations and projects which BPS members have worked with or have on-going links with and also a list of members who are interested in supporting the work of the SIG.

We are extremely grateful for the 144 responses. These largely consisted of doctors (74%), with a total of 65% having had some experience of working in the developing/resource-poor world. Countries visited included India, Zambia, Uganda, Nepal and Lithuania. The majority of work was hospital based (85%) with 50% having some education involvement. Among the 44 people who had clinical involvement, work-settings were broad with individuals often being involved in more that one area, e.g. post-op pain, cancer pain, acute and chronic pain, trauma, burns and palliative care. The majority of the experience was in post-operative pain (68%). 27% have ongoing links, largely with formal educational projects as well as informal correspondence.

Our aim now is to compile a database to which additions can continually be made, so that we can begin to put people and organisations in contact with each other. We will also aim to keep all those who are interested up to date, by publicising new projects and initiatives. Following on from this work, we hope to facilitate the coordination of specific projects identified and supported by the SIG.

One such initiative is based around the Essential Pain Management (EPM) workshops, an educational programme created by Roger Goucke and Wayne Morriss with the Australian and New Zealand College of Anaesthetists, designed to improve pain management and overcome related barriers in resource-poor settings. Many of you will be familiar with EPM, but more details are available on line at http://www.fpm.anzca.edu.au/fellows/essential-pain-management. Over the last few years EPM workshops have become increasingly popular across the world and have been supported by several organisations including IASP.

We are now planning to run a series of three EPM workshops in Mulago Hospital in Uganda later this year, a project which has been sponsored by both the BPS and the AAGBI foundation, for which we are extremely grateful. Leading on from this work, we are also in the process of forming a longer term collaboration with the Faculty of Pain Medicine of the Royal College of Anaesthetists, and potentially other organisations, to coordinate more EPM workshops. These workshops would be led by clinicians based in the UK and we initially expect that they will be run in parts of Africa. If you would like any more information on this or any other work of the SIG please email me at clareroques@hotmail.co.uk.

News

Update from the Pain Education SIG

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Pain News
11(3) 156
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Ethel Hili
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The **Pain Education SIG** is a dynamic, interprofessional network of people passionate about improving pain education for healthcare professionals for the benefit of patients. The SIG members are involved in educational research and development, and influencing change in undergraduate and postgraduate education at local, national and international levels. This short article provides an overview of the SIG, its activities and plans for the future.

The SIG and its members work to:

1. Improve pain education for patients, the public and healthcare professionals
2. Create opportunities to enhance the skills of those delivering pain education
3. Promote educational methods and technologies that are available to deliver pain education
4. Provide an interprofessional forum for debate and collaborative research and development around pain education
5. Organise meetings, seminars and workshops on pain education

The SIG has a two year strategic plan to focus its energies and activities. Over the past two years, the SIG has worked very hard to raise awareness about the importance of pain education for patients, the public and amongst healthcare professionals. This was achieved by a variety of initiatives, such as annual SIG study days, collaborative workshops at the ASM with Primary Care & Community and Pain in Developing Countries SIGs, the continued development of an interprofessional undergraduate pain curriculum document and contribution at an international level, particularly through the IASP Education SIG. Committee members also contribute to a number of educational research projects including a study of undergraduate medical curricula by EFIC. In addition to their work in the SIG, committee members are involved with delivering pain education in both academic and clinical settings.

This is a very exciting time for the SIG and the committee have recently met to discuss the strategy and direction for 2013-2015 (shown below):

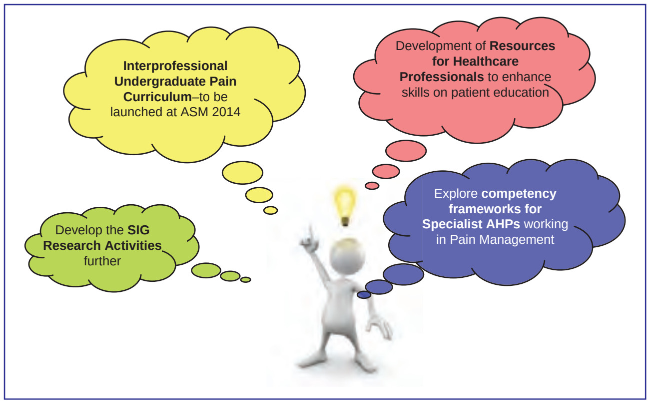
Central to the work of the SIG is our **communication strategy** which is being finalised and we would welcome your feedback on the SIG's strategies or any aspect of our work. Our membership, and therefore our network, continues to go from strength to strength. Everyone recognises the importance of pain education and we welcome SIG members and BPS colleagues who would be interested in being part of the network and making these strategic goals a reality. Would you like to become a SIG member? Do you find any of these projects particularly interesting and would like to contribute? If yes to either of these questions, contact Dr. Emma Briggs (emma.briggs@kcl.ac.uk). We look forward to hearing from you!

Our Committee Members

Officers
Chair: Dr Emma Briggs
Secretary: Dr Alison Twycross
Treasurer: TBC

Lead roles
Undergraduate: Prof Nick Allcock
Postgraduate/Primary care: Dr Janet McGowan & Dr William Notcutt
Patient education: Ms Despoina Karargyri
Website: Dr William Notcutt & Dr Janet McGowan
Communication/newsletter: Dr Sarah Henderson

Committee members working across groups: Prof Michelle Briggs, Miss Ethel Hili, Dr Paul Wilkinson (co-opted members)



The British Pain Society
Pain News
11(3) 157–158
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Securing the future of pain services: harnessing patient power - The British Pain Society Patient Liaison Committee Annual Seminar

Geraldine Granath, Lay Member - Patient Liaison Committee

The British Pain Society Patient Liaison Committee Annual Seminar 2013

Securing the future of pain services: harnessing patient power

Wednesday 12th June 2013, 09:30 – 15:30

This annual event held this year on 12th June 2013 saw a change of time of year and of format for the Patient Liaison committee seminar. Following on from the previous event on Patient Pain Pathways, with an invited voluntary sector audience, the PLC decided to bring patients and professionals into one room together to share learning on a topic that would have major impact on the design and delivery of future pain services.

A small sub group agreed to meet to plan the day and June 12th saw an audience of professionals, patients and patient groups (including visitors from Ireland and Australia) assembled at Churchill House with an excellent line up of speakers for the event.

Antony Chuter, the PLC Chair, welcomed everyone and explained the purpose of the event. The aim was to explore how pain services might be commissioned in the future, bring together patients who were involved in integrated service design, to promote patient and professional dialogue and engagement; and to be part of discussions on where priorities for the development of pain services may lie. He stressed that the aim of the day was to achieve this through open dialogue and communication and the style of the day - presentations in different formats and time for open discussion- reflected this aim.

The keynote session was a presentation delivered by Dr Steven Laitner who spoke about the need for integration, transformation and involvement. Currently working as a part time GP, Steven had recently held the position of the National Clinical Lead for shared decision making. He outlined three challenges for commissioners and service providers: a service that viewed the whole person, the whole pathway of care and the whole system across primary and secondary care. He spoke about the need for “parity of esteem” to enable true partnership with patients and the cultural barriers to asking and receiving explanations were cited as another challenge.

The three main themes in involvement/ engagement were identified as: engagement and participation in own care, involvement and co-production in commissioning and service redesign and co production in service delivery. The NHS Inpatient Survey highlighted that between 2002 and 2009, half of all patients consistently asked for more information about their care and treatment whilst a survey by Doctors net UK reported the view that only a minority of patients required more information. With regard to care pathways and integrated services an 18 week model was used to demonstrate how an integrated approach could inform commissioning decisions and ensure a pathways approach by using an accountable lead provider.

Dr Patrick Hill, Professional Lead for Clinical Health Psychology at Birmingham Community Health Trust then spoke about the challenge of patient involvement. Patrick spoke about the traditional elements of involvement represented by information, feedback and involvement in decision making. He reflected on the ways to achieve partnership; though a different but equal relationship, connecting with the emotional element and the importance of stories. Patient accounts and the perspectives of carers and staff gave valuable insights into changes that were needed to address NHS challenges of ageing, reorganisation, fragmentation and increasing scrutiny. Challenges required change and involvement and partnership were essential to this process. It was important to note that everyone did not necessarily want to be involved for a number of reasons, sensitivities within the black and ethnic minority community, a desire to move on from being ill and concerns about being viewed as a patient rather than a person. The diffuse nature of community services meant that mechanisms for involvement and partnership needed to be sophisticated to overcome issues of access and acceptability. The presentation was summarised neatly by a final slide outlining a model for involvement, after the audience had absorbed this, it was also identified as the gold standard for leadership.

Antony Chuter, Chair of the Patient Liaison Committee and Liz Killick, member of the Patient Liaison Committee, were the next presenters using dialogue to explore her involvement with Pain Patient Pathway development. Liz explained that her involvement had come about through her personal experience and work as a Backcare Helpline volunteer. She worked with her manager as they felt that two of them could provide mutual support and spot critical issues as they cropped up. Work progressed primarily through telephone conferences with the various professional members contributing to the flow chart that was developed. Liz observed that everyone learned from this process which in itself was a positive and the focus from the beginning was on the most vulnerable patients. A key dilemma was to identify where self management could fit into the process as this is a patient journey in itself. Providing advice on pain management alongside diagnosis, rather than once pain has become established was a strong message from the sub-group. The session closed with an update from Antony on the current situation regarding the adoption of pathways with encouragement to the audience to use the BPS site to keep up-to-date.

The last session of the morning was a comprehensive presentation from Mrs Meherzin Das, Clinical Lead at Dorset Pain Management Unit, on the Dorset pain model. Entitled "*Service users - the ace in our pack*", Meherzin started by describing the downward spiral that could accompany chronic pain and its implications, comparing and contrasting two different approaches and the results for patients. Patients referred to a traditional uni-modal service in West Dorset were experiencing long waits for interventions and local patients enlisted the help of the local press and others to publicise their concerns. The commissioners responded by setting up a stakeholder group, informed by public meetings, to look at how the services could be improved. In East Dorset, a different approach was adopted with multidisciplinary teams working with patients and active support from the patients themselves. Patients could join a facebook page and link to the Pain Chain - patient coaches recruited from people who had used the service and who in turn were trained to provide support to others. An early intervention model was adopted to combat the downward spiral. The commissioners decided as a result of these meetings to commission an all Dorset community pain service and as a result the two services are being brought together in an integrated approach. Service users are now involved in a wide range of user lead resource sessions and initiatives and the service is achieving tangible results.

All the presenters participated in a lively question and answer session ranging from advocacy for people struggling to speak, funding, GP education, evidence, access issues and a wide range of thoughtful observations on what had been said.

The afternoon sessions asked delegates to consider a number of questions and come to a consensus on priorities for commissioners; discussion centred on evidence, research, effective interventions, education, speedier diagnosis and better outcomes, real patient involvement, encouraging and valuing self care and good quality information.

Evaluations of the day were extremely positive and presenters were all prevailed upon to provide e-mail addresses for follow up questions. The decision to widen out invitations to the event was supported by comments such as "enjoyed the eclectic mix of people" and " I liked the respect in the room", definitely an example of parity of esteem in action and one to take into our everyday lives.

The British Pain Society's Pain Management Programmes SIG
14th National Conference on Pain Management Programmes

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)

News

New ASM format starting in 2014!

The British Pain Society

Pain News
11(3) 160

SAGE

Prof Gary Macfarlane *Chair, ASM Scientific Programme Committee*

BPS Secretariat

We had a fantastic response rate to the ASM evaluation forms this year. We would like to thank everyone who contributed. The Annual Scientific Meeting is ***your*** meeting, and we want to ensure that we continue to deliver an informative, valuable and enjoyable event for all our members and non-member colleagues alike. We received 400+ responses to the online evaluation survey, from both attendees and non-attendees and there were several recurring themes:

- Drinks reception to be held outside of venue
- Would like the re-introduction of international speakers
- Cost felt to be expensive
- Length of meeting too long

As a result of this feedback, the Scientific Programme Committee and the BPS Council reviewed the format and budget of the ASM, and agreed to the following to try to address some of the concerns raised:

- Delegate rates will remain the same for 2014 (this will be the fourth year that the rates have remained the same, having not been increased since 2011).
- The introduction of a reduced rate Student fee in 2013 appeared to be well received and we will continue to offer this again for 2014.
- International speakers have been invited as keynote speakers (details will follow in the preliminary announcement).
- The drinks reception will be held outside of the conference venue and will be enhanced to become a “party night” allowing delegates the time to network and enjoy the full evening (as well as time for dancing!) (*There will be a nominal fee to attend to contribute towards the evening*).

The main element that has been amended is the format of the meeting. This has been adjusted to make it a three day programme (Tuesday-Thursday). The programme overview is detailed as follows:

Timetable 2014 ASM

Tuesday 29 April 2014

From 08:15	Registration Desk open
09:00 – 10:10	Satellite Meeting
10:15 – 13:10	Welcome, Plenary Session 1, coffee Break, Parallel Session A
13:10 – 14:10	Lunch
14:10 – 17:30	Plenary Sessions 2 & 3, Parallel Session B
17:45 – 19:10	Satellite Meeting
19:20 – Late	Welcome Drinks Reception/Party

Wednesday 30 April

07:45 – 08:45	SIG Business Meetings
08:45 – 10:00	Satellite Meeting
10:05 – 12:00	Plenary Sessions 4 & 5
12:00 – 13:00	Lunch
13:00 – 16:20	Parallel Sessions C, Coffee Break, Plenary Sessions 6 & 7
16:30 – 17:30	Annual General Meeting for members
17:45 – 19:15	Satellite Meeting

Thursday 1 May

07:45 – 08:45	SIG Business Meetings
08:45 – 10:00	Satellite Meeting
10:10 – 12:00	Plenary Sessions 8, Parallel Sessions D
12:30 – 13:45	Lunch + Satellite Symposium
13:45 – 15:15	Plenary Sessions 9 & 10

NB All timings are approximate. The scientific programme may be subject to minor alteration.

The high quality scientific content and amount of CPD points available remains the same. Please ensure that you have the revised dates in your diary: **Tuesday 29th April – Thursday 1st May.** The ASM in 2014 falls at the time of the May bank holiday (Monday 5th May) so we hope that having shortened the meeting you will all be able to enjoy a long weekend

Finally, the trade exhibition remains an important element of the ASM. This is also an area that we are reviewing to ensure that the exhibitors we attract are of interest to our delegates, and of course, remains of value to them. If you have any suggestions as to other organisations that we might consider inviting to exhibit with us, we would be pleased to receive their details. ***This is your meeting, so help us make it work for you!***

Save the date

THE BRITISH PAIN SOCIETY

Annual Scientific Meeting
29th April – 1st May 2014
Manchester

Rayen's column

THE BRITISH PAIN SOCIETY

Pain News
11(3) 162–163

SAGE

Curry cure – spices as analgesia!

Dr Arasu Rayen *Birmingham*

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> *Let food be thy medicine and medicine be thy food*
>
> Hippocrates

Food... Food is important for any living organism. We need food to live. Apparently, people's awareness about food is currently at an all time high. As we all know, supermarket shelves are full of organic, low-calorie and low-fat food. This list goes on and on. The reason why we have so many varieties is not only because people want different tastes and nutrients, they are now looking for food with healing properties and the food with medicinal values. There are websites and books on this subject. Most of you would have had curry. Did you ever think about curry and analgesia? Does it have any medicinal or healing qualities? Do the ingredients of curry have any analgesic potential?

I come from southern part of India where spices are available in many varieties and in plenty! I can't remember exactly but was a child aged 9 or 10 years; I was playing cricket with my friends. I miscalculated the force of the cricket ball while trying to catch. One thing I remembered was that the very next second my forehead started to swell, thanks to the batsman and the ball. When I went home, my mom applied turmeric paste on this cricket-ball-induced traumatic swelling on my forehead. It did settle after few days.

On another occasion, when I had 'tummy pain', my mom applied heat-treated ginger paste and honey on to my abdomen. Similarly, I have had clove for dental pain. The list goes on. It could have been the TLC that I had from my mom making my swelling and tummy pain better. I don't know. But one thing is obvious. We were using quite a few curry ingredients for medicinal purpose. Even now, in many parts of the world, this is a common practice. In this article, I will try to find out whether there is any scientific evidence for this 'folk medicine', especially in pain management.

Curry is made of ginger, garlic, turmeric, fenugreek, chillies, asafoetida, coriander, fennel seed, cinnamon, clove, mustard seed, cardamom, black pepper and others. Let's look at how many of these ingredients made their way in to the basic science laboratory and/or evidence-based medicine.

Ginger

Ginger (or *Zingiber officinale*) is one of the common ingredients used in curry. It has been used for its medicinal purpose for long time. It has been used in reducing pain and inflammation associated with arthritis. Ginger has been shown to be an anti-inflammatory and antinociceptive agent in rodents.[1] Zerumbone, a chemical extracted from ginger is believed to produce the antinociceptive effect of ginger. Antinociceptive effect of Zerumbone could be through the action on cyclooxygenase (COX) and lipoxygenase enzymes. Mice, given Zerumbone regularly, showed to have higher pain threshold; however, human trials are patchy and few. In a randomised, placebo-controlled, crossover study, ginger extracts were not found to be more efficacious than ibuprofen in osteoarthritis.[2] However, one recent study[3] showed that regular use of ginger reduced the muscle pain following severe exercise. It was a double-blind, placebo-controlled, randomised trial in healthy volunteers looking at the effect of regular use of ginger over 11 days. Both raw and heat-treated ginger were used to assess their effect on muscle pain due to severe exercise-induced muscle injury. In addition to the pain intensity and a few other parameters, such as plasma prostaglandin E2 (PGE2), were also assessed. The investigators showed that muscle pain reduced significantly both with raw and

heat-treated ginger compared to placebo. There was no significant difference between raw and heat-treated ginger.

Garlic

Garlic is another spice used in Indian cuisine. It contains Allicin, a pungent chemical that gives garlic its characteristic smell and taste. Allicin acts on the transient receptor potential vanilloid type 1 (TRPV1) receptor. The exact implication of this is not clear. However, as TRPV1 receptors are important in nociception, garlic may have some influence on pain perception.

Onion

Onion has been used in food and for medicinal purpose for a long time. There is evidence that onion was used even in 5000 BC. Analgesic effect of onion is believed to be due to its effects on arachidonic acid pathway[4] or action of flavinoids (one of the active ingredients of onion) on lymphocytes.[5] It has also been suggested that onion might have local anaesthetic effect.[6] One study showed that pure onion juice produced better analgesic effect than diclofenac sodium in rats.[7] However, there are no human studies.

Black pepper

Black pepper is another ingredient in curry. The reason for the 'pepperiness' of the pepper is because of a chemical called piperine. Piperine acts on TRPV1 receptors and produces analgesic effect. In laboratory testing, piperine was shown to reduce production of PGE2, resulting in anti-inflammatory, antinociceptive and antiarthritic effects in an arthritis animal model.[8]

Turmeric

Turmeric (*Curcuma longa*) belongs to the ginger family. It is the reason for the yellowness of the curry and traditionally was used to treat swelling and inflammation. Curcumin is the active ingredient in turmeric. It was shown to be an anti-inflammatory and antioxidant. Turmeric is believed to act on COX 1 and 2 pathways and produce both analgesic and anti-inflammatory effects.

Mustard

Anyone who has taken more mustard sauce than they need for their steak know that mustard is an irritant. It has been used to treat pain in the form of a plaster, especially in France and Russia.[9,10] There is scientific evidence to show that mustard oil acts through transient receptor potential ankyrin 1 (TRPA1) receptors.

Clove

Clove has an active chemical called eugenol, which has analgesic property. Clove is being used around the world for dental pain. There is one study looking at the effectiveness of clove oil gel against local anaesthetic and placebo in dental pain. It concluded that clove oil is as good as local anaesthetic in relieving dental pain and better than placebo.[11] There is now proof that clove works at TRPA1 receptors. Clove oil and gel are freely available as over-the-counter (OTC) medicines.

Chillies

Chillies are well known in pain management because they are already being used as capsaicin cream (0.025% and 0.075%) and patches (8%) to treat neuropathic pain and arthritis. There are well-published trials to support this use in pain management. Chillies work through TRPV1 receptors.

Oh, one last thing!

Looking at the ingredients, curry seems like a primordial soup of agonists with their natural receptors producing analgesic and anti-inflammatory effects. Only a few are not yet found to have any receptor action (cinnamon, cardamom, cumin, fenugreek, coriander and fennel seed). Hopefully, basic science will find out whether they work on any receptors. Until then, every time you have a curry, think '*Heal thyself*'!

I thank Professor Tony Dickenson for confirming that mustard oil, garlic, cinnamon, clove and ginger act on TRPA (1) receptors and black pepper, capsaicin, clove and ginger act through TRPV1 receptors. (Personal communication)

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Advertorial

MedICUs – Data Collection for Pain Teams

Introducing MedICUs Pain Services

Mela Solutions has developed a cost effective approach to the collection, analysis and reporting of patient data with the new version of MedICUs Pain Services. Cristina Willans the MD of Mela Solutions says *"The new version of our system takes specialist data collection for pain teams to a new level. It offers easy access to patient records, a quick and efficient means of data collection, while facilitating communication and clinical auditing."*

The Web App

The web app is Mela Solutions' latest addition to the successful MedICUs - Pain Services product line. This new version can be accessed via a web browser yet still provides the same level of detail as the desktop version, including detailed screens for patient assessment and diagnosis.

As data is entered live into the central database you can avoid the administrative burden of manually retyping the information at a later date.

"One Patient, One Record"

Web access also ensures that there is only one record for each patient, so all members of the pain team can be certain they are accessing the latest information with a complete patient treatment profile.

The system brings patient records to any member of the pain team at the point of contact, ensuring better use of resources and therefore, increasing efficiency.

Better Service Performance

Analysing the activities of the pain team helps to promote good practice, which leads to improvements in service delivery and patient outcomes. It also provides opportunities for staff training and education.

The Ideal Tool for Any Research

MedICUs facilitates effective and accurate clinical audits, enables research and incorporates service planning tools, all of which mean it has never been easier to carry out a performance overview. You can measure the performance of an individual, a team, or identify successful interventions and treatments, while highlighting any cases of concern.

Touch screen questionnaires enable patients to complete them easily prior to their assessment, ensuring that patient-doctor time is not compromised by form filling.

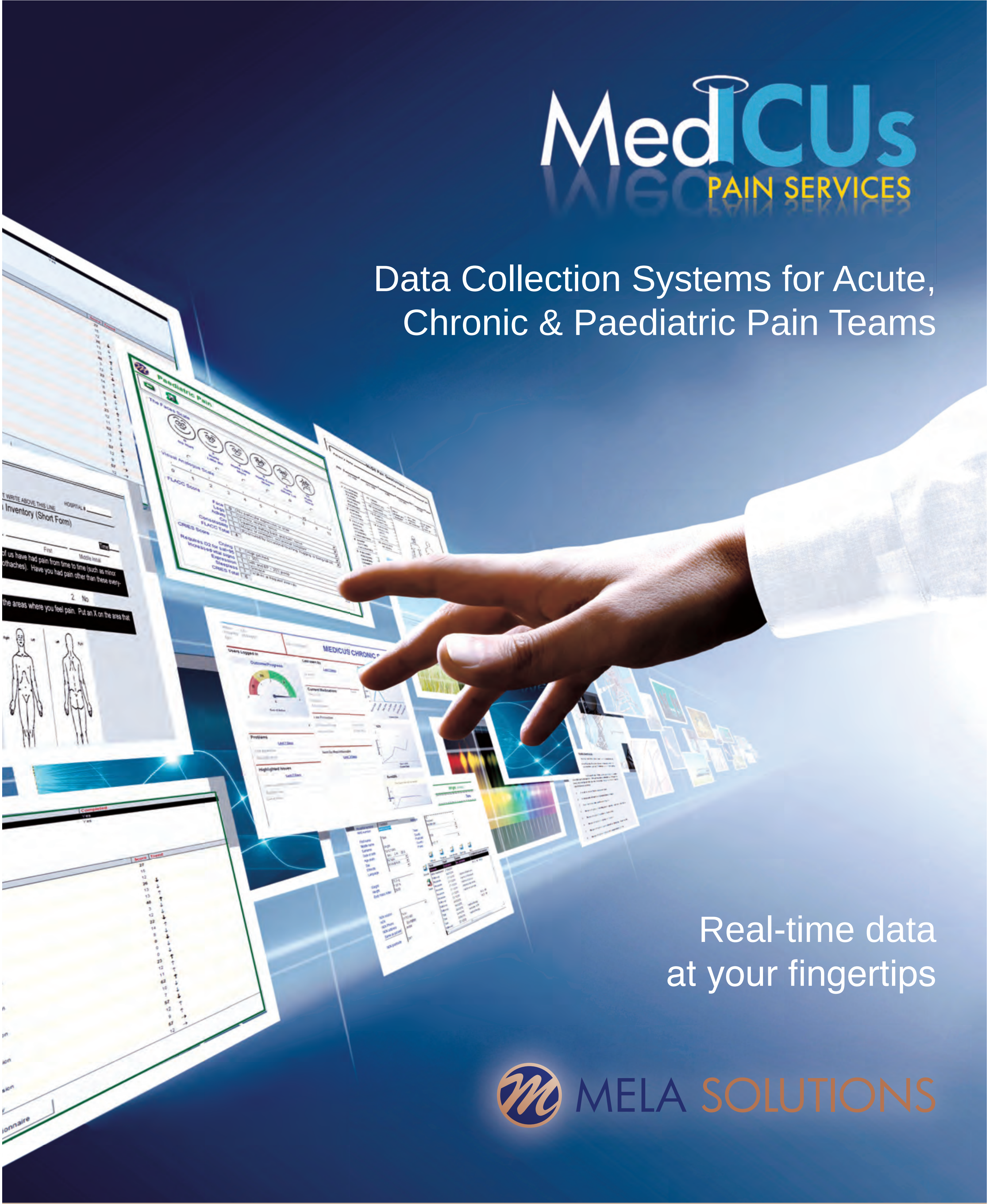
Multidisciplinary Integrated System

MedICUs Pain Services provides a cost-effective, collaborative method of recording and analysing patient care by a multidisciplinary pain team of nurses, consultants, dieticians, psychologists, physiotherapists and data administrators.

The system gives you the flexibility to define fields of interest and to comply with minimum datasets when needed. With a dashboard and a newly implemented desktop, clinicians have immediate access to a patient record summary, which in turn reduces out-of -clinic query time and ensures that data is consistently available.

Conclusion

Tom Jordan, Support Services says, *"We are very excited by the new release of MedICUs Pain Services. By using the latest web technology the system retains the benefits of being highly customisable and easy to use, while now offering clinicians simple, quick data collection on the go and a live patient summary."*



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Strong opioids in post-operative pain management: how did we bring a change in practice and culture?

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This study was presented in part as a poster at the British Pain Society Annual Scientific Meeting in April 2013 at Bournemouth. It was a preliminary case series on the use of Targinact (*combination of oxycodone and naloxone; Napp pharmaceuticals, Cambridge, UK*) in the management of acute post-operative pain management. However, there is more to it as we were trying to influence a major change in the practice not only by the surgeons but also by the general practitioners (GPs).

We know that post-operative pain is often undertreated due to poor assessment of the pain as well as the reluctance by the surgeons to use strong opioids even after major surgery. This is often due to the misconception that strong opioids would delay discharge from the hospital due to side effects like constipation, nausea and vomiting as well as increased drowsiness and somnolence, which may hamper mobilisation and physiotherapy. Patients are often treated with weak opioids like codeine and tramadol even from day 3 after being managed with an epidural infusion following a major laparotomy. This not only results in inadequate pain control and at higher doses of these weak opioids, patients were complaining of constipation and nausea; it was also found that post-operative physiotherapy and mobilisation were negatively impacted due to poorly controlled pain. Unfortunately, the conventional surgical argument against strong opioids was true for the weak opioids as well.

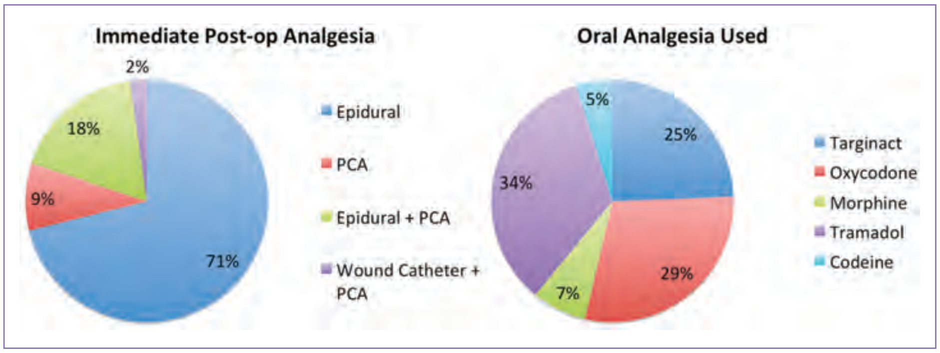
About a couple of years ago, the Enhanced Recovery Programme (ERP) bandwagon arrived at my hospital, The Christie. The impetus for this was provided by the appointment of a laparoscopic surgeon with the additional responsibility of rolling out the ERP. Despite the nature of cancer surgeries that we carry out being either complex major procedures or relatively minor ones, there was a big push to enhance the recovery and facilitate early discharge. This resulted in patients who had undergone surgeries like total pelvic clearance and cytoreduction and hyperthermic intraperitoneal chemotherapy (HIPEC) being discharged early to the surgical ward from high dependency unit (HDU). The epidural infusions that were successful in appropriately managing their pain were discontinued and oral analgesia with tramadol was commenced in addition to the regular paracetamol. Needless to say, the pain service was the first point of call to sort out the pain, and most of these patients ended up with Morphine or oxycodone patient-controlled analgesia (PCA) as there was still reluctance from the surgical team to accept the use of strong oral opioids. Use of transversus abdominis plane (TAP) blocks and spinal diamorphine was being encouraged rather than epidural infusions. Once their effects wear off in 24–36 hours, the use of tramadol was still inadequate to meet the analgesic requirements. Despite all this, most of the surgeons were reluctant to support the use of strong opioids as they did not want to have delay in return of bowel function and constipation.

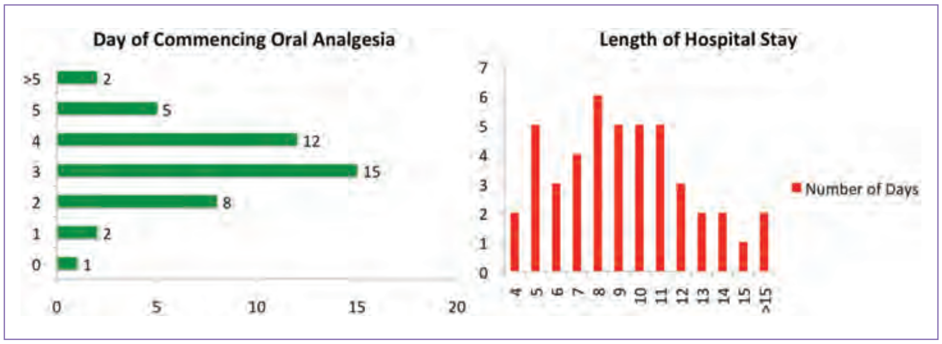
We started using Targinact, that is proven to reduce opioid-induced constipation, as the oral analgesic of choice in the management of acute post-operative pain. We were able to convince some of our surgical colleagues that due to the combination with naloxone, there is very little chance of developing opioid-induced constipation; this was also reiterated by our experience in treating chronic cancer pain. We were asked to audit our practice to see how it impacted on the pain management as well as its effect on bowel function.

Methods

We looked at 45 patients (17 male and 28 females) undergoing major surgery involving laparotomies for colorectal, gynaecological and urological malignancies as well as major reconstructive surgery following mastectomy for breast cancer. Patients already on high doses of strong opioids and those with prolonged post-operative stay in the critical care unit were excluded. During the period when data were being collected, patients undergoing breast reconstructive surgery were not suitable to be included in this series as they were not on Targinact or strong opioids and were discharged home on weak opioids. Data collected included pain scores (Brief Pain Inventory (BPI)) at rest, on coughing, on movement and on straining for bowel movement. Patient satisfaction scores, time of first bowel movement, drinking and eating and removal of nasogastric tube were recorded along with bowel function index. Mobilisation parameters like tolerance to physiotherapy, walking to the toilet and climbing stairs were also noted. Side effects like constipation, nausea, vomiting, sedation and respiratory depression were also monitored till the day of discharge. The use of concomitant drugs like Paracetamol, anti-emetics, laxatives and neuropathic pain medications were also documented. The patients had a telephone follow-up to ascertain the analgesic usage and side effects following their discharge from the hospital. One patient died on post-operative day 12 due to a myocardial infarction.

Most of the patients other than the gynaecological patients had an epidural infusion (0.125% bupivacaine with 2 µg/mL fentanyl) for immediate peri-operative pain management, and both morphine and oxycodone were used in the PCAs. Patients on PCAs with epidurals had it on demand, but patients who were only on PCAs were given a background infusion as well. All the patients were on regular Paracetamol every 6 hours, either orally or intravenously. Oral analgesia was commenced depending on return of bowel function, and this was earlier in gynaecology and urology patients and also those who did not have bowel resection in the colorectal group.

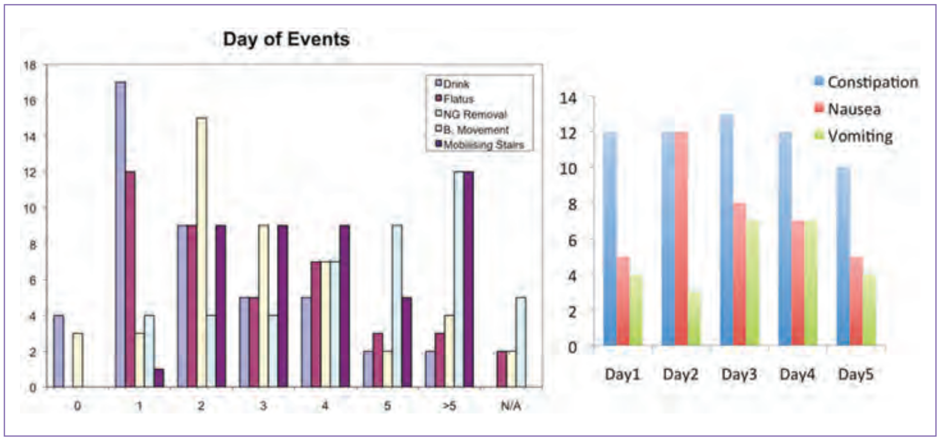




Monitoring the pain scores were not that difficult in the HDU during the immediate peri-operative period, but once the patient started taking oral fluids and was being mobilised out to a chair, some of the other symptoms like nausea and tenesmus along with the discomfort of having an intravenous (IV) line and urinary catheter did influence the patients' perception of pain. Pain scores were recorded accurately while they were in the hospital, but it was unreliable after discharge as patients were not always very compliant with the telephone follow-up. Hence, we only looked at the first 5 post-operative days.

Pain scores were indicative of reasonably good analgesia at rest and also on coughing during the first 2–3 days, as the mainstay of the analgesia was the epidural infusion or PCA with or without spinal diamorphine. When patients were started on oral analgesia, it also corresponded to the starting of oral feeds and mobilisation, which added on to the discomfort of the patients. Patients also reported increased incidence of nausea and vomiting during this period, and this was unrelated to the oral analgesia used. Many patients were still not commenced on oral analgesia at this point in time. It was also noted that patients on strong opioids were much more comfortable and confident in going through the daily nursing care and physiotherapy; they were also requiring lesser amount of rescue analgesia. There were also significant gaps of days between passing flatus and passing formed stools; some patients opened their stoma or passed stools early on, but then could become constipated, possibly due to the drugs. We also noted that there is a considerable delay in getting the patients to be able to climb stairs with support as one of the limiting factors that delay discharge.

Constipation, nausea and vomiting were the major side effects reported by the patients as well as the nursing staff looking after these patients. Patients also had an expectation of moving bowels despite not having adequate oral intake in the post-operative period after major



surgery. Most patients did not move their bowels within the first 48 hours, and it continued for longer in patients who underwent bowel surgery and resection. Nausea and vomiting were the primary concern once oral fluids and analgesia were commenced, and this typically started from day 2 following surgery. The most commonly used adjuvant medications were anti-emetics and laxatives for managing the above symptoms. Additionally, patients on PCA recorded increased sedation, and four patients on epidurals had some dizziness while mobilising, but these were self-limiting and did not require any further intervention. None of the patients had any respiratory depression.

During the study period, we were able to use Targinact in 10 of these patients as the sole opioid analgesic along with Paracetamol for continuing analgesia. Most patients required 40 mg of oxycontin equivalent or less, including rescue analgesia during this period, and were scoring high on satisfaction scores. During the latter part of the hospital stay, bowel function index was favourable for ease of defecation and for completion of evacuation, but was less reliably recorded for the rating of constipation as the patients were finding it difficult to quantify it. Patients were also recording better satisfaction scores on overall peri-operative experience as compared to their previous visits for similar surgery, during the study period. These patients were among the first to have Targinact for post-operative pain in our institution and over a period of time most surgeons have accepted its use as opioid of choice for peri-operative management. Interestingly, there was still reluctance in discharging patients on Targinact or other strong opioids. Most patients were being discharged home on paracetamol and non-steroidal anti-inflammatory drugs (NSAIDs), and on weaker opioids, with the majority of patients receiving tramadol and the remaining few codeine phosphate.

Discussion

It was reassuring to note that most patients had reasonably good pain control following a major laparotomy with epidurals or PCAs. However, patients are being started on weaker opioids along with regular paracetamol soon after the discontinuation of the epidural infusion or PCAs. Most patients find this inadequate and often resort to short-acting formulations of strong opioids for rescue analgesia. This often resulted in dissatisfaction due to poorly controlled pain and sometimes resulted in developing side effects like nausea and vomiting and reluctance to engage with the physiotherapists to mobilise early. It was a challenging experience to instigate the use of strong opioids by oral route following the discontinuation of epidural infusions or PCAs, as the perception of the surgical colleagues were that strong opioids contribute towards most of the complications that delay discharge, that is, constipation, sedation, nausea and vomiting. There was no difference in the incidence of nausea and vomiting whether the patients were on tramadol or strong opioids, but the use of adequate doses of a strong opioid was better in controlling post-operative pain following major surgery compared to tramadol. It was also observed that patients on regular strong opioids required lesser amount of rescue analgesia as compared to those on weak opioids. The addition of naloxone to the oxycodone should effectively reduce the troublesome side effects of constipation and is a viable alternative to conventional strong opioids, which is being implicated as the main cause of post-operative constipation.

Conclusion

The combination of oxycodone and naloxone (Targinact) has been accepted by the surgeons in our hospital as it effectively addresses the issue of opioid-induced constipation that often delays discharge planning and is currently incorporated in the ERP as the strong opioid of choice for the management of post-operative pain following major surgery. Despite developing increased confidence in the use of stronger opioids that would also address the issue of constipation, while the bowel is recovering from major surgery in the hospital setting, both the surgical and primary care colleagues were cautious about discharging patients on strong opioids. An interesting observation after the study was carried out and the patients were being discharged home on Targinact: the GPs were monitoring the patients far more closely and were not very keen to extend the strong opioids with a repeat prescription. Most patients were also not very keen on continuing with strong opioids and it was tapered off within a week or two and seldom required further opioid analgesia. This was in contrast with the use of tramadol or codeine – patients wanted to continue that as their pain was not adequately controlled ever since their operation and the GPs were not unhappy about continuing with the prescriptions. This begs the question – shouldn't there be a case for advocating the use of strong opioids for providing adequate analgesia for major surgery as it kills two birds with one stone? Strong opioids for a short duration in the post-operative period, giving better peri-operative analgesia with GPs ensuring that the opioid prescription is carefully monitored and discontinued within a few days, is a better practice, rather than using tramadol or codeine for very long periods.

Funding

I have received honorarium from Napp pharmaceuticals for participating in an advisory board regarding Targinact.

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Professional perspectives

Using philosophy to make sense of chronic illness

The British Pain Society

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SAGE

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Peter Wemyss-Gorman has provided this transcript from the Philosophy and Ethics Special Interest Group (SIG) meeting; transcripts from previous meetings including the important discussions that followed are available from our British Pain Society (BPS) website; copies can be obtained by email from Peter at pwgorman@btinternet.com

The experience of illness

One of the most important questions that we need to ask when we try to decide whether a life is worth living can only be answered by the person whose life it is: whether it is worth living *for them*. We need to think about the differences between individuals, and within individuals in their own changing positions, and the subjective experience of what illness might be like. It is very easy to make universal stipulations of the kind: all life is sacred. It is not just the life of White relatively well-off people in Western countries that is worth living; if people who purport to hold the sanctity of life position really cared, they would do something about the massive inequality and suffering going on in other parts of the world. Every moral decision we make has to be made against its particular context, and every context has its blind spots.

The experience of illness often involves others' blind spots. Often, people in large institutions such as the National Health Service (NHS) rely heavily upon principles, guidelines, targets and so on, which are fine if you want to establish a minimal threshold for standards, but unhelpful when it comes to trying to work with an individual patient, with their individual story, circumstances and desires. People who are severely disabled may report having a good quality of life in which they are very happy, in contrast to those with chronic depression, who see no point in continuing to exist even though their bodies are working fine. Quality adjusted life years (QUALYs) can be misleading and can result in discrimination against people who are disabled but unperturbed by their disability. So let's try to think more about what it means for a particular individual to have a particular disease at a particular time.

Phenomenology

This is a method within philosophy that helps us to understand the first-person experience. I suggest that illness leads to a disruption of the *lived* body rather than simply dysfunction of the *biological* body. Moreover, it is important to understand that when we change physical possibilities, we actually change people's subjective way of being as a whole. Phenomenology describes the essential structures of human experience and illuminates the quality of subjective experiences, their personal meanings to an individual over time and their pattern and coherence. It may be difficult for health professionals to engage with all these in a systematic and serious manner when you have time constraints and your training doesn't necessarily enable that. Phenomenology doesn't make metaphysical claims about what a person is or what is real but simply uses human experience – things, phenomena – as its fundamental tool and the fundamental object of our study.

As Husserl writes, for us to be able to hear a melody, it is not enough for us just to hear a succession of discrete notes, we have also to be able to retain the note that has just passed and to have some sort of expectation about the notes about to sound in order for us to hear the melody. This doesn't comment on any empirical aspects of experience, but does give us some insight into the conditions of possibility for having a particular experience. If we all look at a painting such as Van Gogh's *Peasant Shoes* and try to use imagination or empathy to try and guess what the shoes are meant to represent, our different reactions and interpretations are influenced by all sorts of extraneous factors and distractions. These different acts of consciousness are actually what phenomenology tries to study. Instead of looking at the painting and discussing *it*, in phenomenology, we discuss *ourselves*, what we feel and what we recognise with respect to a particular phenomenal stimulus. But we may use our imagination quite incorrectly, and although empathy and imagination are very useful tools when you try to understand what somebody else is thinking, we need to be cautious about overestimating our ability to empathise with what is going on in other people's minds.

Embodiment

The kind of phenomenology that I use in my work, and I think might be useful to you as practitioners, is one that takes embodiment as its starting point. Philosophers from Plato through Descartes right through to the 20th century studied the mind as divorced from the body. Merleau-Ponty, writing in the 1940s and 1950s, wanted to reject mind–body dualism and to think about consciousness as an embodied phenomenon. He regarded perception as, first, constitutive of human experience – the most foundational experiences we have are perceptual – and as being intimately connected to the body. This is something that is quite radically undervalued, at least by philosophers, and I should be interested to know whether you think dualist views are still alive in medicine.

A phenomenology of illness tries to remedy this bias and to move away from the causal, solution-based thinking about disease processes to thinking about how patients experience their disorder. Unfortunately, problem-based thinking has failed to solve all our medical problems. There are huge numbers of people living with chronic conditions for many decades. So it is important to attend to and try to understand the *experience* of somebody with impaired mobility, impaired vision, impaired cognitive abilities and so on, to help to think about and choose appropriate interventions that might be useful to ameliorate some of the effects of the illness.

Phenomenology is a very different business from medical business as a '*doctor-I've-sprained-my-ankle-here's-a-bandage-thank you-goodbye*' sort of thing, and a very different kind of thinking about how people assign meaning to their illness and illness experiences, and in what ways those meanings impact on how they live their life more broadly. Disorder is embodied: the experience of every action, like going to the corner shop to buy milk, will be vastly influenced by and changed by the disorder, be it depression, multiple sclerosis (MS) or a broken leg. People's social perceptions and life opportunities radically impact on the experience of their illness.

Using phenomenology

How can phenomenology help to enrich the understanding that people in health professions have of their patients? First, it offers a way of thinking of patients as *being in the world*. 'Being' includes the physical embodied dimension, and 'the world' includes the social dimension, the geography of their world, which might be modified or restricted through having an illness or disability; their relationship with their environment is at the core of their illness experience. It has been suggested that there aren't disabled bodies, only disabling environments. I don't think that's entirely true, but there is a definite sense in which the kinds of environment we provide for people can radically change their experience of disability. Illness and disability affect people's goals and actions and their general attunement to their environment, with loss of agency, productive function, social participation and financial status. Whether an illness disrupts a goal might be critical to the person who is ill, but this hardly ever features in medical consultations, unless they are specifically asked: what were you planning to do? What has the illness prevented you from doing? We need a much more existential appreciation of what it means to be a human being, especially one affected by illness or disability. If you think of chronic pain not simply as a disorder of the physical body, in terms of molecules or signalling pathways, and really try to understand it as a disruption of the lived experience of that body, it will uncover another dimension of the lived experience of illness. When we restrict people's physical possibilities, we also limit their existential possibilities.

Merleau-Ponty proposes that our body has two dimensions: the biological and the lived – that which we experience from within. Illness can remove the body's transparency and offer the rare opportunity to perceive the gap between these dimensions. So maybe, while as a physician you may be attending to the biological body, the patient may be coming to you with their lived body experiences of suffering. For example, take an eating disorder where the subjective experience of the body remains that it is fat however objectively thin it is.

This experience of illness as something that redefines our relationship to the world doesn't just take place for the ill person himself or herself but also includes his or her family members and friends. And it can affect people's sense of time: what they consider worth spending time on. People can adapt and come up with new solutions and ways of achieving things. Although illness is never a good thing, there may be a potential positive secondary consequence of being ill, which is often overlooked: that people's self-understanding and clarity of goals can be enhanced by feeling that they have succeeded in achieving something despite bodily limitations.

Illness and disability, breakdown and homelessness

Returning to the idea that illness disables us, Heidegger defines human lives as possibility. Unlike a tree or a rock or a badger, we have the freedom to choose what to do to exercise our choices (with obvious constraints – I can't choose to fly or to breath under water) to view life as a series of possibilities and have the freedom to choose whether to take them or not. Merleau-Ponty thought freedom was absolutely fundamental to the human being. But of course, possibility involves the physical ability to perform actions, so if somebody wants to be the fastest 400-m runner, they need legs. But forming actions in the world very much depends on the kind of body we have. As Iris Marion Young notes in her essay, 'Throwing like a girl', when a man throws a ball, his use of space, involving his shoulders and whole body in the movement, isn't simply a physical fact about him but an existential fact. Social arrangements that restrict women's embodiment such as restrictive clothing in some cultures or going out after dark, are not just physical, aesthetic or moral constraints, but they are existentially limiting for the women who have to adhere to them.

Another phenomenological way of thinking about illness is to view it as breakdown. Heidegger's tool analysis refers to the way we are happy with tools so long as they work: when the pen writes or the car starts, they enable us to do things but don't actually demand attention; they aren't in the forefront of our minds. But in situations of breakdown, tools become conspicuous. In an analogous way, health can be regarded as transparent: we take our bodies and our abilities to do things for granted. But in illness, the body becomes conspicuous and cumbersome. Phenomenologists have also thought about illness as homelessness. Fredrik Svenaeus suggested that in illness, one becomes alienated from one's body and disoriented; the ill person experiences his or her body as uncanny and the world as a confusing place, in contrast to its usual homeliness. This disorientation is something medicine should tackle and enable people to find a way back to a home-like way of being.

The patient/physician[i] interface

Going back to the question I opened with, how do we go about evaluating people's lives? This is probably a question you grapple with on a daily basis in the clinic. You might take someone like the late disability activist Harriet Johnson and think it must be terrible to be confined to a wheelchair, suffering back pain, but here is what she wrote a couple of years ago:

> *Are we 'worse off'? I don't think so. For those of us with congenital conditions, disability shapes all we are. Those disabled later in life adapt. We take constraints that no one would choose and build rich and satisfying lives within them.*

Sometimes the role of medicine is to enable people to live rich and satisfying lives within their physical or mental constraints.

How does this apply to the patient–physician interface and the interaction in the clinic? The potential for the breakdown of communication is great. The stakes for the patient are high, and health professionals have time constraints and professional pressures. The terms under which the consultation takes place are less than favourable. You've got 10 or 15 minutes within which to make huge decisions with somebody else from any background, any level of education and sometimes with language barriers.

I suggest, following the philosopher S Kay Toombs, that illness represents two distinct realities – two different worlds. In the world of the patient, there may have been months or years of experiences and stories they want you to hear and a build-up of emotionally loaded thoughts and feelings about the illness. He or she has been thinking, 'I am going to see the consultant next month, next week, tomorrow …' He or she may come to you with 20 questions and 19 of them seem to be irrelevant, or with pages and pages of printouts from the Internet. But your professional world is completely different. Maybe you're running behind, maybe you've spilt coffee on yourself, maybe you have problems at home – all these things are in the consultation room as the consultation begins. Toombs described this meeting as involving a *decisive gap* between the patient's experience of illness and the physician's view of disease and the biological processes involved.

Phenomenology can help improve the physician–patient relationship by disclosing how individuals constitute the meaning of their experiences; it brings us to think that illness is not an objective entity, but something that is determined by how it is experienced by the patients, their family, friends and their physician.

This is not to deny that there is a disease; it is simply setting it to one side and focussing on the illness and the radically different ways in which it might appear to patient and physician. The physician might construe the illness as a 'disease state', but the patient encounters suffered illness as well as the disease. The patient also encounters the body as painfully lived.

This leads to different explanatory models and different systems of relevances. You might be interested in diagnosis, but the patient wants an explanation: why did it happen to me? Why did I end up by having lung cancer? I never smoked, and similar questions.

You may want to suggest treatment, but the patient comes with the very clear objective of a cure. You might be able to offer a prognosis, but the patient doesn't want statistics, they want to know what is going to happen to *them.* So the demands on you are great, although your ability to provide the information or the cure that people are after is in some cases extremely limited. The patients seek validation of their experience from you but without always explicitly stating what their values are, so you have to tread carefully around issues such as values and culture.

The essential characteristics of illness

The essential characteristics of illness transcend particular features of different diseases and constitute the meaning of illness as lived. So what do alcoholism, bulimia, flu and kidney failure have in common? What kind of general phenomenological insight can we glean? Toombs characterises illness as involving five losses: loss of wholeness, of certainty, of control, of freedom to act and of the familiar world. Illness thwarts plans and impedes choices. The disruption of the fundamental unity of body and self results in seeing the body as 'other than me' and as a threat to self. We suffer a radical loss of certainty: with loss of control come unpredictable, apparently capricious interruptions to our lives and a sense of isolation from the familiar world. The future is truncated.

> *The phenomenological approach involves not simply taking the patient's experience into account as a subjective accounting of an abstract 'objective' reality, but acknowledging that such lived experience represents the reality of the patient's illness. It requires us to shift from thinking about the subjective processes of an objective reality in abstraction to thinking about it as having a primacy of its own. (Toombs)*

Personal experience – good and bad

> *The human emotion in greatest shortage is empathy and that this is nowhere more evident than in illness. The pain, disability and fear are exacerbated by the apathy and disgust with which you are sometimes confronted when you are ill. There are many terrible things about illness; the lack of empathy hurts the most. (Carel, Illness)*[1]

One of the most distressing experiences I had when I was diagnosed (with lymphangioleiomyomatosis (LAM)) was having a computed tomography (CT) scan looking for abdominal masses caused by lymphatic obstruction. I heard at 4 p.m. on a Friday that the radiologist had reported that something was wrong with my ovaries, possibly ovarian cancer. I was given an appointment with a gynaecologist in 3 weeks' time, but thanks to the intervention of my respiratory nurse who walked over to the Gynaecology Department and asked for me to be seen immediately, I was seen the next day. I was reassured that the scan report was wrong. It is this kind of small mercy – the nurse's kind gesture – that becomes so enormously important in a situation like this.

Carel concluded her talk by reading a moving passage from her book *Illness*, which describes in harrowing detail the experience of being treated with a total lack of empathy by the nurse conducting the respiratory function tests, which have enormous significance for her in charting her disease.

Postscript

The biosociopsychological model can seem to say that all you have to do is add up all these things together and then you won't leave anything out, but what you really need is a metaphysical transition: not just to say human beings are these things put together but all of these things taking place at the same time with complex interactions between them, and then work with that. I don't envy you with your jobs!

Note

i. This of course includes all pain practitioners.

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Professional perspectives

Airing Pain: bringing together the pain community

THE BRITISH PAIN SOCIETY

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SAGE

Paul Harvard Evans *Producer and Presenter of the* Airing Pain *Radio Programme*
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Paul Evans is producer and presenter of Pain Concern's half hour, fortnightly radio programme, Airing Pain. He was an award winning features producer at the BBC for 31 years. He has no medical or scientific training, but 25 years ago, he was diagnosed with fibromyalgia, and just 2 years ago, he had to give up his job at the BBC. He recalls a very stressful and depressing 12-month process, in which he had to convince independent occupational health doctors that he really was ill. It is this lack of two-way communication and cooperation between the health professionals and patient that drives him to make a success of Airing Pain. In August of last year (2012), he was invited to speak about the Airing Pain programmes at a meeting on Professional and Public Pain Education at the International Association for the Study of Pain's World Congress in Milan. He starts by describing how he got involved with Pain Concern's Airing Pain project.

Pain Concern had a fantastic idea. They also had boundless energy and enthusiasm, but they didn't have the experience or expertise or the first idea of how to get a series of radio programmes off the ground. So they got me involved and we talked, and talked, and talked again … and I have to say that at times, I felt guilty of dampening down their enthusiasm by pointing out impracticalities or the downright affordability of many excellent ideas.

On the contrary, many of those same ideas did force me to rethink how things could indeed be done with extremely limited resources. Sometimes a small team of similarly motivated people who listen to and respect each other's opinions can really add up to more than the sum of its parts.

So why was I there? One comment that has crossed my path on several occasions was that programmes don't need to 'sound professional'. In order to save money, we should explore the option of engaging a 'keen amateur' rather than a 'professional'. I believe that a programme expertly produced, taking in all considerations of audience, language, content and structure, has greater authenticity than a thrown-together potpourri of poorly conducted and technically inferior interviews.

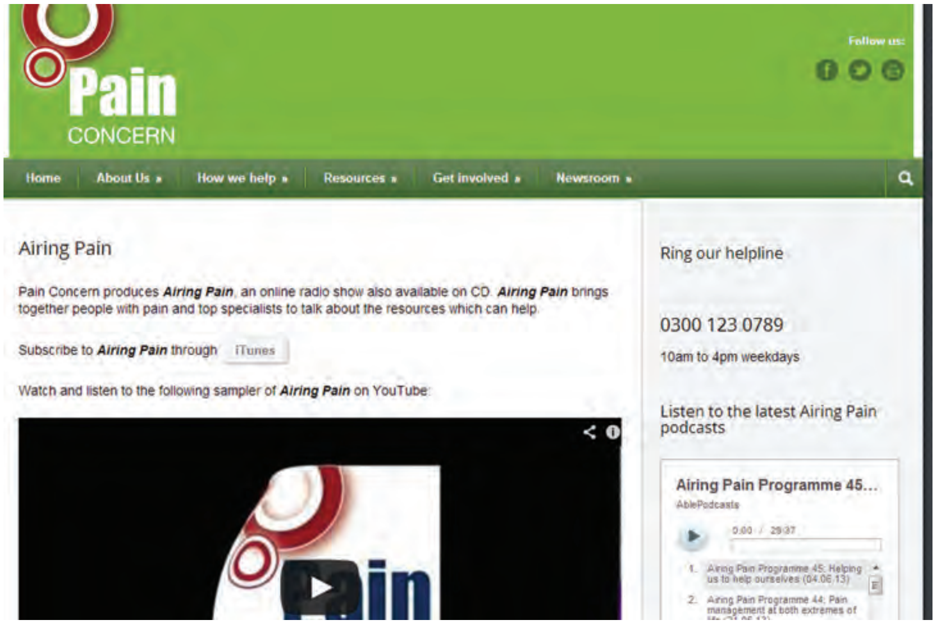
There is no point in broadcasting if no one is listening, so there are some things we really need to understand about audiences. The first is that without them you are nothing, there's no point in going on. Second, they are a fickle breed. If they don't like, understand or are just bored with you, they can, and do, get rid of you with the flick of a switch or the click of the mouse.

So, as a programme maker, I have to make sure the listener stays with me right to the end of the programme; they must not be given an excuse to turn elsewhere. So who is our target audience?

Well, it's every single member of this so-called pain community. Through making these programmes and having interviewed many people living with chronic pain, I feel a strong undercurrent of desperation and anger that many patients feel excluded from this pain community. These programmes are an excellent resource to hear the honest, open views, the frustration, and even desperation, of people who should have been able to have a meaningful conversation with their health professional, but have yet to achieve it!

So, I try to move everyone closer to each other. I'm a firm believer that our programmes need not exclude segments of the pain community, or indeed anyone outside it.

There is no point of making the most informative radio programme in the world if everyone has switched off after hearing 'Professor So-and-so' droning on



Airing Pain

Pain Concern produces ***Airing Pain***, an online radio show also available on CD. ***Airing Pain*** brings together people with pain and top specialists to talk about the resources which can help.

Subscribe to ***Airing Pain*** through iTunes

Watch and listen to the following sampler of ***Airing Pain*** on YouTube:

Ring our helpline

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Airing Pain Programme 45...

AblePodcasts

0:00 / 29:37

1. Airing Pain Programme 45: Helping us to help ourselves (04.06.13)
2. Airing Pain Programme 44: Pain management at both extremes of

interminably about his latest research in a language that no one outside his lab can understand. I want my listener to feel part of the programme, not an outsider. As a patient, I ask those questions that I have always wanted to ask, but been too intimidated to do so. I'm not afraid of using humour or indeed of showing my level of ignorance, and I show empathy.

And if I were to give advice to an interviewee, it would be that enthusiasm is absolutely priceless; don't regurgitate facts and figures as if from an academic paper; don't patronise; think conversation, not lecture, and listen to yourself as if through the ears of the listener.

So, Professor So-and-so does not need to patronise or dumb down to speak to the man in the street. And the man or woman in the street should be able to say, 'I don't know what on earth you're talking about; speak in language that I can understand'.

I was daunted by the enormity of the task in making the *Airing Pain* project a success. What drives me on, however, is that I've learnt more about my condition and how to manage it in the 2 years I've been making these programmes than I did in 25 years of being managed by the National Health Service (NHS). And what is really frustrating is that all the information was there in the first place.

One patient I interviewed was desperate to share his experience with our listeners: 'The first doctor you get, he can either make you or break you … he didn't see me as a person, he saw me as a brain'.

It shows that bridging the gap between professional and public education really is a challenge we all need to act on. But Pain Concern is showing that we can work together. To me, it shows that what we have achieved on *Airing Pain* is a huge step forward in embracing all members of this, our, pain community.

Listen and download 44 editions of *Airing Pain* at: http://www.painconcern.org.uk/how-we-help/airing-pain-2

To order free sampler CDs of *Airing Pain* for your clinic, please email order@painconcern.org.uk

Professional perspectives

Evaluation shows *Airing Pain* benefits people in pain

Tom Green *Editor at Pain Concern*

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Airing Pain 'is an excellent resource that gives good information and support' and 'makes you feel part of the pain community', according to feedback from listeners. These comments were recorded in a recent evaluation of UK charity Pain Concern's radio show to assess how far *Airing Pain* has been successful at reaching out to and helping people with pain.

Airing Pain first aired in September 2010 with the aim of taking support into the homes of people living with pain and over forty 30-minute episodes have now been broadcast. The broadcasts bring together people with pain and top specialists to talk about the resources that can help. All programmes are available for download from http://www.painconcern.org.uk and iTunes. New programmes are broadcast via Able Radio.

The evaluation found that on average, just under 350 people have listened to each of the first 36 programmes and that each edition is downloaded on average 35 times a month. The most popular programmes include 'Power over Mind and Body', which looked at the importance of combining psychological and physiological approaches to pain, as well as programmes on 'Effective Communication' and 'Growing Older with Pain'. Older programmes are still attracting a steady stream of listeners, suggesting that their content continues to be useful long after the time of broadcast.

The team also invited listeners to participate in a survey designed to capture information on the age and location of listeners as well as their responses to the show, both positive and negative. A total of 120 people responded, allowing us to discover, for example, that the majority of listeners (87%) live in England or Scotland and that 83% are aged 40 years or above.

Listeners were asked what they liked about *Airing Pain*, with many appreciating that the programmes, in the words of one respondent, 'highlight the issues that concern people with chronic pain'. *Airing Pain* was also praised for its high production standards, for being 'interesting and lively', for featuring the voices of a broad range of health-care experts and people living with pain and for giving tips on self-management. Many listeners found that the programmes helped them to feel part of a broader 'pain community', a particularly important result as pain can often lead to people feeling isolated and misunderstood.

The evaluation has also provided the *Airing Pain* team with information about areas where there is room for improvement. The old website came in for some criticism from respondents to the survey, and with this in mind, the developers of the new website worked to provide easier access to the programmes. Perhaps the most important suggestion came from the researchers who urged Pain Concern to improve awareness of the show to ensure that more listeners can benefit from this resource in the future. The listening figures from the latest programmes released after the study's completion suggest that progress has been made as programmes 37–42 have already had between 1800 and 3500 listeners each. New programmes are currently in production with funding already secured to produce more in the second half of 2013.

Guidance on the Management of Pain in the Older People

The British Geriatrics Society and British Pain Society have collaborated to produce the first UK guideline on the management of pain in older people. Published as a supplement to Age and Ageing, the recommendations follow an extensive systematic review of the available literature and aim to help health professionals, in any care setting, to consider the options available when managing pain in older patients.

The guideline has been categorised into sections dealing with pharmacology, interventional therapies, psychological interventions, physical activity and assistive devices and complementary therapies.

Copies are available online from both organisations websites at:
http://www.britishpainsociety.org/pub_professional.htm or
http://ageing.oxfordjournals.org/content/42/suppl_1.toc

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SAGE

Saving starfish – integrating care and compassion into a system based on business ethics. Is it possible?

Reflections on Philosophy & Ethics SIG meeting at Launde Abbey

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> *Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.*
>
> Margaret Mead

This was my first visit to the British Pain Society Philosophy & Ethics Special Interest Group's (SIG) annual conference, which is traditionally held at a retreat. This year, the group was meeting at Launde Abbey, which is set in 450 acres of beautiful, green, open parkland on the borders of Leicestershire and Rutland.

In preparation, we were asked to read a paper by esteemed American neurosurgeon and elder statesman in the world of pain medicine, John Loeser and his co-author, Alex Cahana, a professor in pain medicine. John was the conference's special guest. Their powerful paper, *Pain medicine versus pain management: ethical dilemmas created by contemporary medicine and business*,[1] discusses the conflicts that arise when business principles are applied to health-care systems. 'The world of health care and the world of business have fundamentally different ethical standards'[1] and consequently not only produce conflicts in the physician and patient's mind, but directly affect the actual treatments offered. The paper talks about the state of pain medicine in the United States, but there are many parallels with the United Kingdom and other countries. What you get is not necessarily what you need, but rather what is dictated by financial drivers, pressure from providers of devices and drugs and an incorrect belief that chronic pain is a result of a broken body part which can be fixed.

The conference's agenda reflected the approach we were seeking to promote for the treatment of persistent pain – it focussed on the whole person. Each day began with a session of Tai Chi on the lawn, followed by breakfast, a morning of talks and discussions, lunch, a long country 'walking and talking' session, afternoon tea and cake, evening lecture and discussion, then supper and chat in the lounge and grounds of the abbey, a format which nourished us in many ways.

Changing culture

In his talk *Can we change the culture of pain management?*, John Loeser spoke about the conflict of interests and values which have arisen as a result of business ethics being imposed on health-care systems. I was struck by his comment that 'Patients get what the provider does, not what the patient needs', and how there is no time in the system to hear the patient's story because of the requirement to measure success by throughput of patients rather than by successful outcomes.

The management of persistent pain by a multidisciplinary team of specialist clinicians has been shown to be more effective, in terms of helping the person in pain to manage his or her symptoms over the longer term, than direct interventions. However, this is often overlooked. John and Alex's paper states that 'As hospitals are also searching for revenue generation, they have facilitated utilisation of revenue-producing procedures and removed support from multidisciplinary pain clinics'.[1] In John's opinion, '*Money always trumps ethics … Profits are the bottom line, not efficacy or humanity of care*'.

John also spoke of the huge opioid problem in the United States which we are beginning to see reflected in the United Kingdom and other countries. More people in the United States die from an overdose of opioids than from heroin. His co-author, Alex Cahana, put it more starkly in a TEDx Bellvue video (http://www.youtube.com/watch?v=VF_WQK0eWik): '*Today (in the US), 50 people will die from an overdose of pain killers. Painkillers kill*'.

Morphine is neither a desirable nor an effective solution for persistent pain, yet in many developed countries, it is hugely overused for this purpose. Alex Cahana made it clear in his TEDx talk when he said, '*Pain is not an opioid-deficient state*'. Opioids play an important role in managing acute pain but are often under used in this area, so there needs to be a shift in thinking and practice on a number of levels across the world. This point was reinforced by Consultant in Pain Medicine and Chair of the British Pain Society Pain in Developing Countries SIG, Clare Roques, in her talk entitled *Changing the culture of pain medicine: a desirable and achievable international goal*. Alex Cahana illustrates this in his video with photographs of badly injured soldiers – morphine enables us to deal with the acute pain of stepping on a mine, but months down the line, when injuries have healed, it has no place to play in pain that persists.

This belief that morphine is an answer is a huge problem and leads to a false expectation that a pain specialist can fix all pain. I have encountered patients unable to keep their eyes open or be a part of life because of their high morphine intake; so it is food for some thought that these are prescribed by doctors who have a duty of care. The conflict is that they are also trying to fulfil their patient's expectations that their pain can be fixed, so there is a wide-ranging need for education across many levels.

Education, education

There is a need to educate populations about the true nature of persistent pain to change the focus away from short-term fixes in favour of longer term management. John called for a move away from the belief that chronic pain is a by-product of disease – the belief that if you fix the disease, you fix the pain. This biomedical approach promises the abolition of pain, which is currently not possible. John and Alex both stress that pain should not be considered as a 'THING' – a noun. Pain is a process – a verb, so perhaps we should be saying that people are 'paining' rather than people have something called 'pain'. Alex Cahana argues that we have developed a culture of medicalising life.

John went on to discuss how pain and suffering have become synonymous in our culture and language – the language of pain is used to describe all types of suffering. As Alex Cahana put it in his video, '***Pain is mandatory – suffering is optional***'. Many people in pain will find this a difficult concept to grasp. Again, it comes back to education and changing our cultural beliefs about pain. It also highlights a need to change the message and language the media promotes and the benefits of making research articles more widely accessible and readable. We need, however, to be careful that the message that persistent pain isn't the result of a broken part which can be fixed isn't interpreted as, '*I'm sorry you have chronic pain so there is nothing we can do for you*'. There is a lot we *can* do to change the experience of pain and alleviate suffering, but this needs to be done from a baseline of accurate knowledge.

Success needs action

Patients who hold the belief that pain can be cured by the doctor 'doing something to them' are passive in managing their pain. Long-term success depends on the patient taking an active role in their treatment, physically and mentally – being involved, owning a way forward. Being successful at anything requires action. That decision to change and take action needs to be made before any progress is possible.

I emphasised this in my talk on knitting as a tool in health care. I spoke about how knitting can be used as a springboard to action – becoming involved in the world. About how enabling our patients to be successful at something was an important first step in helping them to accept their pain and successfully manage it so that the process of change can begin.

Change almost invariably needs to involve lifestyle changes, changes in mental attitude as well as increasing levels of physical movement. In John Loeser and Alex Cahana's words,

> *Chronic inactivity has been shown to be deleterious for every organ system in the body. Certainly if rest and inactivity are prescribed by the physician, the patient acquires a disability that may not be driven by the underlying injury at all.*[1]

I see this frequently – people with persistent pain who haven't moved or exercised for years, so their pain and disability is accentuated and perpetuated by being generally out of condition and unfit.

Making changes to deeply rooted ways of life isn't easy, so people need ongoing support to achieve this. The culture of measuring success by throughput doesn't allow for ongoing longer term support, so it should be no surprise that patients keep bouncing back asking for help. Perhaps we should take a message from successful weight-loss organisations which recognise that ongoing support through groups, run by an expert, is an effective long-term strategy. Praise and reinforcement of success have been shown to minimise the risk of failure.

Long-term conditions need a longer term view, although within this model, it is important to recognise that an effective multidisciplinary approach may require a short-term interventionist procedure (such as an injection) to enable movement to begin the journey along that longer term path. These decisions should be made within the multidisciplinary team with a specific desired outcome in mind, and then be monitored appropriately and happen within a system which enables ongoing support and motivation. It's all too easy to fall by the wayside and develop other problems without support along the way.

This is exactly what thriving businesses do, and indeed, there are many good practices we can take from business models, so I would caution against turning our backs on ideas just because they have come from the business world. Successful business strives for and depends on customer satisfaction. A thriving, successful health-care system should strive for patient satisfaction.

Are we compassionate?

Giving clinicians time to reflect and talk about difficult cases enables them to improve their care and manage their own personal mental health. A stressed out clinician cannot offer a compassionate ear to his or her patient. As Yoga teacher Sarah Dixon emphasised, to show compassion, we have to start with ourselves.

BBC Radio 4's programme *You and Yours* on Tuesday, 20 June 2013, discussed quality of care and compassion. I was struck by the comments of one caller who said, 'Without compassion there is no dignity or respect'. He also said that no matter how compassionate individual carers were, imposed time constraints forced compassion by the wayside, 'Without time there can be little compassion'. This is also my impression; measuring success by throughput of patients introduces time constraints which can seriously impede the clinician's ability to show compassion and therefore the quality of care they provide.

In her talk, *Compassion in healthcare: report of the Royal Society of Medicine meeting*, Sarah Dixon told us that the psychologies of threat and compassion are incompatible. In a situation of threat, it is difficult to be compassionate. When the threat level is high, threat focus takes over leading to threat-focussed solutions. If threat level is low, collaborative relationships and creativity flourish.

This highlights how the structure of organisations and the status of pain education create conflicts: the values of business versus the values of effective health care; the values of clinicians versus that of the system; the patient, who enters the consulting room with an expectation of finding a fix, versus the clinician who is unable to deliver.

Special Interest Group of the British Pain Society for Philosophy and Ethics

Changing the Culture of Pain Medicine

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

Meaningful message

The importance of finding shared values was reinforced by Ed Peile (Professor Emeritus of Medical Education, University of Warwick) in his talk, *Learning and teaching about pain: the evidence and the values*. He focussed on improving the clinician–patient relationship by exploring shared values. I think this can be expanded to include the system within which the clinician/patient relationship occurs. If we have a system which builds on shared values, ethics and goals, then surely this will be beneficial for everyone – management, clinician and patient. Knowing what our focus is as a whole will help to create order from the chaos that John described. Managing order must surely be more cost-effective than managing chaos.

Ed Peile spoke about the essentials of values-based practice, where the best available scientific evidence is combined with clinical experience and knowledge of the patient's individual values. He argued that the most effective approach is to explore values which are shared by patient and clinician – the need to ease suffering is a good place to start – and build on these. He stressed the danger of making assumptions and the importance of realising that not everyone thinks alike – 'Not everyone thinks like I do'.

These shared values should guide actions. By knowing what really matters to their patient, clinicians will be aware of how these values may impact on their clinical approach. This process of empowering patients by using the thoughts and beliefs they deem important gives the process meaning, and in so doing makes it more likely that guidance on managing pain is adhered to. The message was that we should be learning to listen before learning to format.

According to John Loeser, this is exactly what is not happening in health care in America, and we are seeing this trend spreading. To reiterate his statement, 'Patients get what the provider gives, not what the patient needs'. Is there any surprise therefore that we're unsuccessful in our treatment of persistent pain?

Do we care?

Janet Holt (Senior Lecturer, School of Healthcare, University of Leeds) in her talk entitled *Do nurses care?* asked what we mean by 'care' and discussed whether we thought 'care' was a defining characteristic of nursing. Should we be choosing prospective nursing candidates by their ability to care? Should this take precedence over competence? How do we ascertain whether a person is caring in an interview? She got me thinking how difficult it is to get it right. It's easy enough to say that nurses should be more caring, but what do we actually mean by that? I think reassuring touch plays an important part in showing we care, but in a society that doesn't encourage touch, how do we train someone to do so in a way which conveys they care?

Janet identified the elements of care as Attentiveness, Responsibility, Competence and Responsiveness. Good care requires all these elements and involves the context of the care process plus the ability to make judgements about conflicting needs and strategies. So in the context of health care, 'care' goes much further than ensuring someone is fed, washed, watered and comforted.

In the follow-up discussion, the training of health-care assistants was raised. How do you develop those caring skills in such a short period of time? How do you move someone from operating an inanimate supermarket till to touching caringly and giving intimate care to sick people in a few days? Can we teach compassion, I wonder? Do we only train those people who demonstrate a propensity to be able to practise it? How do we measure that? Confusion can also arise about who is a nurse and who is a health-care assistant, so perhaps we expect too much of these 'carers'? Where is our duty of care to them?

Patient people

There was an interesting discussion on whether the patient should be referred to as a patient or a person with pain. I don't think the two are mutually exclusive. My personal view is that there are millions of people who have pain, but at some stage, some of them require our help. I think at this point they also become patients. A patient is still a person with pain in the same way as the pain specialist is a person with knowledge about pain. When a person with pain seeks our help, we enter into a mutual contract, the relationship changes and needs to change. This point was emphasised by General Practitioner (GP) Bernd Strathausen. The clinician–patient contract enables the clinician to touch and examine the person with pain. It gives us a duty of care which we don't have to all the other people who live with pain in society, apart, of course, from having a duty of care for them as fellow humans. Therefore, in my view, we need a word which describes the person with pain who seeks our help, and for want of a better word, I am happy to 'patient' for the duration of their treatment.

Musings about pain

After supper on day 2, we were treated to a wonderful few hours of reminiscence by John Loeser who spoke about the early days of establishing the International Association for the Study of Pain (IASP) and its journal, *Pain*, in 1973. It was a privilege to sit with a small group listening to him talking about the great names in the world of pain medicine. His lovely wife Karen chipped in with tales of her own, which brought the stories to life.

Beatrice Sofaer-Bennet (Honorary Fellow, Clinical Research Centre, University of Brighton) added her own amusing anecdotes of her experiences in this early era of pain management. She expanded on this in her session, *Tales, stories and memories: a Pain Clinic Compendium*, on the last morning of the conference. It is thanks to clinicians like John and researchers like Beatrice, who are passionate about their subject, that pain medicine has advanced as it has, so let's hope people will take heed of John and Alex's paper which warns health-care systems around the world against continuing on the path of using business ethics.

Chaos versus order

John spoke of the chaos currently present in pain medicine. It is my view that without an agreed standard for treatment or makeup of clinical teams based on outcomes, there can be no consistency of treatment. How, therefore, can we expect consistency of care or success? Several people rightly pointed out that there are areas where the level of care and competence is wonderful and works well. I would agree, but in my opinion, this is down to some remarkably hard working individuals who manage to provide exemplary care despite the broader, target/numbers driven system they find themselves in.

As a reminder of these good things, Clare Roques spoke about advances being made in pain management in developing countries. She is working to educate clinicians in these countries to enable people to access effective pain management.

Consultant Nurse Karin Cannons has crafted order from chaos in her Department in Frimley Park, London. In her talk, 'Know-what-I-mean? Do we hear what is said and what is meant? Developing a common culture of communication amongst the Pain Multidisciplinary Team using reflection', Karin described team meetings in which clinicians are encouraged to reflect on their work, patients and problems, and how it had been a fight to secure these non-clinical hours. Again, the conflict between business ethics and those of health care raised its head but, despite this, she has been successful in securing this non-patient (zero revenue-making) time for her team to meet. We can learn from her example and perhaps begin to bring order to the chaos. Learning from areas that *are* functioning well is also what good business practice does.

Knitting it together

The third morning pulled together many of the issues raised over the conference. My talk on *Getting the right hand to work with the left: knitting together – a future for health care* was well received and other pain clinics will be setting up Therapeutic Knitting groups as a result.

I focussed on the importance of the 'other things' going on in people's lives and the benefits of listening to and hearing the patient's story which was an underlying theme of discussions. This was reinforced by John when he reminded us that a major cause of persistent pain is poverty and this situation is worsened when those who are 'paining' have to give up work and rely on the uncertainty of handouts. This is a situation we've seen made worse by the recent introduction of a new benefits system in the United Kingdom.

It is my opinion that we *can* address many of the issues raised over the 3 days at low cost if we change the focus of our delivery. We can influence positive change in the body's physiology by applying the principles of positive psychology to change the chemical processes that cause us to feel the way we do. We can exploit the fact that our amazing nervous system changes with experience to influence positive change. This point was reinforced by physiotherapist Ian Stevens in the last talk of the conference. We need to change the belief that all medical conditions require medication. Sometimes there are easier, cheaper options.

Ian Stevens has a special interest in the interface between arts and science, so his talk on *Allegories of change: the poetry of Ted Hughes and images of the natural world* was a fitting way of winding up a conference that had debated wide-ranging, serious issues in such beautiful surroundings. Ian spoke about how context and meaning can dramatically change the nature of pain. His first slide reminded us of the difference between pain and suffering. It showed a graphic image of a painful ritual where the cultural context completely changed the degree of suffering. The meaning had changed, so it was a great way of reinforcing the importance of hearing the patient's story, of knowing their values and of finding out what their pain means to them.

I was struck by the metaphors he used. He likened the state of persistent pain to a balloon bouncing on the underside of a branch and continuing to hit the branch time after time. 'If you have the same stimulus you travel in the same direction, but it only takes a small breath of wind to change that direction and free the balloon'. He brought our focus back on to our amazing nervous system and how we can influence positive change in its very makeup by utilising positive psychology – the strengths and virtues that enable people and communities to thrive.

Call to action

John Loeser and Alex Cahana's paper calls for change. 'Financial incentives for all sectors of healthcare delivery systems must change so that they reinforce doing what is right for the patient. What is funded should be based upon long-term outcomes studies that are patient-centred'.[1] In terms of whether we choose to change or not, Ian Stevens told us, 'Stasis – a period or state of inactivity – is the opposite of change and flux and is incompatible with life'. We need to change to flourish, and this is true of the individual who suffers from persistent pain, the clinician and the system we find ourselves in.

We *can* learn from appropriate, successful business models and what better way to win an argument than to turn the opponent's rationale around. Success needs action, so we need to spread our message far and wide. Trish Groves, Deputy Editor of the *British Medical Journal* (*BMJ*), in her talk on *Social media in medicine: benign influence or just more spin?* focussed on how we can use social media as a tool to enable us to reach millions of people around the world. Let's take full advantage of it.

Beatrice Sofaer-Bennet told the story of a mother and child walking along a beach strewn with thousands of stranded starfish. The little boy throws one back into the sea and his mother says, 'There's no point. You can't save them all. There are too many to make a difference', to which the boy replies, 'Oh but I can make a difference to this one'.

If we all throw back a starfish, we might have an impact! I am reminded of Margaret Meed's words, 'Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has'.

Reference

1. Loeser JD and Cahana A. Pain medicine versus pain management: ethical dilemmas created by contemporary medicine and business. *Clin J Pain* 2013 29:311–6.

Informing practice

The British Pain Society
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SAGE

How do we follow up our patients after injections? A survey of pain consultants

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Blockade and modulation of the nociceptive pathway by the route of interventional procedures provides varying degree of relief to chronic pain patients. Pain injections need to be reviewed, but currently, there is not much information on when and how they are reviewed. This is important to achieve a streamlined efficiency in providing our pain services. This survey of pain consultants aims to provide a snapshot of current practice in the United Kingdom.

Objectives

- To find out who is tasked with the follow-up of chronic pain patients after a pain intervention.
- To determine the timescale of patient follow-up.
- To determine the proportion of patients whose outcome is assessed by a health-care professional other than a pain physician (such as a nurse or physiotherapist).
- To find out the proportion of patients who are referred back to be reviewed by pain physician after assessment by another health professional.
- To determine the proportion of patients who are followed up by another health-care professional who then routinely discusses the management plan with a pain physician.
- To find out whether a standardised algorithm is used for patient follow-up after interventional therapy for chronic pain.

Methods

The Google group of pain consultants is an active discussion forum and comprises about 300 members. The members were requested to fill in an online questionnaire (SurveyMonkey – free version). Many of these pain physicians are registered members of the British Pain Society.

The following four questions were asked:

1. Do you perform pain injections?
2. If yes to question 1 above, who performs the injection assessment?
3. When is the injection assessment performed?
4. What happens to patients after their injection outcome has been reviewed?

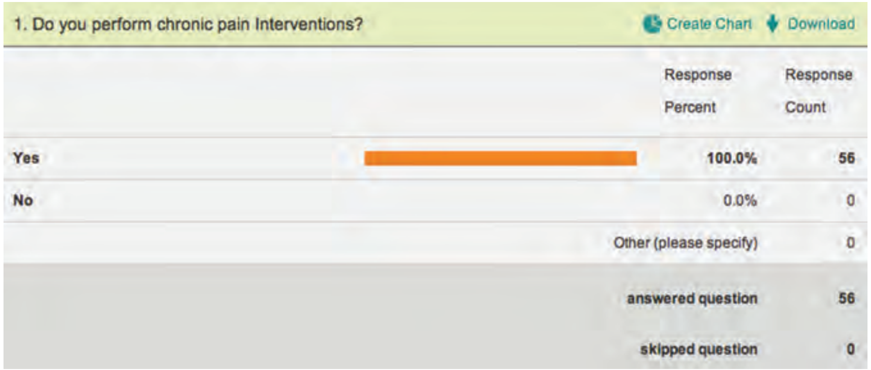
A total of 56 responses were collected during the 2 weeks that the survey was open online in April 2013.

Results

The results are presented in Figures 1–4.

Overall, 56 consultant interventional pain physicians completed the survey out

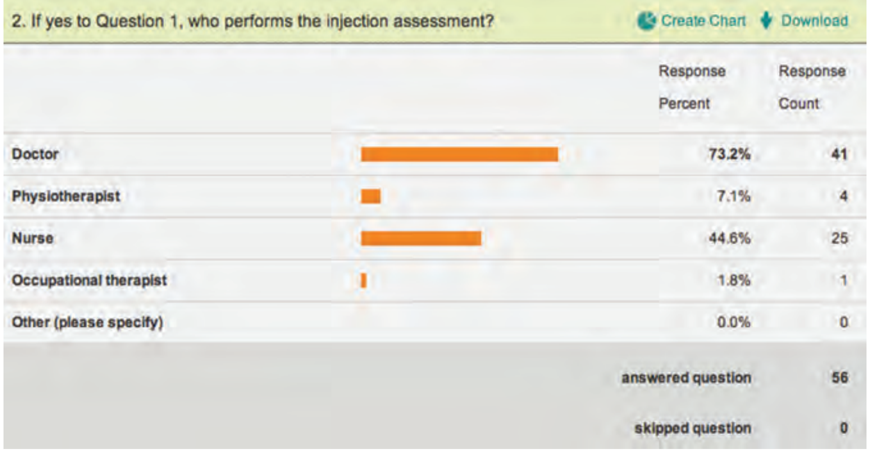
Figure 1. The number of physicians who performed interventions 56/56 (100%)



1. Do you perform chronic pain Interventions?

	Response Percent	Response Count
Yes	100.0%	56
No	0.0%	0
Other (please specify)		0
answered question		56
skipped question		0

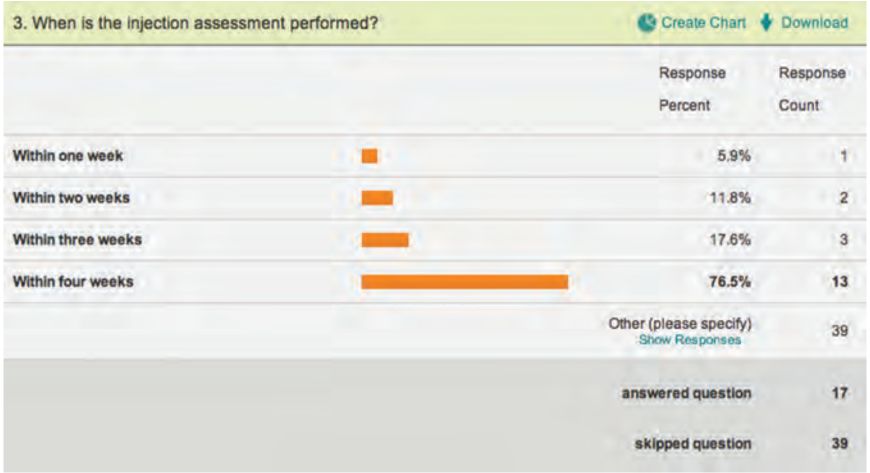
Figure 2. Majority of injection assessments were performed by doctors



2. If yes to Question 1, who performs the injection assessment?

	Response Percent	Response Count
Doctor	73.2%	41
Physiotherapist	7.1%	4
Nurse	44.6%	25
Occupational therapist	1.8%	1
Other (please specify)	0.0%	0
	answered question	56
	skipped question	0

Figure 3. There is a wide variation in the time when injections are assessed



3. When is the injection assessment performed?

	Response Percent	Response Count
Within one week	5.9%	1
Within two weeks	11.8%	2
Within three weeks	17.6%	3
Within four weeks	76.5%	13
	Other (please specify) Show Responses	39
	answered question	17
	skipped question	39

of a total of estimated 300 UK Google pain consultants group. All consultants who responded did perform interventional procedures.

In 73.2% of injections, a pain physician carried out the injection review or follow-up, with a lower proportion carried out by other health professionals: nurses (45%), physiotherapist (7%) and occupational therapist (2%) were involved in performing injection reviews in the remaining patients.

Only 23.2% of injections were reviewed within 4 weeks. The remaining, which is 76.8% of injections, were reviewed at times ranging from 4 weeks to 6 months, with the majority reviewing their injections within 4 months. There was one response that stated the time before post-injection review to be 12 months. There were two responses that stated that they do not review injections at all.

In all, 18 of the 56 respondents answered the last question on what happens after the injection review; 9 respondents skipped the question and 29 respondents provided an answer that was different from the choices provided. Of those who answered, in 34% of cases, the injection assessor referred back the patient to the pain physician for further review. In 40.4% of cases, it was the non-medical assessor who decided on further management. In 38.3% of cases, the assessor contacted the pain physician for further management. In all, 31.9% respondents stated that they followed a standardised algorithm for common procedures.

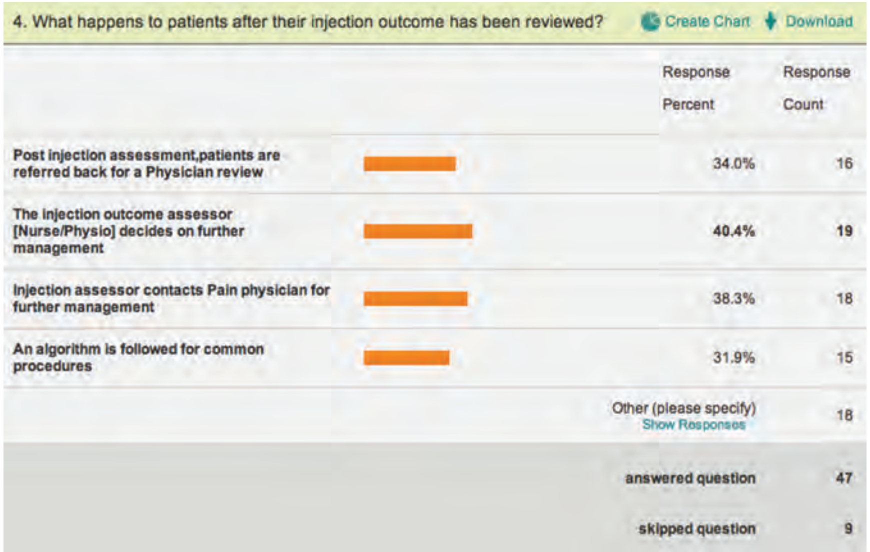
Discussion

This survey provides a snapshot of the follow-up practices of interventional pain physicians in the United Kingdom. There are standardised guidelines for the performance of interventional procedures such as epidural steroid injection (BPS; Australian and New Zealand College of Anaesthetists (ANZCA)), spinal cord stimulation (BPS), medial branch blocks (ANZCA) and intrathecal therapy (BPS). However, these publications offer very little guidance on the nature of patient follow-up in the weeks (and months) post procedure. This is guided more by availability of local manpower resources, workload and local adaptation.

The results of this survey indicate that the majority of patients are followed up by a pain physician who is arguably best placed to assess the success of the intervention, but potentially may lack a certain degree of objectivity. International Spine Intervention Society (ISIS) guidelines place an emphasis on objectivity of assessor, and an operator performing the outcome assessment may have an element of bias.

Interestingly, a considerable minority of patients are typically followed up by another health-care professional such as a nurse, physiotherapist or occupational therapist. This may be a reflection of the pragmatic use of limited resources.

Figure 4. Post assessment, there is wide variability in patient management



4. What happens to patients after their injection outcome has been reviewed?

	Response Percent	Response Count
Post injection assessment,patients are referred back for a Physician review	34.0%	16
The injection outcome assessor [Nurse/Physio] decides on further management	40.4%	19
Injection assessor contacts Pain physician for further management	38.3%	18
An algorithm is followed for common procedures	31.9%	15
Other (please specify)		18
answered question		47
skipped question		9

While another health-care professional may possess a high degree of objectivity, they may lack the in-depth knowledge of the interventional pain physician. This is important because as well as assessing the success or otherwise of the intervention, it is essential to observe for complications that may need focused questioning or examination to elicit or exclude their presence. If we look outside our speciality, surgeons and other interventionalists like cardiologists and radiologists frequently perform outcome assessments of their procedures.

Another noteworthy finding of the questionnaire was that a specific algorithm was implemented routinely for common procedures. As the speciality of pain medicine matures, it is perhaps time for pain specialists to formulate and agree upon standardised algorithms for post-procedure follow-up. These may incorporate established multidimensional tools pre- and post-procedure, such as the McGill and the SF-15 questionnaires (Melzack,[1] SF-15[2]) as well as straightforward assessments such as the visual analogue scale or the verbal rating score.

Perhaps the most contentious issue is the time frame in which pain injections should be reviewed. This survey shows that injection reviews are performed at varying periods of time from the day of procedure to 6 months in majority of the cases. Diagnostic injections may best be evaluated soon after the injection to eliminate recall bias. For therapeutic injections, because of the variability of benefit, it is hard to set a time frame. At our centre, we review our steroid injections at 4 months and radiofrequency interventions at 6 months with a proviso for the patient to contact our service in case of inadequate/no pain relief. This is not perfect but works given our limited staff capacity. Perhaps the best method would be to audit the mean duration of benefit of various pain injections locally and then formulate local review protocols.

Limitations

Only 56 interventional pain physicians completed the survey, so the results are not a complete representation of all clinicians; however, it is a very useful snapshot. In order to maximise the response rate of clinicians, the survey was deliberately concise. This meant that a more in-depth analysis of the potential variability of follow-up of specific procedures was not possible. In addition, the nature of any algorithm used by clinicians was not explored in detail. Finally, the opinions of pain physicians to whether or not they desired a more standardised follow-up process based on national guidelines was not sought. However, the aim of this survey itself was to promote debate regarding this issue.

Conclusion

This survey highlights the differences in the follow-up practices of pain physicians after therapeutic interventions across the United Kingdom. It is the first survey of its kind and sheds light on potential national discrepancies in approach. Of note, a significant minority of patients are followed up without the direct input of the pain physician who performed the intervention. In addition, the questionnaire seeks to stimulate discussion regarding the potential creation of a standardised national approach to patient follow-up.

Acknowledgements

The authors would specifically like to thank the participants for completing the survey.

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Informing practice

Physiotherapy after spinal injections

The British Pain Society
Pain News
11(3) 185–187

SAGE

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Dr Kristin Ullrich *Consultant in Anaesthesia and Pain Medicine, Barts Health NHS Trust*

There has been much debate surrounding the commissioning of interventional procedures in the treatment of back pain under the auspices of the National Health Service, in particular following the controversial National Institute of Clinical Excellence (NICE) document CG88.[1] Recent evidence-based guidelines forming the patient pain pathways for sufferers of lower back pain suggest that repeated interventions should only be considered if the benefit has been maintained for 6 months or longer.[2] Interventional treatments may be used as facilitators to involvement with exercise programmes in patients with chronic back pain, and there is evidence that post-treatment exercise programmes can prevent recurrences of back pain.[3,4]

Despite this, we were concerned that patients undergoing spinal interventions at our Trust were not benefiting from physical therapy during their ‘relief period’ following interventions. We reviewed a cohort of such patients attending follow-up clinics to see whether they had actually accessed physiotherapy services after their interventions.

Methods

Patients presenting for follow-up after any form of spinal intervention initiated locally were asked about access to physiotherapy following their respective treatments. The intervention may have been initiated at either a physician-only (PO) chronic pain clinic or a multidisciplinary team (MDT) pain clinic, where pain physicians review patients alongside physiotherapists and psychologists. Patients who had been referred for their intervention from another speciality (such as spinal surgery) or another organisation were excluded from the analysis.

If physiotherapy had been accessed during the patients’ treatment pathway, a note was made of the timing in relation to the anteceding spinal intervention and also of the source of referral. In cases where physiotherapy was not accessed at all, the original clinic letter suggesting the intervention as well as the discharge letter following the intervention were interrogated in order to ascertain whether the referring clinician had made reference to physiotherapy.

Data were gathered by pain consultants and anaesthetic trainees on rotation through the pain departments and specialist pain nurses at all follow-up pain clinics across Barts Health Trusts over an 8-week period starting from September 2012.

Results

Data were collected on 44 patients in the 8-week period. Of the 44 patients, 28 had been referred to interventions from PO clinics, with the remainder being referred from MDT clinics where physiotherapists were present during the initial assessment.

Patients had received, on average, 2–3 spinal interventions (range: 1–10) to include caudal injections (n = 15), epidurals (n = 3), facet joint injections (n = 23), paravertebral nerve blocks (n = 1), nerve root blocks (n = 2), radiofrequency nerve ablation (n = 1) and trigger point injection (n = 8). In the majority of cases (36/44), the intervention was intended to be therapeutic.

Less than 37% (16/44) of patients overall received any physiotherapy following their interventions. Subgroup analysis identified that the proportion of patients receiving physiotherapy in PO clinics was lower than in MDT clinics, 29% versus 50% (Figure 1); however, the numbers in the groups were too small to perform any meaningful statistical analysis of the cohorts. The average time delay

Figure 1. Access to physiotherapy following spinal intervention

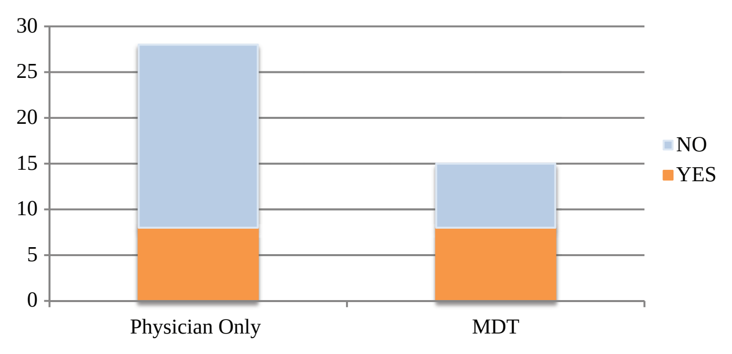
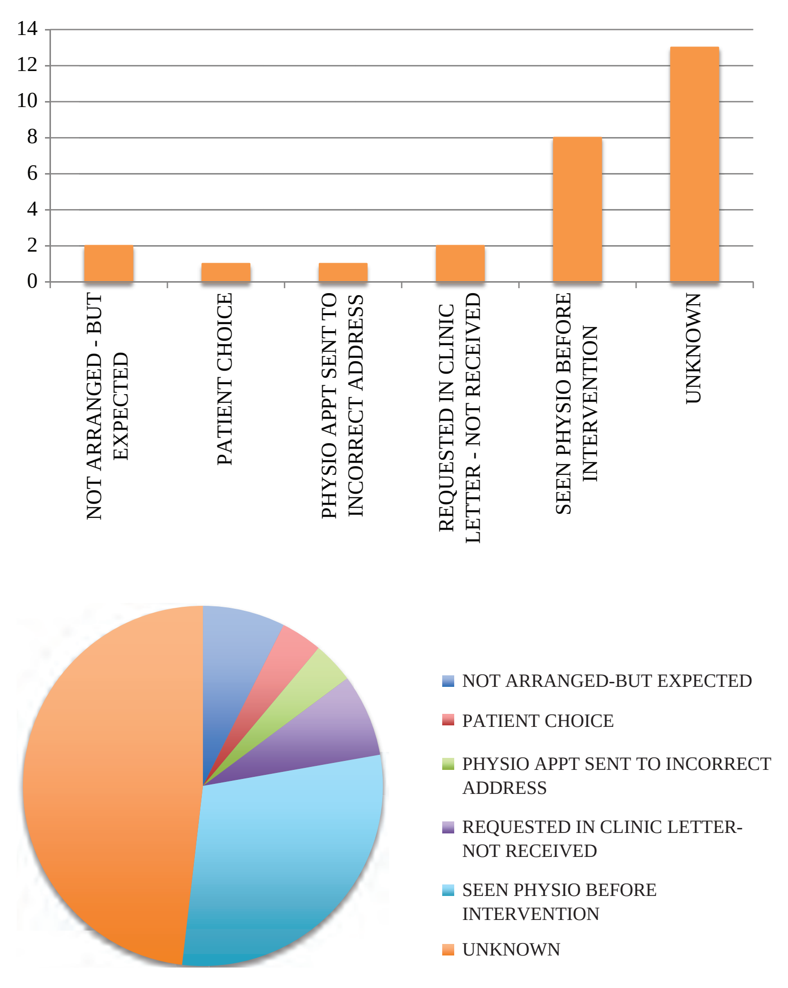


Figure 2. Reasons why physiotherapy thought to have been omitted



between the patient's most recent intervention and physiotherapy was 2.4 months (range: 1–6 months). At our PO clinics, a request for referral to physiotherapy was only mentioned in 21% (6/28) clinic letters to the general practitioner (GP), and subsequently, physiotherapy was only delivered in 33% (2/6) of these cases. The possible reasons cited for omission of physiotherapy are included below (Figure 2).

Conclusion

The majority of our patients are not receiving physiotherapy after interventional procedures, despite, in many cases, re-attending for further interventions. Patients are more likely to access the service if they were originally referred from a MDT clinic, but even in this cohort, less than half the patients were meeting the target despite being seen by a physiotherapist during the opening consultation.

In practice, there are several steps involved in the referral process that need to be met to ensure that the patients receive physical therapy following interventions. The referring clinician must indeed recognise the need for physiotherapy at the time of decision of need for intervention and communicate this to the patient in order to maximise their compliance. This need should then be translated to a referral – either directly by the physician to a local physiotherapy service (as should be done from the MDT clinic) or if more convenient for the patient via the GP, in which case this decision would need to be communicated via the GP letter. A physiotherapy appointment would need to be arranged that coincides favourably with the appointment date for the spinal intervention and sent to the patient. Finally, the patient would need to attend both intervention and physiotherapy at their respective allotted times. When presented this way, the complexities of a seemingly simple referral seem impossibly daunting – it is perhaps surprising our patients ever make it to timely physiotherapy at all. We have used this referral process as a reference point in analysing our audit results. Referral letters from our MDT clinic were not available at the time of analysis, but those from PO clinic demonstrate that physiotherapy appointments were mentioned in only 21% cases. Consequently, our first step in addressing this issue was to highlight the importance of physical therapy following interventions in the hope that referring clinicians would be more engaged with the process. It is also clear that in a system where physiotherapy may either be arranged by the GP or pain clinician, it is imperative that the GP referral letter identifies which route is expected – to this effect, we are drafting a template addendum clarifying the referral process for insertion at the end of any letter referring a patient for intervention, thereby maintaining clinician autonomy with regard to the best referral source for the patient. Our pain secretaries could introduce this template during letter transcription in order to standardise its integration across the various clinics. Our next step would be to repeat the audit in order to gauge improvement in communication from the pain clinics and how this translated to physiotherapy access following interventions.

Our audit also highlighted the fact that despite an appropriate referral request from the pain physician, a physiotherapy appointment was only arranged in 33% of the cases by the GP. Whether this represents inadequate understanding of the importance of physical therapy in the context of spinal intervention among primary care providers and patients (who we could use as a lobbying group for such referrals) or whether this reflects inadequacies in our patient pathway following initial assessment remains to be seen. Either way, this is likely to be a more challenging hurdle for our department to address and may require further discussion with our clinical commissioning groups and organisational managers.

Part of this study was presented as a poster in the British Pain Society Annual Scientific Meeting at Bournemouth, April 2013.

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ERRATUM

Pain News apologises for the error in the *New Members* section of the last issue; Dr Alireza Feizerfan is aST6 Anaesthetics trainee from the Warwickshire School of Anaesthesia and is doing a pain fellowship at present in Australia.

Informing practice

Endocrine dysfunction in male patients with painful diabetic polyneuropathy on long-term strong opioids

The British Pain Society
Pain News
11(3) 188–189

SAGE

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Peripheral neuropathies are disabling complications of diabetes mellitus affecting 25%–50% of patients with 15–20 years of diabetes.[1] In all, 10% of patients have pain and need long-term symptom control. Opioids have been found to be effective in reducing pain severity when applied short term.[2] There is evidence that opioids cause dysfunction of hypothalamo-pituitary-adrenal and gonadal axis when used for long-term management of chronic non-malignant pain.[3]

Aim

We hypothesised that male patients with painful diabetic neuropathy are at risk of developing hypogonadism, when treated with opioids long term. Worsening of clinical condition may therefore be a result of endocrine dysfunction and not disease progression.

Material and methods

We studied the symptom progression in 22 complex pain patients of gender male, with mean age of 56 years (42–71 years). The patients presented with distal symmetric diabetic polyneuropathy with autonomic dysfunction and multiple systemic co-morbidities – cardiovascular disease, renal impairment, cerebrovascular disease and osteoarthritis. All patients received comprehensive assessment and multimodal treatment in our specialised Diabetic Polyneuropathy Pain Clinic from January 2008 to October 2012.

A strong opioid medication has been prescribed when their pain remained severe (visual analogue scale (VAS) > 8/10) despite treatment with anticonvulsants (gabapentin or pregabalin), antidepressants (amitriptyline, duloxetine or venlaflaxine) and topical agents (capsaicin cream or lidocaine 5% medicated plaster).

A total of 15 patients (15/22) were prescribed oxycontin 20–80 mg bd, 6 patients (6/22) – morphine sulphate 30–120 mg bd, and one patient (1/22) – buprenorphine patch (Butrans®) 20 mgh/h.

The mean duration of treatment with opioids was 18 months (12–30 months).

We identified a group of patients who developed tiredness, malaise, increased pain and reduced mobility. We chose to measure the free biologically active testosterone (Vermeulen equation),[5] free androgen index, cortisol, prolactine, fasting glucose and glycated haemoglobin levels (see Table 1).

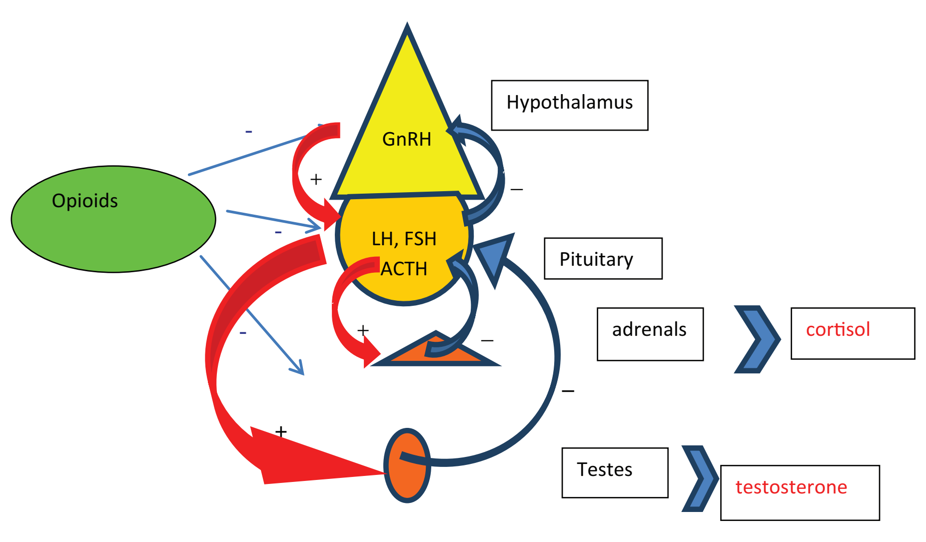
Results

Seven patients (7/22 or 31.6%) developed worsening of symptoms and were investigated. We found that all of them had low free biologically active

Table 1. Measured free biologically active testosterone (Vermeulen equation) and free androgen index

Parameter	Mean value	Individual values	Reference normal value	Comment
Free testosterone Vermeulen equation	0.22 nmol/L	0.3–0.05 nmol/L	0.25 nmol/L	Low
Free Androgen index	21.9	7.6–35.4	23–129	Low

Figure 1. Effect of opioids on hypothalamo-anterior-pituitary-adrenal and gonadal axis



testosterone and low free androgen index. One patient had raised prolactine levels: 388 mIU/L (reference range: 53–360 mIU/L). Two patients had low cortisol levels – 4 and 8 nmol/L, respectively (reference range: 138–635 nmol/L at 09:00 a.m.).

Fasting blood glucose levels were between 12.9 and 21.6 g/L (mean: 16.2 g/L). The glycated haemoglobin levels were between 41 and 107 mmol/mol (mean: 72.8 mmol/mol).

Discussion

Diabetes is primarily metabolic disorder affecting the glucose metabolism and may result in micro- and macro-vascular complications. The condition of the patient affected by painful neuropathy may worsen as a result of the progression of the neuropathic disease and deterioration of cardiovascular, renal or neurological status.

We considered the possibility that such deterioration may also be related to endocrinopathy caused by long-term strong opioid intake, affecting the hypothalamo-pituitary-gonadal and adrenal axis (see Figure 1). We used Vermeulen equation to measure the free biologically active testosterone, which is unaffected by protein binding. The Free Androgen index is used to correct for binding abnormalities, but is not an accurate measure of testosterone status. Our findings show that male patients with complex pain and co-morbidities developed hypogonadism, and they all had suboptimal glycaemic control.

We consider that an endocrine dysfunction may have been pre-existing prior to treatment with opioids, and in such case, the opioids have made it worse. Monitoring of endocrine function in patients on long-term opioids is still not universally adopted.[3] We managed to improve clinical symptoms with opioid dose reduction, opioid rotation, discharge from opioid treatment and supplementing gonadal and adrenal hypofunction with testosterone gel and hydrocortisone.

Conclusion

We raise the awareness that hypogonadism can be a reason for worsening of clinical condition in male patients with painful diabetic polyneuropathy and systemic co-morbidities, who take strong opioids for long-term treatment. The appropriateness of opioid prescribing in the first place as well as initial assessment and subsequent monitoring of endocrine function may need to be considered for better clinical outcome and improved patients' safety.

Part of this study was presented as a poster in the fourth International Congress of Neuropathic Pain in Toronto, 23-26 May 2013.

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THE BRITISH PAIN SOCIETY

Pain News
11(3) 190–194

SAGE

Managing Pain: Essentials of Diagnosis and Treatment by Chad M Brummett and Steven P Cohen, Oxford University Press, ISBN 978-0-19-985943-6

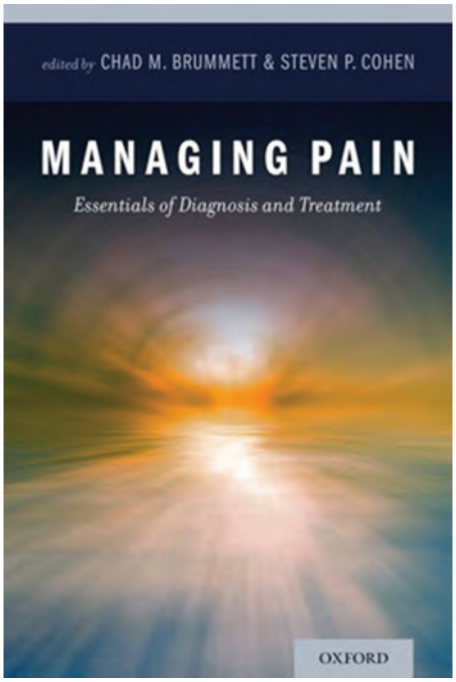
Reviewed by Dr Praveen K Ganty, The Walton Centre NHS Foundation Trust, Liverpool

> *"If there's a book that you want to read,*
> *but it hasn't been written yet,*
> *then you must write it."*
>
> *Toni Morrison*

The Editors of this excellent book have done just that - they have brought together 39 well-known authorities in their own area of expertise and have added their own expertise to the team. Seldom would you find an undergraduate student, and an MD from The Department of Forensic Medicine listed as contributors to a book on Pain. The result is a fascinating book that informs and intrigues in good measure. The book has been described as a 'primer' by the Editors, and is apparently pitched at the non-pain-trained healthcare provider. However, there is lots of information in the book that would be extremely useful to a clinician in Pain Medicine, be it a trainee or an established practitioner of Pain Medicine.

The cover of the book depicts what looks like an abstract painting of a sunrise reflected in water. It seems to depict the intentions of the book: Like all opposites in Life, information in the world of Pain can be seen as a visual paradigm, and reality could be affected, but one needs to strike a balance. This book goes a long way in striking that perfect balance between too much information being given making the purpose banal, and keeping the topics so short so that it would have read like a collection of abstracts.

The book is divided into four parts. The first two parts cover the pharmacological and non-pharmacological pain therapies. The opening chapter on Opioids is an elegantly written prose on the pharmacology of Opioids including their myriad side-effects and these have been described in a systematic manner. There is a ready-reckoner table on the formulations and dosages of the most commonly prescribed opioids. It is heartening to see that generic names have been used although there is a frequent mention of the numerous brand names for these drugs in use in North America. There is a brief section on opioid-induced hyperalgesia and on addiction. The treatment of common side-effects is well tabulated. The patient-clinician contract before prescribing opioids is also mentioned. The next chapter on NSAIDS and adjunctive pain medications touches on the commonly used medication for a patient with chronic pain. I was pleased to see a chapter on 'Phytomedicines for the treatment of Pain', that reads as a brief summary of the common phytomedicines used, and the effect they have on the various enzymes involved in inflammation. The section on Non-pharmacologic Pain Therapies has been extensively researched, and the authors make a strong case for including exercise and cognitive-behavioral therapy as a part of the treatment plan for a patient in chronic pain. The evidence for massage, acupuncture, and chiropractic treatment is well summarised in the next chapter.



Parts Three and Four of the book involve the reader by introducing a case presentation format. There is a brief description of a Case, and then the discussion follows on the etiology, description of the condition, and evidence-based treatment. The Chapter on Chronic post-surgical pain especially excels in this regard. The cases have been well thought of, with a very clear history and presenting complaints so that the diagnosis comes to mind immediately, or atleast is in the top three of possible differentials. The quality of the discussion that leads is of a truly high standard and very informative. Common presentations like primary headache, pelvic pain, non-cardiac chest pain and functional abdominal pain have been highlighted within those named chapters.

Each chapter is followed by a list of well-researched references, and most of these are topical and recent. There are very few references older than a decade but where mentioned, these are classic papers, like the Physiology and Pharmacology of Spinal Opioids by Tony Yaksh, published in 1985. The Editors' and authors hard work is evident when one casually glances at the list of References. It must have been a tough task to keep the article contemporary and to maintain equipoise in each chapter given the numerous publications on each topic mentioned in the book.

The book is set in an easy-to-read typeface, and is sized in such a manner that it would easily fit in an average handbag or briefcase.

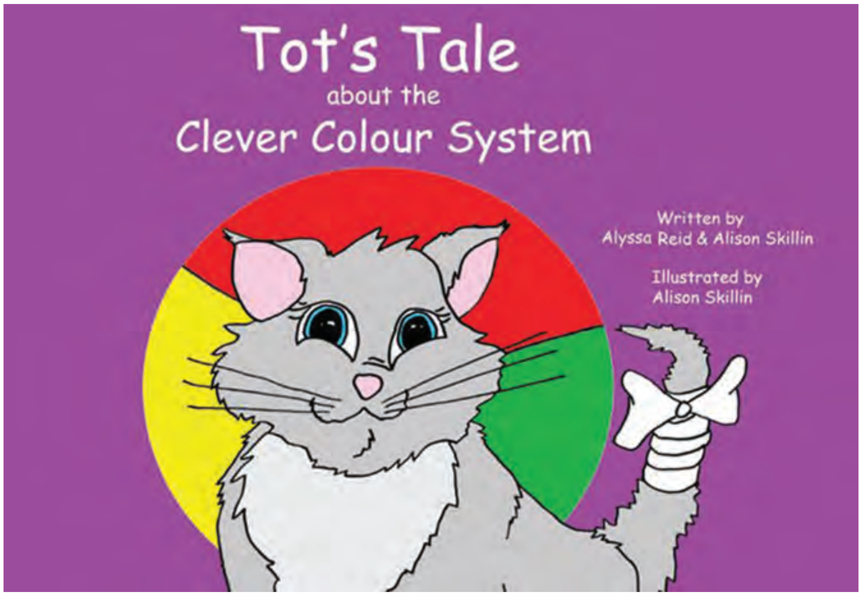
Like everything else in this world, there are things that could have been improved on. There are a few typographical errors interspersed in the book, but that would be more to do with the proof-reading at the publisher's end, I presume. However, there is one that seemed more of a comment by the authors (? Editors) to the publisher, but has been printed, and is found in the Table on effect mechanisms of phyto-anti-inflammatory drugs. Most drug names are North American (eg Meperidine for Pethidine), but the use of generic names makes it easier to comprehend.

Overall, this is the kind of book that would fit easily, both physically and metaphorically, between larger texts like the Textbook of Pain, and concise books like the Oxford Handbook of Pain Management, on your book shelf. Although this book is aimed at the General Practitioner and clinicians of other specialties, it would make an excellent read for any Pain clinician, and would probably help advanced Fellows in revising for their FFPMRCA. It is by no means exhaustive when it comes to the syllabus of this exam, but does give useful insights into many pain conditions.

As Mortimer Adler said, "In the case of good books, the point is not to see how many of them you can get through, but rather how many can get through to you", this is a book that would get through to the reader, and is highly recommended as an addition to any good library.

Tot's Tale about the Clever Colour System by Alyssa Reid and Alison Skillin, ISBN 978-1-4669-7156-1 (soft cover), 978-1-4669-7155-4 (electronic), Trafford Publishing.

Reviewed by Alison Harvey



This inspired picture book is aimed at helping youngsters with parents suffering from chronic pain and invisible illnesses. It is, in truth, written for us all.

'Tot's Tale' is the creation of two women who suffer from fibromyalgia. It introduces us to the Clever Colour System, a means of explaining what sort of day a parent is having and importantly, what activities they are able to do with their child at that time.

Through the words of Adam and his cats Kappy and Tot, children learn that a Green Day means Go. A look inside the family's Green Box will reveal plans for an active day, such as a trip to the park or swimming.

A Yellow Day means a Slow-Down Day and the Yellow Box comes out, containing perhaps some board games or the equipment to do scientific experiments together.

A Red Day and the Red Box means Stop . . . it's a day in bed for Mum, in this case, and maybe a time for watching movies together.

There are plenty of examples of activities but, of course, it can all be personalised to suit individual circumstances and lifestyle. It shows there is always something to do apart from watching TV.

This is such a positive coping strategy and one that can make a real difference to a child's understanding of a fluctuating condition and bring the family closer together.

The traffic-light system also works well for anyone with chronic pain who wants to avoid those draining conversations with well-meaning friends or carers about how they are feeling that day. Everyone knows someone who lives with chronic pain and knowing they are having a Red Day says it all.

Make everyone who comes to the house familiar with the system and it will help people talk about things other than the illness, which can only be positive.

Friends Alyssa Reid and Alison Skillin conceived and worked on the book from their beds - despite neck splints, hand splints etc. They wrote it because while there was plenty of information for adults understanding their condition, they could find nothing for families and carers.

I found some illustrations confusing (the kitten looks like a mouse in the first picture) and the layout clunky, but it is obvious this book is written from the heart by people who understand only too well the family difficulties caused by a fluctuating illness.

Not only has the book helped their families, but it has also helped them bond with them and escape the depression that can stalk people with chronic and painful conditions.

As they say: "*Now is the time to live in the present and create a positive way forward with our kids*."

This is a book to cherish. It should be on every shelf.

Opioids in Non-Cancer Pain, Second edition, 2013 by Cathy Stannard, Michael Coupe and Tony Pickering, Oxford Pain Management Library, ISBN 978-0-19-967807-5

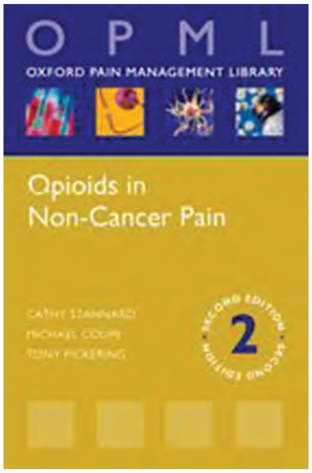
Reviewed by Dr Joan Hester, Kings College Hospital NHS Foundation Trust, London

This is a very useful small book which is intended to bring clinicians up to date on the current use of opioid drugs in patients with non-cancer pain and highlights the potential benefits of therapy as well as the problems that can occur.

There is a short section describing the historical context of opioid use, a useful chapter on opioid pharmacology that includes tapentadol, and a new chapter covering the emerging field of pharmacogenomics that provides insight into differing responsiveness to opioids and propensity to adverse effects. This highlights the known variations in metabolic pathways for tramadol and codeine and suggests an important role of other polymorphisms which could explain the known variation in clinical response.

An international perspective on opioid prescribing trend highlights the huge increase in per capita consumption of opioids, in USA by 400% in the decade 1997-2007, and in UK by 300%, though UK appears to have a much more modest drug misuse problem than US.

Benefits of long term use of opioids for non cancer pain appear to be modest, and undesirable effects are clearly described with an analysis of current evidence including that on the ability to drive. There is a short chapter on opioid–induced hyperalgesia; I would have liked more information on the clinical management of patients suspected of having OIH. Drug interactions are clearly described, and the evidence for the clinical use of opioids in back pain, arthritic pain and neuropathic pain is discussed in a balanced way. Practical aspects of prescribing are well covered and there is a detailed and useful chapter on opioids and addiction to conclude the book.



I highly recommend this short but information packed book as essential reading for all opioid prescribers. It provides a nice summary of current evidence for and against the use of opioids, leaving the reader to formulate his or her own assessment of benefit versus risk. The book may be too complex for the non specialist, but is a most useful resource for pain specialists.

Opioid therapy in the 21st century (Oxford American Pain Library) by Howard S Smith, Second Edition, Oxford University Press, SBN 978-0-19-984497-5

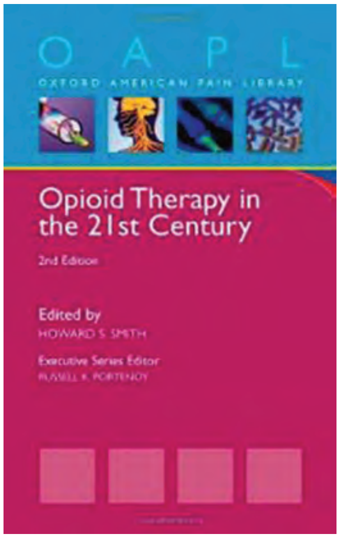
Reviewed by Prof. Roger Knaggs, Nottingham

Since the publication of the first edition of *Opioid Therapy in the 21st Century* in 2008, controversies have continued to grow around the use of opioids, particularly their long-term use in non-cancer pain and this is reflected by the fact that this slim pocketbook has increased by over 100 pages in over such a short period. The overall structure of the book has not changed since the first edition but each of the chapters has been expanded markedly, in part reflecting the growing number of publications in the area over the last five years.

The book aims to provide a comprehensive up-to-date, evidence-based overview of opioid use for primary care clinicians and begins with a concise summary of our current understanding of molecular and cellular mechanisms of the peripheral, spinal and supraspinal effects of opioids and their pharmacological effects. The most substantial chapter of the book attempts to describe how to optimise outcomes with opioids and considers the pharmacodynamics and pharmacokinetic differences between individual opioids, routes of administration with an emphasis on the new rapid acting fentanyl formulations and intrathecal opioids. Further sections consider assessing and managing side effects, opioid induced hyperalgesia, principles of opioid rotation, and individualisation of opioid treatment.

The effectiveness of opioids in cancer pain and long-term opioid therapy in persistent non-cancer pain are briefly reviewed. General screening tools and opioid specific tools for identifying patients at risk of misusing opioid medication are considered, however their relevance and validity to the UK has yet to be determined. Strategies used in the US for managing the risk of abuse, addiction and diversion, such as urine drug testing and the role of treatment agreements, are discussed in more detail. Several special populations (paediatric and palliative care patients, the elderly and patients with a history of substance misuse) are identified and specific issues relevant to these patient groups are considered. There are several appendices that reproduce an example consent form and contract, several assessment tools and a summary of the most recent US guidance on the use of opioids in non-cancer pain.

The book is referenced extremely comprehensively and is part of the Oxford American Pain Library; so it inevitably provides a US perspective on opioid use where the controversies and concerns are different in many ways to the UK and Europe. However, combination with the second edition of Opioids in Non-Cancer Pain by Stannard *et al*, provides a comprehensive overview of opioid use relevant to UK practice.



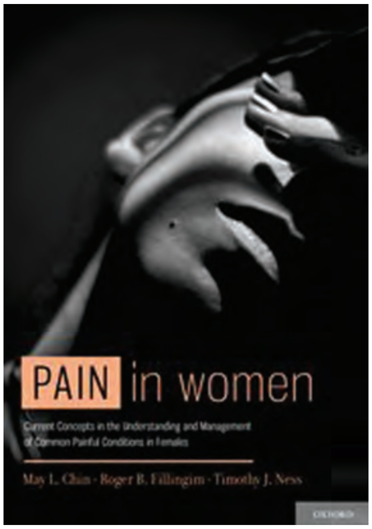
Pain in Women by Chin ML, Fillingim RB, Ness TJ Oxford University Press USA, ISBN 978-0199796410

Reviewed by
Dr Beverly Collett,
Consultant in Pain Medicine,
University Hospitals of Leicester.

This is a fantastic book. Everything that you wanted to know about pain in women and gender differences in pain between men and women is here and expertly and comprehensively reviewed. Pain is prevalent and has a significant personal and public health cost. As the burden of pain is substantially greater for women than men, this book is important and timely.

The aim of this book is to address the current understanding of the mechanisms related to sex differences in pain, and the clinical management of common acute and chronic painful conditions in women using up-to-date evidence based information. It fulfills this goal handsomely.

The first section deals with basic science topics related to sex differences



in pain, and includes a great chapter on epidemiology, a chapter on experimental pain, one on sex differences in cerebral responses in somatic and visceral pain and a chapter on analgesic responses. The second section covers a stimulating chapter on potential genetic influences and a comprehensive review on the role of sex hormones. A chapter on psychosocial influences and interventions is authoritative and draws the reader back to the clinical situation.

The third and fourth sections of the book deal with female-specific pain and painful conditions with a female prevalence. I found the three chapters dealing with labour pain and pain in the pregnant patient interesting and extremely informative. The chapter on the opioid-tolerant pregnant patient is especially relevant in today's clinical practice. Visceral pain is often not well covered in textbooks and yet is a condition frequently seen Pain Management Services. The two chapters dealing with chronic pelvic pain and vulvodynia are comprehensive, evidence based and easy to understand. Thus, they should be suggested reading to every clinician involved in pain management today. The chapter on cardiac pain in women is important. My impression is that the complexity of cardiac chest pain in women is poorly understood by cardiologists in the UK and this chapter written by North American authors explains the differing characteristics of this symptom in women and its relevance to clinical practice and female morbidity and mortality.

This book is multi-authored by renowned international experts, both basic scientists and clinicians, covering all aspects of pain in women. This book has broad appeal as it is easy to assimilate for the general clinician and yet wide-ranging and well referenced for the specialist. There is minimal repetition between chapters and each chapter is refreshingly new and exciting.

I thoroughly enjoyed reading the book. It encapsulated much essential knowledge in one easily accessible book. I would recommend it most highly.

End stuff

Why do we need to legalise assisted dying?

Raymond Tallis

This is a summary of the lecture from the Philosophy and Ethics Special Interest Group (SIG) meeting; the Editor thanks Peter Wemyss-Gorman for submitting this transcript. The views given here are that of the author and do not represent the British Pain Society.

The reason I can be an authority on the misconceptions and bad arguments against assisted dying is that at one time, I was in thrall to them myself and believed a lot of the things that I now know to be untrue, illogical or fallacious. A year ago, I was elected Chair of a new group – Healthcare Professionals for Assisted Dying (HPAD); I took over this role from Dr Ann McPherson whose hideous death in 2011 was described in harrowing detail by her daughter in the *British Medical Journal* (*BMJ*) on 16 June 2012[1] – a bitter irony. The key aim of HPAD is to change the law to permit physicians to assist the death of mentally competent, terminally ill patients, who are suffering unbearably despite receiving optimal palliative care, at their request (by writing them a prescription for life-ending medication, within strict legal safeguards). This was a choice Ann McPherson was herself denied.

Opposition

Opposition to a change in the law has been highly organised. Some opponents have appealed to religious principles such as 'the sanctity of life', but sometimes use pragmatic concerns intended to instil fear, such as the 'the slippery slope' argument that people with disabilities might be pressurised to choose death against their wishes and 'burdensome' older people would be advised that they were surplus to requirement. Although they are at odds with 70% of their flocks in successive polls, unelected Bishops had a major role in the rejection of Lord Joffe's Assisted Dying Bill in the House of Lords in 2006. Perhaps more shockingly, there appears to be strong opposition from the medical profession: the Royal College of Physicians and the Royal College of General Practitioners are currently against assisted dying (although the latter are in the process of re-thinking their position) as is the British Medical Association (BMA).

HPAD

HPAD was established in October 2010 by Ann McPherson and Joe Collier, supported by *Dignity in Dying*. Its aim is very simple: to change the law, medical culture and medical practice 'so that needless suffering at the end of life becomes a thing of the past', and to this end, to permit physicians to assist the death of mentally competent, terminally ill patients, who are suffering unbearably despite receiving optimal palliative care, by writing a prescription for life-ending medication at their request, with strict legal safeguards. HPAD challenges the medical profession's illegitimate extension of its authority to matters that are for society as a whole to decide, although individual doctors are of course entitled to express their views on the ethical case for liberalising the law. So long as no health-care professional is obliged, against their conscience, to help a dying patient achieve an assisted death, the role of their representative bodies should be confined to speaking on those areas where they have special expertise, for example, the safeguards and codes of practice necessary should any law be implemented, and more explicitly medical matters such as determining prognosis and setting guidelines for optimal end-of-life care. I believe that for the profession to go beyond this is a gross example of paternalism. It has been suggested that it is sometimes the duty of the medical profession – and indeed parliament – to be paternalistic and to ignore public opinion. But those in favour of assisted dying are advocating something they would want for themselves or for those they care for, and the paternalism argument is irrelevant.

In its very short life, HPAD has acquired over 600 members committed to working for a change in the law. Many of them feel their voices have been silenced and resent how the debate has been hijacked by special interest groups. Recent polls have suggested that between 30% and 40% of doctors are in favour of decriminalisation, and only one-third of 1,000 doctors in a survey in October 2011 were opposed to having assisted dying *for themselves*. In a survey of 1,000 general practitioners (GPs), 62% of respondents felt that the representative medical bodies should adopt a stance of neutrality towards the issue, as the BMA has done. In contrast, the *BMJ* vote in the wake of the call to the BMA to be neutral revealed the oppositions' remarkable efficiency in organising their membership to create an inaccurate impression of the views of the medical profession as a whole and purported to show 83% against neutrality. But the *BMJ* found votes coming in from Mongolia and Nigeria, many of them not doctors, and the poll enabled people to vote more than once. One individual from Iceland appeared to vote against neutrality 168 times! Given that there are physicians with passionate views on both sides of the debate, the proper stance of medical bodies is one of neutrality. This does not mean indifference, rather what has been called 'studied neutrality'. The Royal College of Nursing has chosen this, after a survey of its members that produced 49% of responses in favour and 40% against. That they are more in tune with the public on this issue is not entirely surprising. Doctors do not have to experience the sufferings of others minute by minute, hour by hour and day by day as nurses do. I believe that we shall bring these bodies round to an appropriate stance of neutrality, that parliament may indeed come to support legislation in favour of assisted dying, and that rational argument, rather than pre-rational opinions, will win the day. Unfortunately, most of our efforts, and my present focus, will have to be directed at countering the bad and sometimes dishonest arguments that are already in play.

Factoids

Most of those who object realise that appealing to the sanctity of life would cut little ice in a present-day British society – even among those who profess religious beliefs, there is little opposition to assisted dying. The most recent British Social Attitudes Survey reveals that religious belief seems hardly to reduce the tendency to be in favour of assisted dying, with 82% in the general population and 71% of those who designate themselves as having religious belief supportive of assisted dying. Indeed, for many (including some members of

HPAD), religious belief is a key factor in their *support* for the availability of compassionate assistance to die.

I am not arguing against religious belief or indeed the right of people who believe that assisted dying is wrong because of their religious beliefs to make their case. My objection is to how religiously motivated opponents will duck and weave between absolutist arguments based on faith and pragmatic or consequentialist arguments that appeal to empirical 'evidence' about anticipated adverse consequences for society.

The commonest argument is that assisted dying is actually unnecessary – or would be unnecessary if optimal palliative care were universally available. This is not true as my experience as a doctor for over 35 years made clear, when I was responsible for patients whose symptoms were uncontrolled even when they had first-rate palliative care. And Ann's own death – typical of so many others – is eloquent testimony to the occasional failures of palliative care. International experience also confirms that palliative care fails some patients. For the last 10 years, assisted dying has been legal in Oregon under the *Death with Dignity Act*. Oregon has among the best palliative care of the 50 states in the United States, and yet nearly 90% of those seeking assisted dying are in receipt of hospice care. This is not to belittle the huge importance of palliative care, but to acknowledge honestly that it, like other modes of health care, has its limitations.

There is no evidence that the availability of assisted dying as an 'easy' option will inhibit investment in palliative care, and indeed, international experience suggests that liberalisation of the law has the opposite effect. In Oregon, the proportion of people dying in hospice care – a marker of the availability of palliative care – has more than doubled since the *Death with Dignity Act* was introduced. A report (2011) from the European Association of Palliative Care, which actually opposes assisted dying, comes to the same conclusion.

The assertion that liberalising the law will break down trust between the doctor and patient is not borne out by the evidence. A Europe-wide survey put levels of trust in the Netherlands at the top. In countries with assisted dying, there is the tradition that discussion of end-of-life care is open, transparent, honest and mature, not concealed beneath a cloud of ambiguity, as it so often is in the United Kingdom. And the knowledge that your doctor will not abandon the therapeutic alliance with you at your hour of greatest need will foster and not undermine trust.

Then there is the slippery slope: the suggestion that if assisted dying for terminally ill people is legalised, we will have embarked on a trajectory that will lead inevitably to assisted dying for people who aren't dying but have a non-terminal chronic illness or disability, then to people who do not wish to die and/or cannot express their wishes either way, and finally to a culture in which when you are judged to be a burden to others, you will be expected to seek assistance to die. But a law to permit mentally competent terminally ill adults who are suffering unbearably to receive medical assistance to die at their considered and persistent request is not the same as *assisted suicide*, which is to help chronically ill or disabled people who are not terminally ill to end their lives, and *we do not advocate legalising this*. Nor are we in HPAD, or our partners in *Dignity in Dying*, in favour of voluntary euthanasia, when terminally ill adults (or sometimes chronically ill or disabled adults) can have their lives ended by a doctor. More specifically, we are opposed to any law that would go beyond assisted dying to assisted suicide and extend it to people with disabilities who are not terminally ill, elderly people who are not terminally ill, people with non-terminal illness and people who are not mentally competent, including those who have dementia or depression. The distinctions are not vague or unclear and there is nothing equivocal about our position. Interestingly, the general public is quite clear about the distinction. While a consistent 80% plus people support assisted dying, the support for assisted suicide is much less at about 40%.

The most relevant international experience refuting the slippery slope argument is from Oregon, where the *Death with Dignity Act* which was introduced over a decade ago is very close to the laws that have been considered in England, although the Joffe and Falconer Bills have more safeguards. Since it was introduced, the proportion of deaths that are assisted has never risen above 0.2% – about 1 in 500. The average age of those who have assisted dying is lower than the average age of deaths, so the elderly people are not disproportionately represented. The typical profile of a person who avails himself or herself of assisted dying is a strong-willed, middle-class person used to getting his or her way – not groups traditionally depicted as 'vulnerable'. There is neither evidence of extension of assisted dying to assisted suicide for people with non-terminal illnesses, nor any advocacy in Oregon for this.

If there is a slippery slope, legislation with all the safeguards included in Lord Joffe's Bill (2006) – and currently Lord Falconer's Bill (2013) – would apply crampons rather than skis. In Holland, rates of non-voluntary euthanasia (i.e. doctors' actively ending patients' lives without having been asked by them to do so) decreased from approximately 1,000 deaths in 1991 to 550 in 2005. In the United Kingdom, a study published in Palliative Medicine in 2009 found that in 0.21% of deaths attended by a doctor, life was ended with an explicit request from the patient (in other words, voluntary euthanasia), and in 0.30% of cases, life was ended without an explicit request from the patient (in other words, non-voluntary euthanasia).This means that approximately 2,600 people are being given direct help to die, with or without their explicit request, outside any relevant legal framework. The present clinical, ethical and legal fudge, in which ploys such as continuous sedation, starvation and dehydration are used to get round the prohibition on assisted dying, is unacceptable. Those who are concerned for the safety of patients, far from opposing a change in the law, should support legalising assisted dying in view of the scrutiny it would bring to bear on medical practice (which is exactly what has happened in Holland and Oregon). Not only is it possible to devise a law with sufficient safeguards against abuse without making it unusable bureaucratic, but such a law would itself be a mighty safeguard.

The final group of factoids involves the fear of irreversible mistakes. Our opponents often treat us to tales of individuals who asked to be assisted to die, and then, after talking to an understanding physician, change their minds and subsequently live long and happy lives. Some of the stories beggar belief but carry huge potential weight and lead people to draw very large conclusions from them. There is a concern that physicians may not read the patient's mind or their ability to make a rational decision correctly, but it is easy to build in time for reflection in any law which should include ample opportunity to change one's mind. In Oregon, only 1 in 100 of those people who discussed assisted dying with their doctors actually received and cashed the prescription, and of those, only 1 in 2 actually took it. Many people will have taken comfort from having banked a prescription and the knowledge that they have the opportunity to escape from an unbearable situation. All the bills including Lord Joffe's, which I have seen, envisage a cooling-off period. You can make a decision well in advance of the final weeks' phase, so you have the option when and if you want to use the prescription. Where there is doubt about the patient's mental competence or about the absence of a treatable depression, psychiatric advice can be sought. This is less easy to sort out in the case of trips to Dignitas or self-administered suicide, given that as the law stands at present, patients cannot even discuss assisted dying with their doctors. I suspect that once you have embarked on a journey to Switzerland, it is very difficult to change your mind. As for the rationality of a decision, there are ways of testing competence and the presence or absence of reversible depression. What is more, in every other area of medicine there is a presumption of competence unless there is clear evidence to the contrary.

The worry that the diagnosis could be wrong seems completely unjustified in most cases. A candidate for assisted dying will have widespread advanced illness, clear objective reasons for suffering, in which palliation has failed, and the ultimate outcome will not be in doubt. Similarly, the likelihood of the prognosis being seriously wrong will be considerably less in very advanced disease. Most studies have shown that doctors overestimate prognosis, expecting patients to live longer than they do. But it may be irrelevant: people who receive a prescription take it at a much later stage than their initial negotiation. One could argue that the unavailability of assisted dying spares doctors from making decisions. Without a law in place, the decision is already made: '*I can't help you*'.

Codes of ethics

The notion of the professional code of ethics that is supposed to prohibit assisted dying is summarised in a recent letter in the *BMJ*. The correspondent said, 'I went into medicine to save lives, not to end them', implying that to participate in assisted dying is to contravene the solemn undertakings of doctors entering the medical profession. The classical version of the Hippocratic Oath includes the following promise: 'I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan', but much of the rest of it is obviously anachronistic. It has been brought up to date in various ways. One widely used version introduced in 1964 has this key paragraph:

> *Most especially must I tread with care in matters of life and death. If it is given to me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my frailty.*

This seems to allow for assisted dying. And the Declaration of Geneva, adopted by the General Assembly of the World Medical Association at Geneva in 1948, and most recently amended in 2006, says only that

> *I will maintain the utmost respect for human life.*

So the claim that support for assisted dying violates the fundamental ethos of the medical profession is unfounded.

Principles

I want to focus on two principles or bases for values: the sanctity of life which is invoked to demonstrate that assisted dying is wrong in all circumstances, and the principle of respect for individual autonomy – the right to have one's choices supported by others, to determine one's own best interest, when one is of sound mind. In both cases, I shall test their validity by looking at consistency of their application.

Sanctity of life

'*Life is a gift of God and we may not take away a life God has created, even at the request of the person whose life is at issue*' – can this be an absolute principle? In actual practice, the history of those religions that explicitly profess the sanctity of life as an absolute, basic principle – Christianity, Judaism, Islam – are not at all consistent in its application. The notion of the 'Just War', where people will be killed in large numbers and against their will rather than individually at their request, is accepted; in many explicitly religious countries, judicial execution is commonplace. Why do the opponents of assisted dying invoke a clearly vulnerable principle whose theological resonance would be rejected by most people? I think it is because it seems to them to be the only way of defending something that we would all wish to protect: the fundamental ethic of valuing human lives – our own and those of others – as infinitely precious:

> *[Assisted dying] will create an ethical framework in which the worthwhileness of some lives is undermined by the legal expression of what feels like public impatience with protracted dying and 'unproductive lives'. (Rowan Williams)*

Behind the appeal to the absolute (but in fact negotiable) principle, there is the implicit claim that the religious notion of the sanctity of life is the only source of the value we place upon life – as much in a secular as in a religious society. If we question it, we shall devalue life; and we shall particularly devalue the lives of those who are powerless or are already likely to be devalued. I feel that this argument is nonsense. If I were to become terminally ill, nearing the end and in unbearable misery and wanting to die, I would like to be allowed to seek help from a physician to help me to die. Indeed, we are enhancing the value of life by doing our best to prevent our lives being diminished by pointless suffering.

Autonomy

Most of the reasons for attacking the appeal to autonomy – the right to determine one's own best interest, when one is of sound mind – may be set aside. The first that we do not belong to ourselves but are God's possessions does not get much traction in a secular society. Most of us happen not to believe this. If it were true, however, it might lead us to deny ourselves the right to any autonomy, not particular expressions of autonomy in certain highly specific circumstances. The second is what is called the harm principle. I have already argued that assisted dying concerns not only the directly affected individual but society as a whole. But there is another challenge which relates to the question of consistency: if you argue for assisted dying on the basis of respect for autonomy, why do you restrict its availability simply to people who are terminally ill and meet all the criteria we have been talking about? We do not simply accede to people's wishes even over things that seem to affect directly only themselves. This may seem to be a rowing back from the assertion of the primacy of autonomy. Surely, the invocation of the principle autonomy as sovereign should authorise the progressive extension of the cases in which dying could be assisted? The application of a non-absolute ethical principle has to be put in context; it is right to begin with the principle, but it may not always be right to apply it without limit, and this applies to every aspect of human life. Assisted dying respects autonomy and it has a clearly defined scope.

Judgement of the place where the gain in individual autonomy is offset by harms to society as a whole will to some extent involve a calculus of benefits, harms and risk of harm. This apparent rowing back from the boundless application of the principle of autonomy is entirely different from any deviations from the principle of sanctity of life, a principle that is claimed to be absolute and inviolable, into killing in war and other modes of behaviour that require further justification. This latter principle sits ill with a utilitarian calculus of greater and lesser benefits, unlike the harm principle that limits autonomy and makes up part of a coherent picture that weighs autonomy and harm in the same scales.

There is, in short, nothing uniquely flawed about limiting the application of the principle of autonomy when we use it to support the case for assisted dying. The main point is that the legalisation of assisted dying extends the application of the principle of autonomy, although it does not render it boundless. There remains the fact that any good principle cannot determine from within itself the scope of its application and can always theoretically justify actions we do not wish. We have to decide on an age of criminal responsibility but the sharp cut-off is an artefact. In the case of assisted dying, the application of the principle of respecting autonomy has clear points at which it can be considered no longer to be sovereign. There are clear distinctions between terminal and non-terminal illness; between people who do and people who do not have a serious illness; between people who have and people who do not have mental competence; between assistance to die and euthanasia; and between voluntary and involuntary euthanasia.

The Law

Even those who accept the facts and the arguments that I have set forth still oppose legislation on the grounds that only a small minority of dying people would seek assistance and an even smaller number would use the prescription. Wouldn't legislation prove a sledgehammer to crack a nut, a leap in the dark which threatens all of us, for the sake of a few people? Well, I happen to believe that even small numbers of people going through unbearable Hell are important and there is something wrong in a society that cannot see that. What is more, the availability of assisted dying would bring much comfort to many more sufferers than those who actually use it because it brings an all-important sense of having some control, as we know from the Oregon data that I referred to.

It has been argued that since the Director of Public Prosecutions (DPP) has not referred any cases sent to him for prosecution, things are fine at present, no law is needed, so let us muddle on in the usual British way. This will not do: First, assisting someone to die remains a criminal offence – the relative or friend is the suspect and the patient the 'victim'. Since 'suspects' usually spend months under investigation before being told whether or not they are to be prosecuted, there is huge anxiety and stigma at an already intensely distressing time. Thus a *de facto* history of sensible decisions by the DPP so far is not as good as a law that permits assisted dying within clear limits and safeguards. What is more, a future more-hawkish DPP may have a quite different attitude and use the 16 tests of motivation (to determine whether an action is either malicious or compassionate) to draw different conclusions. And, above all, it remains a criminal offence for any medical qualified practitioner or other professional to give advice. So it is all down to amateurs who have to carry the unbearable burden of responsibility. We therefore need a change of the law – and soon.

Healthcare Professionals for Assisted Dying is a group of doctors, nurses and other healthcare professionals who do not believe that dying patients should have to suffer against their wishes or travel abroad to die. Alongside access to good quality end-of-life care, we support a change in the law to allow terminally ill, mentally competent adults the choice of an assisted death, within upfront safeguards.

Such a law would, we believe, not only respect patient choice but better protect potentially vulnerable patients, allowing them to make informed decisions in consultation with healthcare professionals. Assisted dying is not about the right to die, but the right, when dying, to die peacefully and with dignity.

If you are a practising, retired or student healthcare professional you can make a difference by joining HPAD free of charge here http://www.hpad.org.uk/contact-us/ and adding your voice to the campaign for change.

Reference

1. McPherson T. Without assisted dying our mum died slowly and in pain: Personal view. *BMJ* 2012; 344(7861): 35.

New Members

Ratified at the June 2013 Council Meeting

Name	**Position**	**Institution**
Mrs Helen Macdonald	IAPT CBT Teacher and Private CBT Practitioner	Clinical Psychology Unit, University of Sheffield
Dr Shankar Ramaswamy	Pain Fellow	Charing Cross Hospital
Mr Fergus Coutts	Veterinary Surgeon	Pain Management and Rehabilitation Centre, Broadleys Veterinary Hospital
Mrs Janet Randall	Pain Support Nurse	Colchester Hospital University Foundation Trust
Dr Hadi Bedran	Specialty Registrar ST6	Royal Marsden Hospital
Dr Sarah Aturia	Consultant Anaesthetics/Pain Medicine	Milton Keynes Hospital
Dr Sarah Louise Woods	Principal Clinical Psychologist	Wansbeck Hospital, Northumberland
Dr Pranab Kumar	SESA Trainee Anaesthetist	Medway Hospital, Gillingham, Kent
Miss Zoe Franklin	PhD Student	Manchester Met University
Dr Takashi Ito	Consultant in Pain Management	Dr Ito Clinic, Harley Street