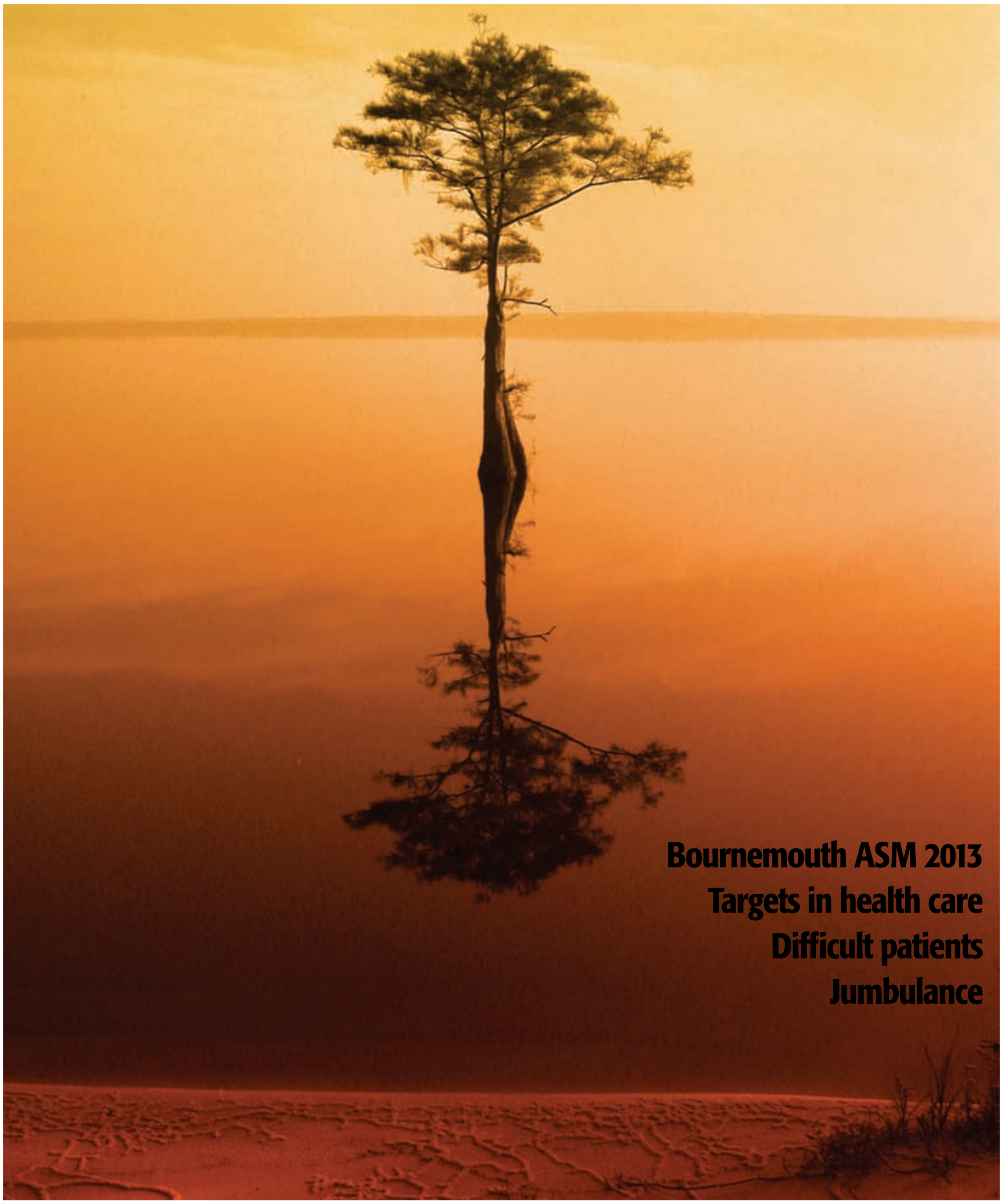
JUNE 2013 VOLUME 11 ISSUE 2

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



Bournemouth ASM 2013

Targets in health care

Difficult patients

Jumbulance

THE BRITISH PAIN SOCIETY

ISSN 2050–4497

THE BRITISH PAIN SOCIETY
PAIN NEWS

contents

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

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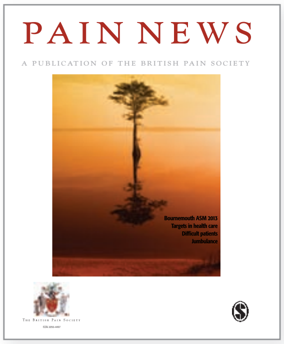
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The British Pain Society
ISSN 2050-4497

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

Next submission deadline : 12th July 2013

Material should be sent to:

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Regulars

News

Professional perspectives

Informing practice

Book reviews

End stuff


News
BPS Honorary Medal of Distinction - Dr Douglas Justins
BPS Honorary medal of distinction was awarded in Bournemouth ASM 2013 to Dr Douglas Justins; the citation was provided by Prof. Richard Langford
The British Pain Society
Pain News 11(2) 98–99
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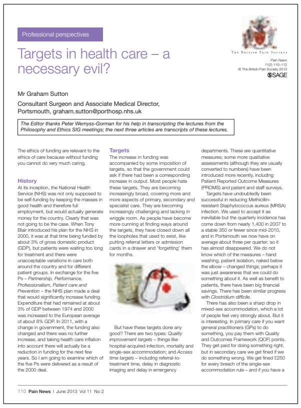
Professional perspectives
Targets in health care – a necessary evil?
The British Pain Society
Pain News 11(2) 110–112
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SAGE
Mr Graham Sutton
Consultant Surgeon and Associate Medical Director, Portsmouth, graham.sutton@porthosp.nhs.uk
The Editor thanks Peter Wemyss-Gorman for his help in transcripting the lectures from the Philosophy and Ethics SIG meetings; the next three articles are transcripts of these lectures.
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Professional perspectives
Difficult Patients and the 'Victorian Values' Narrative
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SAGE
Claire Martin
Claire.Martin@jpaget.nhs.uk
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THE BRITISH PAIN SOCIETY

British Pain Society Calendar of Events

2013

Commissioning Pain Services (28th Study Day)
Monday 10th June
Churchill House, London

Securing the future of pain services: harnessing patient power
Patient Liaison Committee Annual Seminar
Wednesday 12th June
Churchill House, London

Changing the Culture of Pain Medicine
Philosophy & Ethics SIG Conference
Monday 10th to Thursday 13th June
Launde Abbey, Leicestershire

Visceral Pain (29th Study Day)
Tuesday 3rd September
Churchill House, London

To do, or not to do, that is the question: Unintended negative consequences in pain management and rehabilitation
Pain Management Programmes SIG Biennial Conference
Wednesday 25th to Friday 27th September 2012
Hotel de France, Jersey

Interventional Pain Medicine SIG Annual Meeting
Friday 18th October
Churchill House, London

Topic TBC (30th Study Day)
Tuesday 19th November
Churchill House, London

2014

Annual Scientific Meeting
29th – 2nd May
Manchester Central, Manchester

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


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Formerly Reviews in Pain
Official Journal of the British Pain Society
Edited by Felicia Cox
www.sagepub.com/bjp
The British Pain Society

Editorial

Whatever the path taken…

THE BRITISH PAIN SOCIETY

Pain News
11(2) 81–83

SAGE

Thanthullu Vasu

> *The Pessimist complains about the wind;*
>
> *The Optimist expects it to change;*
>
> *The Leader adjusts the sails!*
>
> – John Maxwell

Thank you Richard!

While some of us were pessimistic that still worse things were going to come after the National Institute for Health and Clinical Excellence (NICE) low back pain guidelines, and some were optimistic that things would change for the benefit of our patients, it was time for the need of a leader. At that right time, Richard took the responsibility of the President of our Society. Given the motivation of Prof Sir Michael Bond, who showed us the right direction, Richard steered the Society towards various vital successful projects during the next three years.

I have known Richard since I was a trainee at Barts; his friendliness and care towards his colleagues always amaze me. Whatever the problem, his smile and positive energy will always help us to find a solution with ease. The Society has been very fortunate to have Richard's presidency; there is no doubt that we have moved significantly forward under his leadership. The Council has worked in an ideal environment of trust, friendliness and comfort under his leadership. It is sad that he will be missed as a President, but I am sure that he will support us in all our future endeavours. I will take this opportunity to thank him profusely on behalf of all the members of our Society.

Welcome back William and John!

I also welcome William Campbell as the incoming President. I have known William for the past few years as a colleague in the Council as well as in the Communications Committee. His hard work, incessant smile, and the ability to strongly express what he has on his mind in a productive way has helped our Society immensely in the past. I am sure he will be the right person to lead us now.

I take the opportunity to congratulate John Goddard on being nominated as Vice-President. His excellent fiscal knowledge during his reign as the Honorary Treasurer is good proof that our Society is going to benefit more from his services in the future.

Our Council members work hard to help the Society and raise the profile of the pain management services – and I would like to thank Austin and Suzy, our outgoing Council members, for their voluntary hard work and invaluable time devoted to the specialty. I hope that their service to the Society and the specialty will continue in various other ways in the future.

What is inside this issue?

This issue contains some news from our Annual Scientific Meeting (ASM) held in Bournemouth. For those (like me) who were unlucky and unable to attend, this will explain the ASM to some extent. To those who attended, it will attempt to refresh your memory of the enjoyable time you had. Please note that our next ASM will be held in *Manchester on 29 April to 2 May 2014*. Please check our website for details very soon.

This is the International Association for the Study of Pain (IASP) global year against *visceral pain*. Jane Quinlan from the Acute Pain Special Interest Group (SIG) has helped me with a few articles to remind us of this. As usual, Peter Wemyss-Gorman has gifted us with the transcripts of a few lectures from the Philosophy and Ethics SIG meeting. Please do not forget about this year's meeting of the SIG in Launde Abbey, the details of which are available on our website.

Feedback?

As I said in the last issue, I look forward to receiving comments and criticisms of the articles published in our newsletter. I was expecting strong comments on the article by Dr Skinner (*Home Run*, March 2013, vol. 11, no. 1, pp. 23–4). Although there were lots of internet forum comments before and after this publication, I was dismayed that there was no feedback for the newsletter. Good dialogue and debate is a vital part of any newsletter to make forward progress. Please write or email your opinions as they are sincerely appreciated. *The last date for submission of articles for next issue is 12 July*. Please note this in your diary.

The pen is mightier…

My three years' responsibility as the Editor of *Pain News* will come to an end next spring. I will be liaising with the Council to advertise this post in the next issue of our newsletter. This will help the new Editor to observe the editorial process for at least one issue before taking the role. It is a vital role, which I have thoroughly enjoyed. Our newsletter has huge importance and it reaches more than 1,500 members. Furthermore, many non-members read it as they are freely available on the internet. As contributors to *Pain News*, we have the opportunity to mould the views of a huge number of clinicians practising pain management in this country as well as abroad. On the other hand, the executives and the Council strongly feel that the newsletter is the vehicle to put the views of the Society forward to its members.

As the newsletter contributions are increasing significantly with more varied and interesting themes, I personally feel that it will be essential to have a team of people to manage this – ideally with an Honorary Editor and two Associate Editors. I feel that the measure of the success of an Editor is that the publication moves further forward after he or she departs; I will make sure that I leave the newsletter in a stronger position than ever. However, I have to put this proposal to the Council soon and will keep you updated. Meanwhile, if you are interested in any of these roles, please start preparing yourself and look out for the advert in our next issue.

Welcome to new councillors

I welcome the new Council members Neil Berry and Tim Johnson. On behalf of the Society, I congratulate them on their success in the Council election. We were lucky to have more candidates than usual in this election. For those who did not succeed this time, let me reassure you: the Council needs a lot of help with its ever-growing demands. Please donate your time for the various needs of the Society and consider standing for the election again. Please accept our thanks for the offer and standing in the elections.

> *Both optimists and pessimists contribute to our Society;*
>
> *The optimist invents the air plane,*
>
> *And the pessimist invents the parachute!*
>
> – *G B Stern*

In the same context, can I take the opportunity to ask you all to think how you can help our Society more. Being a Council member for three years, followed by the responsibility of the Honorary Editor of our newsletter, I have seen many dedicated people who have devoted their invaluable time to our Society and the specialty. Although most did not want to publicise these accolades, I feel that many of these acts have neither been thanked for nor have been appreciated. The fact that this 1,500-member, multidisciplinary Society has tided various difficulties is standing proof for all their veiled devotion.

The paths might differ, but…

In the great Indian epic *Ramayana*, Lord Rama goes in search of his wife Sita, who has been abducted by the demon Ravana. On the way, to cross the ocean to reach Lanka, they have to build a bridge with rocks. Small squirrels wanted to help Rama in this task; they carried small stones and gravel to help build the bridge. Rama appreciated this noble act and the myth goes that the squirrels have lines on their back as a consequence of Rama stroking them by way of thanks. Although hard to believe the story in this scientific age, the moral of the epic is that even small dedicated acts can lead to a great successful result; these small acts of endurances should never be underestimated. Our acts as members might be like these – please always think of ways to contribute to the Society. Any amount of help is always appreciable to move our Society forward.

My sincere apologies for talking in relation to religion if you have strong feelings; I am in fact not a very religious person, but rely on learning from the good teachings of all religions. Whatever the religion is, they always advise only good morals. No religion teaches hatred against others. The path of all the religions, including the views of atheists, might be different, but they all lead to goodness at the end. Please allow me to quote one of my favourite Tamil-language poems with the translation that follows:

Avar avar thama thamathu arivari arivagai
Avar avar iraiyavar yenavadi adaivaargal;

Avar avar iraiyavar kuraivilar iraiyavar
Avar avar vithivazhi adaiya ninranarey

–N aalayira Divya Prabhandham,
Thiruvaimozhi, 1.1.5, verse 2795

People pray to various gods
And follow different religions based on their knowledge;
All those gods are pure and without deficiency;
However, if you have belief and dedication,
Then your path will lead to the god.

Does anyone feel that this correlates with what we do in our Pain Services? We have various ways – we follow various disciplines; we approach with different techniques; our interventions all might differ; we speak in our own scientific language – but in the end, our aim is to help the patient to manage his/her pain. If that is so, then why should we bother about what religion we belong to and how we pray? Let us respect all other religions and be sincere in our own prayers.

Please enjoy this issue of our newsletter and write to us with your views. Sincere thanks for all your contributions,

Thanthullu Vasu
Bangor

Pain
Relief
Foundation

The Walton Centre NHS
for neurology and neurosurgery
NHS Foundation Trust

HOW TO SET UP A REGIONAL SERVICE
FOR COMPLICATED/LONGSTANDING CRPS
LIVERPOOL

19TH NOVEMBER 2013

For Pain Specialists, who wish to establish a regional interdisciplinary service for patients with longstanding and/or complicated CRPS. A ‘region’ would typically include 0.5 million population or more, with a number of pain services providers operating within its borders. Pain Specialists are welcome to attend either on their own, or together with additional team members.

Limited to 20 participants.

FEE £120
Additional member from same team £90 (max of two)

To develop an overview on the component parts of a specialised CRPS service for patients with a longstanding/complicated disease. To provide practical information , which will support the teams within Pain Medicine to build a regional service.

Contact: **Mrs Brenda Hall, Pain Relief Foundation, Clinical Sciences Centre, University Hospital Aintree, Lower Lane, Liverpool L9 7AL UK. Tel + 151 529 5822 b.hall@painrelieffoundation.org.uk**

www.painrelieffoundation.org.uk
Registered Charity Number: 277732

In association with The Walton Centre for Neurology & Neurosurgery NHS Foundation Trust

astellas
Leading Light for Life

2013
licence update

New pre-treatment option.

You can now pre-treat with an oral analgesic [1]

Qutenza™
(capsaicin) 8% patch

1 hour application, 3 months' pain relief

PRESCRIBING INFORMATION. **Presentation:** QUTENZA™ (capsaicin) 179 mg cutaneous patch. Each 280 cm^2 cutaneous patch contains a total of 179 mg of capsaicin or 640 micrograms of capsaicin per cm^2 of patch (8% w/w). Excipient: Each 50g tube of cleansing gel for QUTENZA contains 0.2mg/g butylhydroxyanisole (E320). **Indications:** QUTENZA is indicated for the treatment of peripheral neuropathic pain in non-diabetic adults either alone or in combination with other medicinal products for pain. **Posology and administration:** QUTENZA should be applied to the most painful skin areas (to a maximum of 4 patches). The QUTENZA cutaneous patch should be applied by a physician or a health care professional under a physician's supervision. The painful area should be determined by the physician and marked on the skin. Nitrile gloves should be worn at all times while handling QUTENZA and cleaning treatment areas. Latex gloves should NOT be worn as they do not provide adequate protection. Use of mask and protective glasses should also be considered, particularly during the removal of the patch. The area may be pre-treated with a topical anaesthetic (e.g. topical lidocaine [4%] or lidocaine [2.5%]/prilocaine [2.5%]) or the patient might be administered an oral analgesic prior to application of QUTENZA to reduce any application related discomfort. If necessary, hair should be clipped not shaved. QUTENZA must be applied to intact (unbroken), non-irritated, dry skin, and allowed to remain in place for 30 minutes for the feet (e.g. HIV-associated neuropathy) and 60 minutes for other locations (e.g. post-herpetic neuralgia). When removing the patches they should be rolled inwards to minimise the risk of aerosolisation of capsaicin. Cleansing gel should be used to remove residual capsaicin and the area washed with soap and water. QUTENZA treatments may be repeated every 90 days, as warranted by the persistence or return of pain. Acute pain during the procedure should be treated with local cooling and oral analgesics. Paediatric population: QUTENZA is not recommended for use in children and adolescents due to lack of data on safety and efficacy. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions:** Nitrile gloves should be worn at all times while handling QUTENZA and cleaning treatment areas. Latex gloves should NOT be worn as they do not provide adequate protection. Use of mask and protective glasses should also be considered, particularly during the removal of the patch. QUTENZA should be used only on dry, intact skin and not on the face, above the hairline of the scalp, and/or in proximity to mucous membranes. Application site reactions: transient local application site burning, pain, erythema and pruritus have been reported. The cleansing gel for QUTENZA contains butylhydroxyanisole, which may cause local skin reactions (e.g. contact dermatitis) or irritation of eyes and mucous membranes. Cardiovascular: Blood pressure should be monitored during the treatment procedure as transient increases (average <8.0mmHg) in blood pressure during and shortly after QUTENZA treatment may occur. The risk of adverse cardiovascular reactions due to the potential stress of the procedure should be considered prior to using QUTENZA in patients with unstable or poorly controlled hypertension or a recent history of cardiovascular events. Opioid tolerance: Patients with high opioid tolerance may not respond to oral opioids when used as rescue medication during and following treatment with QUTENZA. An alternative pain reduction strategy should be used. Neurological function: Patients with increased risk for adverse reactions due to minor changes in sensory function should be cautious when using QUTENZA, as minor and temporary changes in sensory function have been reported following administration of capsaicin. No treatment-related reductions in neurological function have been observed in clinical studies with QUTENZA. **Pregnancy and lactation:** No clinical data on exposed pregnancies are available. Since human pharmacokinetics show transient, low systemic exposure to capsaicin, the likelihood that QUTENZA increases the risk of developmental abnormalities when given to pregnant women is very low. However, caution should be exercised when prescribing to pregnant women. No clinical data on breast-feeding women are available. **Undesirable effects:** Very common (≥ 1/10): application site pain, application site erythema. Common (≥ 1/100 to < 1/10): *Application site:* pruritus, papules, vesicles, oedema, swelling, dryness. Uncommon (≥ 1/1,000 to < 1/100): *Application site:* urticaria, paraesthesia, dermatitis, hyperaesthesia, inflammation, reaction, irritation, bruising, peripheral oedema. *Others:* pain in extremity, muscle spasms, pruritus, nausea, cough, throat irritation, hypertension, first degree atrio-ventricular (AV) block, tachycardia, palpitations, eye irritation, dysgeusia, hypoaesthesia, burning sensation, herpes zoster. Consult Summary of Product Characteristics for complete information on side effects. **Basic NHS Cost:** QUTENZA™ 179 mg cutaneous patch plus 50g tube cleansing gel £210 per pack. **Legal Classification:** POM. **Marketing authorisation number(s):** EU/1/09/524/001-002. **Marketing authorisation holder:** Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, Netherlands. **Date of revision:** February 2013. Detailed information on this product is available on the website of the European Medicines Agency (EMA) http://www.ema.europa.eu. For full prescribing information refer to the summary of product characteristics. Further information available from: Astellas Pharma Ltd, 2000 Hillswood Drive, Chertsey, Surrey KT16 0RS. **Medical Information: 0800 783 5018**

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Astellas Pharma Ltd. Please contact 0800 783 5018

Date of preparation: March 2013 QUT12049UK(1)

Reference: 1. QUTENZA Summary of Product Characteristics, March 2013 Astellas Pharma Ltd.

From the President

Dr William Campbell

The British Pain Society

Pain News
11(2) 86–87

SAGE

I do feel very honoured to have the opportunity to take up this role as President of the British Pain Society (BPS), although it is with a sense of trepidation that I do so, considering the many activities to be overseen in the immediate future. Our Immediate Past President was not as fortunate as others, commencing his role without a lead-in year. Despite this, he has guided the Society through some magnificent achievements – so many that I refer you to his final message in the last issue of *Pain News*. I am very grateful for the advice that Richard has imparted over the past year, and I am sure that this will continue over the coming year in his position as Immediate Past President.

Since we have just had an Annual General Meeting (AGM), it is the time of year when we lose some of our Council members but gain others. Our past Honorary Secretary Pat Schofield not only looked after the membership and memoranda of the Society, but also was an active member of the Communications Committee and the Patient Liaison Committee. Although we will miss her in these roles, Pat is going to co-chair the Education Committee with one of our other Council members, Paul Cameron. Pat is succeeded as Honorary Secretary of the Society by Martin Johnston, who is most welcome to the Executive team, as is Andrew Baranowski, our new Honorary Treasurer. Andrew has led the large team that developed the Pain Patient Pathways, which are currently on our website, as well as on the Map of Medicine site. He is currently also leading on Specialised Commissioning and chairs the NHS England Clinical Reference Group, Specialised Pain Services for this. The Implementation and Dissemination phase of the Pathways and Commissioning project has been led by Andy Nicolaou and naturally his input to this task is most appreciated. To register for these go to http://www.britishpainsociety.org/meet_pathways_roadshows.htm

Although John Goddard steps down as Honorary Treasurer, he has been elected as the new Vice-President of the Society. John has successfully dealt with some very difficult tasks while on Council, in addition to being our liaison officer for National Institute for Health and Clinical Excellence (NICE) a few years ago. His attention to detail and unflappable manner will be an ongoing asset to the Council and the Society as a whole.

Two Council members' terms of office are now complete. Suzy Williams made a considerable contribution to the Society through her role on the Patient Liaison Committee, in addition to her role on working parties – Healthcare Resource Groups, Recommended Guidelines for Pain Management Programmes for Adults, and Core Pain Curriculum for Pre-Registration Healthcare Education. Suzy also represented the Pain Management Programmes Special Interest Group (SIG) on the Pain Patient Pathway working group. We wish her well for her future endeavours. Austin Leach, though leaving as an elected Council member, will continue as BPS photographer, as well as continuing to sit on the Patient Liaison Committee, as he did in the past. Austin dealt with many of the increasing requests for information from the media and he will continue to do so, on behalf of the Society.

The election of Council members was carried through the Electoral Reform Services, as in recent years. The turnout was very poor this year as I am sure our Honorary Secretary will allude to. The voting was dramatically close for some. I am delighted to welcome our two new Council members Neil Berry and Tim Johnson. Well done and you are both very welcome to the Council of the Society.

The Annual Scientific Meeting (ASM) was very well attended this year in Bournemouth; with more than 500 delegates registering prior to the event and more registering on the day, there were over 550 attendees in total. Industry, Dr William Campbell

trade and charitable organisations were present in abundance, leading to a well-attended meeting in general. We do appreciate the considerable support from industry, which helps keep the costs of a meeting of this size down, and are looking at how we may improve the experience for them for future meetings. For those who did attend the meeting, we really need your feedback to establish what your likes and dislikes are for future events. Your programme contained the web link for this purpose and after completion of the online evaluation form, your certificate of attendance will be issued. The evaluation form is available online at http://www.britishpainsociety.org/2013asm/evaluation.htm. For those of you who did not attend, please also let us know if you have specific preferences for the future by contacting me at president@britishpainsociety.org.

For those of you interested in networking with world-leading colleagues working in the area of pain, the BPS ASM must surely be the best annual event to attend. In addition, if you also wish to focus on one topic in particular, do consider attending one of the Society's study days. Further details are available at http://www.britishpainsociety.org/meet_bps_study_days.htm

On 15 April we heard that the application for a bid to the National Institute for Health Technology Assessment Programme has been provisionally recommended for funding a multi-centre three-arm randomised controlled study to test the feasibility of a definitive trial assessing the clinical and cost-effectiveness of facet-joint injections in a subset of patients with non-specific low back pain of six to 24 months duration. This is very much down to the expertise and hard work of Prof Richard Langford. This is a major achievement and shows that his hard work has paid off. Well done Richard, and his team.

Over the coming weeks it will be *essential* that you provide details of your pain service activities, in relation to quality and efficiency, so that the commissioners can decide from where to purchase their services in the future. You should make contact with the commissioning directors within your trust, as well as notifying the commissioners for your area directly – if you have not already done so – so that they are made aware of the services that you provide. This is essential so that patients in your area may continue to receive the appropriate level of attention and appropriate therapy in both primary and secondary care. Over the next few months we hope to complete the BPS guide to commissioning document; however, you need to engage now with those within your hospital who are involved in the contracts commissioning of your services. You and only you are in a position to drive this forward.

I wish you a very pleasant summer.

William Campbell

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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10
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80

From the Honorary Secretary

Dr Martin Johnson

THE BRITISH PAIN SOCIETY

Pain News
11(2) 90–91

SAGE

It is pleasant to work in my office with the sun shining through the window for a change, indeed it has taken nearly four weeks for the snow to vanish in my part of Northern England. True to form the sun only graced us with its presence right at the end of this year's ASM in Bournemouth. However inside the BIC we were treated to numerous outstanding talks. Thanks to Jenny and her team for their organisation of the event, Gary and his team for arranging the programme & also Meherzin and her local team of volunteers for sitting at the desks. A big thanks to all of the sponsors of the event, thank you to all of the chairs & speakers and simply a big vote of thanks to all of you who attended. It is always important to remember that the financial survival of the BPS is dependent on the ASM.

As I mentioned in my last column we saw the official launch at the BPS of the *'Guidance on the Management of Pain in Older People'* in the British Geriatric Society Journal *age & ageing.* The guidelines were jointly launched in the same week at our conference and the BGS Conference in Belfast. May I commend this superb document to our members.

BPS Council have also endorsed another important document '*Pain in Secure Environments*'. This has been produced by a consensus group lead by one of our two new Honorary Members, Dr Cathy Stannard. Congratulations to Cathy and also congratulations to our other new Honorary Member Dr Amanda Williams.

I am pleased that the *British Journal of Pain* goes from strength to strength. A recent report has shown that both of the top downloaded articles in 2012 came from the opioid themed edition in February 2012 [Vol.6 Iss.1] - the top downloaded article being Hasan Pathan's: *Basic opioid pharmacology: an update.* I must admit I use this edition as my main opioid reference guide plus notes from Cathy Stannard's wonderful BPS Lecture at the ASM – for those that didn't stay until the end of the conference you missed a superlative treat!

Membership

If we combine the above membership with the potential lapses of membership that are due, our total membership is down by about 70 from this time last year. Most of the members lost are from our Anaesthetist and Nurse members with minimal movement in numbers from the other professions. The main reasons that are provided for lapses in membership are due to retirement or no longer involved in pain management. We have not recorded any negative feedback of the BPS.

	April 2012	April 2013
Members	1536	1447
Pending Ratification	42	42

My main disappointment over the last few months was the low response (turnout) from the membership for the election of Council Members (22.7%). Compared to many societies we are relatively small so hopefully will know some of the candidates. We are looking into the possibility of giving an online vote option to improve response. William discusses the result in his message – congratulations to Tim & Neil!

The results of the 2013 election were as follows:

JOHNSON, Dr Tim	114	Elected
BERRY, Mr Neil	101*	Elected*
LEACH, Dr Austin	100*	
TAYLOR, Dr Ann	98*	
LIOSSI, Dr Christina	31	
HASNIE, Dr Fauzia	28	
PANCH, Dr Gnanie	14	

*confirmed by a recount.

We have 13 Special Interest Groups at present; some more active than others. May I suggest that in the future all SIG chairs give me a couple of lines of information every six months that I could pick use for my *Pain News* column?

Then it becomes what you wish to say about your SIG rather than what I think! They could either be activities of the SIG or areas of interest from the specialised clinical area of the SIG.

As previously mentioned we have one new SIG this year – the Information and Communication Technology (ICT) SIG which has been ratified at Council. Their inaugural meeting has yet to take place, though it is proposed that the first meeting may wish to take the form of a scoping meeting to see how technology could help the BPS. If you have any initial thoughts please feed them back to me at the BPS.

Finally I would like to express my thanks to John for his work as Treasurer (and welcome to the team Andrew!) and also to express my congratulations to John in becoming Vice President. I would like to give my support to William as he starts to explore his Presidents role. In particular I would like to thank Richard on a personal, professional & societal basis. His vision has been simply inspiring and has been essential for survival of pain as a specialty in this brave new world.

Dear Member,

Further to my update in the February issue of Pain News, I am delighted to see that so many members have already responded to confirm their membership fee band. This greatly assists the Society in determining realistic and appropriate membership fees for the future, thank you for your cooperation in this regard.

We will review the information provided against the data we already hold for members, and any changes to membership bands will be adjusted for your 2014 membership fee (which will become payable in January 2014) and notified to you as part of the membership renewal notifications sent in December this year.

If you have not yet completed or returned the form, please do so at your earliest opportunity, or alternatively you can contact the Secretariat by phone (020 7269 7840) or email (membership@britishpainsociety.org) stating your name and membership number, and income band.

Each year at the time of the membership renewals, we will continue to send out a copy of the income bands with corresponding membership fees, and would ask that as a matter of course you review your details and update the Secretariat at that time of any changes.

Kind regards,
Dr John Goddard
Vice President

The British Pain Society
Pain News
11(2) 92–93
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SAGE

Thank you Richard!

Lots of thanks messages to our outgoing President Prof Richard Langford; however we could only accommodate a few in this issue!

"So much achieved during his term as President, especially considering he started the post as President without a lead in year"

—Dr William Campbell

"Richard has been outstanding in his role as President. I am really proud of what we have achieved - his support has been tremendous and crucial to the success of the National Pain Audit and Pain Patient Pathway project. What has been most impressive is that he has been prepared to take difficult decisions and challenge where needed in a really constructive way. I am really aware of how much time the Presidency has taken and hope he will take a well deserved time off with Bernadette and his family. Thank you so much."

—Dr Cathy Price

"Richard has provided the Society with dynamic and thoughtful leadership. From the moment he took office, he realised that Pain world would be greatly challenged with the changes in the NHS, especially the emerging power of commissioning – thus his vision initiated the concept of the Pain Pathway project; our most complex project. On a personal note, I wish to thank him for all of his guidance, support and friendship."

—Dr Martin Johnson

"Congratulations on a job truly well done. You've been a fantastic and visionary leader who has revitalised the BPS – many thanks for all your hard work and efforts. Enjoy the deserved rest from it all!"

— Prof. Irene Tracey

"Thank you so much for all your enthusiasm, hard work and support for a scientific approach to pain research and management. It has been a pleasure working with you."

—Prof. Maria Fitzgerald

"Amazing and the right person at the right time. We owe him a lot."

—Dr Andrew Baranowski

"Richard took over the Presidency of the BPS at a very challenging time and has steered the Society through some of its most ambitious projects using his substantial knowledge, skills, and insight. He has been immensely supportive of the members of council and I would like to offer my thanks to him for all that he has done for the Society, its members and for those experiencing pain."

—Prof. Nick Allcock

"Richard Langford: a true gentleman and scholar in the most old-fashioned (and therefore most apposite and applicable) sense of the expression. A natural navigator with a firm hand on the tiller, however stormy the sea. He will always be '*The President*' to me."

—Dr Austin Leach

"Richard, Congratulations on a most impressive Presidency. A Tour de Force in this role! You have been responsible for so many successful projects that will have a real legacy and should alter and endorse how patients in pain are managed in both primary and secondary care. May I wish you all the very best for the future- and a continued profile in national politics- after a well-earned rest."

—Dr Beverly Collett

"Thank you for your commitment and wise leadership during your Presidency."

—Dr Rajesh Munglani

"Richard interviewed me for my role at the BPS - he was great at putting me at ease and making me feel very welcome. I think that sums up Richard, his relaxed style but sharp and to the point mind has made a great impression on me in a short time. I imagine him to be the same with his patients, what a lovely caring man!"

—Mr Antony Chuter

"Many thanks for all your efforts as BPS President. You have worked tirelessly to take us forward. In particular your personal vision has helped shape strategy for the great benefit of all our members."

—Dr Andy Nicolaou

"The supportive and palliative care communities congratulate Richard on his successful term of office. In particular, the Association for Palliative Medicine would like to thank him for his warm support of developments in cancer pain, notably the establishment of the joint committee between the BPS and APM. This collaboration will be a reminder of Richard's diplomatic skills in bringing us closer together!"

—Prof Sam Ahmedzai, Sheffield

"Affable, somewhat garrulous: always a pleasure to work with, although his Council meetings tended to be a little long! A man with strategic views - He has developed and strengthened the Society's influence with Commissioning, Governance and Industry."

—Dr John Goddard, Sheffield

The ROYAL MARSDEN
NHS Foundation Trust

'Pain in the Cancer Patient' National Study Day

Thursday 27 June 2013

This one day event will be relevant for healthcare professionals from all areas of the cancer multidisciplinary team especially those with an interest in cancer pain. It will also be highly relevant for pain trainees who are planning on taking the pain exam, the FFPMRCA Examination.

The day will give a comprehensive summary of the mechanics of cancer pain, its epidemiology and address its management with multidisciplinary input'.

Visit **www.royalmarsden.nhs.uk/paincancerpatient** to book and view the programme

The Sixth Annual Pain and Opioid Conference

Friday 01 November 2013

Now in it's six year this popular and informative conference presents novel approaches to the assessment and management of patients on opioids, working to improve pain management through rational and individualised prescribing. Topics to include: Implications of basic science, Opioids in clinical practice, Other aspects of opioids, Opioids for specific indications

Visit **www.royalmarsden.nhs.uk/painconference** to book and view the programme

Venue: The Education and Conference Centre, Royal Marsden Hospital, Stewart's Grove, London, SW3 6JJ
For further information please email **conferencecentre@rmh.nhs.uk** or call **020 7808 2921**

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)

GLOBAL YEAR AGAINST visceral pain

OCTOBER 2012 - OCTOBER 2013

To learn more about the core features of visceral pain, download these fact sheets:

- Epidemiology of visceral pain
- Neurobiology of visceral pain
- Acute vs. chronic presentations of visceral pain
- Psychological aspects of visceral pain
- Pancreatitis
- Bladder Pain Syndrome
- Male Chronic Pelvic Pain Syndrome
- Functional abdominal pain
- Chronic chest pain

Visit the IASP website to learn more:
www.iasp-pain.org/GlobalYear/VisceralPain

International Association for the Study of Pain
IASP®
Working together for pain relief

Tel: +1 206 283 0311 Fax: +1 206 283 9403 Email: iaspdesk@iasp-pain.org Web: www.iasp-pain.org

News

Outgoing Council Members

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Pain News thanks the outgoing Council Members Austin Leach and Suzy Williams who have worked hard for the last three years.

Austin has participated in many roles in the Council including being a media contact for the Society (along with Mick Serpell and other Executives). He has been a professional member for the Patient Liaison Committee since April 2010. He is also the BPS representative and sits as a member or the *Airing Pain* advisory board.

Suzy has been a Council liaison officer of the PMP special interest group since April 2010. She also has been a professional member of the Patient Liaison Committee since April 2010. She has been the BPS representative for the Specialised Healthcare Alliance (with Sam Eldabe) since January 2012.

The Council Members give their valuable time and efforts to help the Society and raise the profile of our Specialty. *Pain News* conveys sincere thanks to Austin and Suzy and wishes them best to continue all the efforts in future.

News

New Council Member - Neil Berry

If you recognise my name, the chances are that you know me from my self-help CD, '*Living with chronic pain'* or from my British Pain Society activities. Over the past four years, I have been an active and enthusiastic co-opted member of Council. I have taken a lead role in trying to ensure that the new (English) IAPT psychological therapy services are better informed about people with chronic pain. I have also served on the Education Committee, the BPS/Map of Medicine pain pathways group on 'Chronic Widespread Pain' and the Core Undergraduate Pain Curriculum working party.

I work full-time as Consultant Clinical Psychologist with the Pain Services in The New Forest and Southampton.I became a full-time pain clinician in 1999. Prior to that I worked for four years in a cardiac rehabilitation team and, for sixteen years before that, I was Senior Lecturer in Clinical Psychology at The University of Central Lancashire (or Preston Polytechnic as it used to be). As an academic, I studied and lectured on pain and pain control, both acute and chronic. I believed then, and believe now, that it is a field which, perhaps more than any other, exemplifies biopsychosocial models and interdisciplinary treatments. I very much value being a member of a Society which embraces research, education and clinical practice and which brings a diverse multiprofessional group of people together through our shared values and interests.

News

New Council Member - Tim Johnson

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For the last 20 years I have worked alongside nurses, pharmacists, physiotherapists, psychologists and managers to develop a well resourced multidisciplinary pain centre that delivers the whole spectrum of pain therapies. This has emphasised to me the immense complexity of all forms of pain and the importance of proper management to prevent destructive effects on our patients' lives. I have supported the Acute Pain, Pain Management Programme and the Developing Countries Special Interest Groups of the British Pain Society, from whom my patients and I have received enormous support.

I can offer the Society my experience and insight as an educator who has implemented Modernising Medical Careers sensitively, and in the process supported many doctors in training, SAS doctors and consultants, especially in developing their own educational expertise.

I am now in a position to contribute more at a national level to ensure that best practice is available to all patients in pain, and that scientific evidence is thoughtfully interpreted before it is used to determine clinical care. To achieve this I want to work to ensure full implementation of the BPS Pain Patient Pathways, notwithstanding the continuing momentous changes within the NHS.

News

BPS Honorary Medal of Distinction - Dr Douglas Justins

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SAGE

BPS Honorary medal of distinction was awarded in Bournemouth ASM 2013 to Dr Douglas Justins; the citation was provided by Prof. Richard Langford

The BPS Medal of Distinction is our premier award, occasionally bestowed on the most outstanding contributors to our Society and specialty, and the only honour presented before the whole assembled Society. It is therefore a great pleasure to announce the award of this medal to Dr Douglas Malcolm Justins and to deliver this citation in recognition of his major achievements in progressing Pain Medicine:

Doug qualified in medicine from the University of Queensland Medical School in Brisbane, Australia, at the age of twenty-three. Over the next few years, he held posts in general practice and a year as a flying doctor, specifically as a flying anaesthetist, before moving south to a senior resident's post in the Royal Prince Alfred Hospital, Sydney.

Those of you with advanced level geography will know that Sydney like all major Australian cities is coastal, and hence Doug was perfectly placed to respond in 1975 to the invitation for a doctor to join the crew of Anaconda II competing in the Financial Times Round the World Clipper Race for the leg from Sydney to Dover. In so doing, he become a member of the "Cape Horner's Club" having rounded Cape Horn under sail. Doug described this voyage in his CV as 'non-stop', but I am not sure that this is completely correct, as I'm informed that capsizing was the first (but not only) occasion when his long-suffering family spent an anxious period while he was "missing presumed dead". However all ended happily with Doug reaching UK dry land and securing anaesthetics training posts in London at the Charing Cross, St Thomas' (including an academic time as a lecturer) and GOS, gaining en route his FRCA in 1979.

In 1982 he was appointed to his Consultant post in Pain Medicine and Anaesthesia at St Thomas' Hospital and rapidly immersed himself in education, training and pain medicine, the enduring professional interests, which have made a huge contribution and continue to the present.

One of his first initiatives was co-founding PANG, the Pain and Nociception Group with Peter Evans in1983, and which ran for twenty-five years. Another important step came in 1987 on securing a 'King's Fund for London Grant' to develop the in-patient Cognitive-Behavioural Pain Management Unit, this of course being the renowned INPUT Unit at St Thomas'.

During the 1990's, Doug embarked on his glittering career in Postgraduate Training, initially in anaesthetics for the South East Thames Region, becoming the Royal College Regional Educational Advisor 1993 until being elected a member of College Council in 1995. Over the next decade, Doug served in a number of senior College positions, including leading the Training Committee, and culminating in his term as Vice-President from 2002 to 2004.

In preparing this citation, my research has solved the mystery of when and where Doug acquired the skills that led to greatness – I believe that it was his time as a Queensland GP that afforded him the opportunity to hone his leadership and training skills, as custodian of 'Rug' and 'Roo', his pet lamb and kangaroo.

Famously, or some would say, infamously, he never missed an opportunity to champion the cause of pain in the College, chairing the Pain Management Committee for ten years, and through his negotiating and strategic skills and sheer dedication, he succeeded in turning his vision of a Faculty of Pain Medicine of the Royal College of Anaesthetists into reality. Doug chaired the Faculty's Founding Board from 2005, and in 2007 he became the first Dean, and *awarded himself* the FFPMRCA. Being the first of the Faculties to be developed in the Royal College of Anaesthetists, Doug was quick to describe the Faculty of Pain Medicine as the 'Senior Faculty'. He was the obvious choice to be the first recipient of the Faculty's Gold Medal.

This competitive spirit is of course central to Doug's make-up, and is just as manifest in passion for sports particularly cricket, rugby, *Cross Country Running* (member of Thames Hare and Hounds) and as you've already heard, sailing. His support, especially with respect to cricket, is of course fiercely partisan.

He ran in the first London Marathon and thereafter half marathons every year until relatively recently. He has taken part twice in Bordeaux's Marathon du Medoc, which you will note features many runners in fancy dress, and provides the local beverage, in fact at 21 semi-compulsory stops in the 26 miles of routing through vineyards. I am informed that Doug required much imbibed solace, when one year he suffered the ignominy of being overtaken by a clown!

Of course, Doug has also played a major part in the life of this Society as an elected Council member, Chairman of the Scientific Meetings Committee, Honorary Treasurer and of course President from 2001 to 2003. In 2006 he jointly founded and chaired the Education Special Interest Group, and also in that year gave the inaugural British Pain Society Lecture on 'Education and training in pain'. His work in education continues as Champion for our DoH funded joint BPS/FPM e-learning for pain project.

Doug has also been very active internationally, as a member or chair of ten International Association for the Study of Pain (IASP) committees and task forces, and for EFIC, he chaired the Scientific Programme Committee for the EFIC 1997 Pain in Europe Congress in Barcelona.

Doug has made so many domestic contributions that in the interests of time, I will simply mention a selection of the main bodies:

12 Department of Health and NHS committees

Multiple roles in other Colleges and the Academy of Medical Royal Colleges

Postgraduate Medical Education and Training Board

General Medical Council

National Confidential Enquiry into Peri-Operative Deaths

Advisory Committee on Clinical Excellence Awards

NICE National Collaborating Centre for Acute Care

British Medical Association

Royal Society of Medicine

He has held five editorial positions including 17 years as an Associate Editor of Pain and 37 publications of which I believe his favourite is First Aid at Sea, *"as recommended by the Royal Ocean Racing Club".*

And in case you thought he is now planning to rest on his laurels, last month he was teaching in Myanmar, and he has just been appointed as vice-chair of the NHSCB Specialised Commissioning Clinical Reference Group and a Senate member for South London.

Finally, aside from work he makes time for his family, sports, his passion for the arts including opera, theatre, history and geography. Last Summer, he ensured what he called the best seat in the house, when he led a Field of Play Medical Recovery Team in the Olympics Athletic Stadium.

I therefore commend Douglas Malcolm Justins to the Society for the award of the Medal of Distinction.


LAUDATUM EST OPUS


David P. Finn PhD
nal University of Ireland, Galway
NUI Galway
OÉ Gaillimh


lankenburg et al. Pain 2012
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g et al. Neuropaediatrics 2007

ASM Bournemouth

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Honorary Membership for Dr Amanda Williams

Citation provided by Prof Chris J Main and presented by Prof Chris Eccleston

It is my great pleasure to give this citation in support of Dr. Amanda Williams for Honorary Membership of the British Pain Society (BPS).

Amanda graduated in Psychology from the University of Bristol in 1976; followed by M.Sc. in Clinical Psychology in 1985 from the NE London Polytechnic and a Ph.D in Psychology from UMDS in 1996. From 1988 – 2004, she was at the heart of the development of the renowned INPUT Pain Management Unit at St. Thomas's (initially as a Senior Clinical Psychologist and since 1990 as a Consultant Clinical Psychologist). While at INPUT, she also had an academic attachment to UMDS, initially as an Honorary Lecturer in Clinical Health Psychology and since 1996 as Senior Lecturer and since 2003 as a Reader in Clinical Health Psychology.

Since 2004 she has been Reader in Clinical Psychology at University College London, with a clinical attachment to the pain management centre at UCL and appointment as a Research Consultant to Freedom from Torture (MF), the only organisation in the UK dedicated solely to the treatment and rehabilitation of survivors of torture, in London.

Amanda has made a major contribution not only to the professional of clinical health psychology in general, but to pain management in particular. Indeed she is one of the most distinguished pain psychologists of her generation. She has made a significant difference to the suffering and quality of life of pain patients both as a front-line clinician, and as a generous advisor to fledgling pain management programmes and disheartened colleagues.

Her approach to the challenge of pain is by fairness, equality and caring concern, perhaps characterised best by her work with torture victims, an example to us all, and a challenge to which very few of us could rise. She has served as a clinical mentor to countless clinicians and researchers. Indeed it has been observed that she sees future swans in students where others see only ducklings. She contributed to our understanding of pain not only a distinguished researcher, and frequent reviewer or publications and grant proposals but also as a powerful theoretician, as evident in her 2002 evolutionary account of facial expression, a tour de force. She is an inspiring colleague who is a delight to work worth. Her C.V. illustrates a wide range of professional collaborations, the most noteworthy of which perhaps have been with Craig, Eccleston and Morley. Her penetrating and powerful insights have not only illuminated dark corners, but have punctured intellectual pretension with an honesty and candour which sets a standard for us all. These qualities in addition to her charm, warmth and sense of humour promote the best from her colleagues.

She has been a stalwart of both the BPS and IASP. She is a past Council member of the BPS and served as Chair of Science and Research Committee; as Chair of guidelines development group for Pain Management Programmes, as a Member of Scientific Programme Committee and as a member of the Patient Liaison Committee.

She has also represented the UK at IASP, and has served on its Scientific Committee; its Research and Awards Committee; and finally as both Chair and founding member of the IASP Special Interest Group on pain from torture, organized violence and war; and its newsletter editor 2008-2012.

Her irrational love of water (comparable with my fondness of malt whisky) extends to taking holidays swimming down the Thames or between Scilly isles, and her attainments as an exponent of free diving. I am informed that she frequently used to leave INPUT with a bag containing a costume and nose clip and head off to a pool in north London where she would practice breath-holding in the bottom of a public swimming pool.

In summary, her breadth of her knowledge is remarkable and her deep commitment to furthering the cause of pain relief around the world is second to none. She has made a massive contribution to the alleviation of pain and suffering. She's proved to be a wonderful friend and colleague to many of us over the years. It has been a pleasure and privilege to commend her to you for Honorary Membership of the BPS.

Honorary Membership for Dr Catherine Stannard

Dr Catherine Stannard was awarded Honorary Membership in the ASM; citation was provided by Dr William Campbell outlining her career, achievements and her current interests.

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Acute Pain Special Interest Group - Update

Dr Jane Quinlan, Oxford; Chair, Acute Pain Special Interest Group

I am delighted to announce that the leadership of the Acute Pain SIG has expanded over the past year with the new APSIG committee reflecting our multidisciplinary membership.

- Giancarlo Camilleri is a consultant in pain and anaesthesia at Ashford and St Peter's Trust;
- Fiona Duncan is a nurse specialist at Blackpool Victoria Hospital, and a research fellow at Manchester Metropolitan University;
- Chandran Jepegnanam is a consultant in anaesthesia and inpatient pain management at Manchester Royal Infirmary;
- Andrea Magides is a consultant anaesthetist and the lead clinician for the acute pain service at Torbay Hospital;
- Sophie Moran (Secretary) is a senior acute pain specialist nurse in Cheltenham General Hospital, part of Gloucestershire Hospitals NHS Foundation Trust;
- Jane Quinlan (Chairman) is a consultant in anaesthesia and inpatient pain management at the Oxford University Hospitals Trust;
- Mark Rockett is a consultant in anaesthesia and pain medicine at Derriford Hospital, Plymouth;
- Keith Stevens (Treasurer) is a consultant in anaesthesia and inpatient pain management at Arrowe Park Hospital in the Wirral.

As well as meeting at the BPS ASM with a lunchtime business meeting and, for the first time this year, a joint workshop with the Pain in Children SIG, we also meet at the National Acute Pain Symposium held every September in Chester. We look forward to seeing you there.

News

Details of the National Acute Pain Symposium

Dr Keith Stevens *Arrowe Park Hospital, Wirral*

The National Acute Pain Symposium is due to take place at the Crowne Plaza Hotel in Chester on Thursday 12th and Friday 13th September 2013. This meeting has been underway for 23 years now and is the premier acute pain forum in the country. It is attended by 200 –250 delegates each year, most of whom return time and again. The delegate list reflects the multi-disciplinary nature of the Symposium, with about half the delegates being anaesthetists of various grades, and the balance being acute pain nurses, recovery room nurses and HDU/ITU nurses. There is even the odd physiotherapist and pharmacist in attendance. It attracts 8 CEPD points from the Royal College of Anaesthetists.

The informal and relaxed nature of the Symposium is usually thoroughly enjoyed by all who attend. Chester, a beautiful and historic walled city, has been the home of the Symposium for the past 13 years and is a favourite with the delegates. An informal delegate dinner is arranged at a local Brazilian restaurant and makes for a wonderfully relaxed and friendly evening. The Crowne Plaza Hotel is a first class venue for the event with delegates rating the venue, refreshments and lunches highly year upon year.

As always, the program finds a balance between academic/scientific topics presented by the country's top authorities, and everyday pragmatic issues with daily practical application. A case report presentation is part of the programme with animated discussion from the floor. A debate will also take place this year – the controversial motion being *"Chronic pain specialists, not anaesthetists, have the right skills to treat inpatient pain"*. A poster competition attracts about 20 posters each year and provides an opportunity for those who have done innovative work to highlight their efforts. Three prizes are on offer for the best 3 posters and winners are each given 10 minutes to speak about their posters to the delegates. As usual, an interesting and diverse program with plenty of content for all is planned. Many of the presentations are by speakers of national and international repute – most of whom have spoken before at the meeting and who return to join us every couple of years.

There is also a meeting of the Acute Pain SIG of the British Pain Society at lunch time of Friday 13th September over lunch. If you would like any further details of the Symposium, please contact Georgina Hall who will be delighted to give you any further information that you might need (Telephone: 0151 522 0259 or e-mail : medsymp@btinternet.com). An advertisement will also appear in *Anaesthesia News* in due course with further details

News

British Association for the Study of Headache

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The British Association for the Study of Headache is a registered charity of healthcare professionals that seeks to reduce the burden of headache in the UK. BASH wish to widen the circulation of our newsletter to all those who have an interest in headache and not just our membership.

The newsletter is published three times a year and contains educational material, research updates and headache related news. It is edited by Dr Brendan Davies (consultant neurologist) and Dr David Kernick (General Practitioner with a special interest in headache). If you would like to receive this publication by e-mail which is free and non-sponsored, please send your contact details to pastwood@migrainetrust.org. BASH assures that they will not send you any other material or release your details to third parties. If you would like further information please contact david.kernick@nhs.net.

News

Reading Well Books on Prescription

From June there will be a step change in the way that libraries across England are working with health partners to use reading to deliver a new early-intervention well-being service to help the 6 million people suffering from depression and anxiety. A new Reading Well Books on Prescription scheme will provide book-based cognitive behavioural therapy (CBT) to help people understand and manage common mental health conditions. The scheme comes from independent charity The Reading Agency and the Society of Chief Librarians.

This initiative is timely, given the need for better mental health care against a backdrop of tough economic times and cost savings. There is growing evidence that self-help reading can provide effective support for people with common mental health conditions. Reading Well Books on Prescription will enable general practitioners (GPs) and health professionals to recommend book-based CBT either as a stand-alone treatment, alongside medication and psychological approaches and as a key element in a supported programme.

A list of 30 expert-endorsed self-help books will be available from local libraries in England to help people understand and manage common conditions such as anxiety, depression, phobias and some eating disorders.

The scheme works within National Institute for Health and Clinical Excellence (NICE) guidelines. It is supported by the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Psychiatrists, the British Psychological Society, the Department of Health's Improving Access to Psychological Therapies Programme (IAPT), the British Association of Behavioural and Cognitive Psychotherapies, the British Association for Counselling and Psychotherapies and Mind.

Paul Blenkiron, Consultant in Adult Psychiatry, York, NICE Fellow said:

> *I am delighted to have been involved in this exciting project to bring help to the millions of people who suffer from anxiety and depression. I am sure GPs and other health professionals will value the Reading Well Books on Prescription scheme. Cognitive behavioural therapy can be a highly effective treatment for people with common mental health problems. The core list of 30 CBT-based self-help books will be a real boost to the treatments currently available.*

Janene Cox, Society of Chief Librarians, and Debbie Hicks, The Reading Agency, said:

> *We're excited to be working together to launch new services in libraries to help people suffering from mental health conditions such as anxiety and depression. This is a step change in partnerships between libraries and local heath partners to improve our communities' health and well-being. Evidence tells us that many people see the local library as a trusted place to go for health information. A library visit can be the first step on the road to recovery.*

If you would like to know more about the Reading Well Books on Prescription scheme go to http://www.readingagency.org.uk/readingwell or contact readingwell@readingagency.org.uk

Professional perspectives

Rayen's column: *I wish we had…*

THE BRITISH PAIN SOCIETY
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Dr Arasu Rayen *Birmingham*

> Any sufficiently advanced technology is indistinguishable from magic.
>
> – Arthur C. Clarke

(In, 'Profiles of the Future: An Inquiry into the Limits of the Possible')

Seven years ago, I visited a pain clinic near Amsterdam. At that time its patients completed the pain clinic questionnaires on a computer! The clinics and theatres looked futuristic. I could see the technology in action in every aspect of the patient's clinical experience. I wondered how the medical landscape would look like if we had 'bit more of magic' from technology. The following are my imaginings of 'technology magic'. You can decide whether it will soon be a reality or just 'pie in the sky'.

National health card

This electronic card is the size of a credit card with similar swipe and pin technology. It contains a chip that holds encrypted patient information, like biography, biological data (updated photograph, iris and fingerprint patterns), medical history and drug history from birth, and any other relevant medical information such as address of general practitioner (GP). Every registered patient carries this card on their person. When the patient attends the clinic or GP practice, a secured card reader brings up the patient information from the electronic record.

Seamless electronic patient record

Implementation of the 'National Digital Health Superhighway' paves the way to the seamless electronic patient record scheme. As the name suggests, it is a national digital network where all the registered patient's health records are stored and accessed across the country from any authorised medical facility by any authorised registered user. Gone are the days when each hospital and GP practice had its own software and systems for patient records that do not 'talk' to each other. Currently, the seamless electronic patient record is the only electronic patient record used across the National Health Service (NHS). Even if a patient from Cornwall goes to a medical facility in Land's End, the medical professionals should be able to access all the electronic medical records of that patient at any time without any problem.

Total electronic prescribing with NFC

Currently, no prescriptions are given out in paper form. All the 'in hospital' and 'out of hospital' prescriptions are sent either to the smartphone app or the patient's national health card through the near field communication (NFC) technology. NFC is a form of contactless communication between devices like smartphones or tablets. Contactless communication allows a user to wave the smartphone over an NFC-compatible device to send information without needing to touch the devices together or go through multiple steps setting up a connection.[i] The same happens when the patient goes to the pharmacist. The NFC readers in the pharmacy read the electronic prescription, cross-check for validity and authenticity, and dispense the medicine.

Video games for treating painful conditions

Video games have been shown to be of immense help in managing painful conditions.[1,2] Currently, prescription video games have an important role in managing chronic pain. 'Open world' ('Sandbox' or 'free roaming') video games[ii] are much better than conventional video games. In open world video games, the player can design their environments, target and obstacles with minimal restriction (e.g. Assassin's Creed, Brotherhood). Functional MRI studies have shown improvement in brain activity following series of video game sessions.

Virtual reality in pain management[iii]

Virtual reality video games. These are like any other video game but with added visual and acoustic involvement from the user. With the help of virtual reality, patients immerse themselves in the virtual reality environment. This distracts, reduces pain and helps to improve mobility.

Virtual reality biofeedback, hypnosis and mindfulness meditation. Virtual reality is also used in these psychological techniques to improve patient's pain management.

Virtual reality-assisted treadmill to help movements. As the virtual reality environment is so immersive, patients forget their pain and disability and do more physical work like walking on the treadmill.[3–5]

3-D ultrasound for interventions

3-D ultrasound is ubiquitous now. It gives a clear image, which has 50 times the clarity of ultrasound machines that we used 20 years ago. These machines use modern techniques like 3-D metamaterial[iv] and Oxford electromagnetic acoustic imaging[v] technologies.[6] Currently, 4-D ultrasound machines are also in production. They give the tactile feedback of the deeper structures through the probe and needles. It is believed to be very useful in interventions.

Algoneuoropeptide

This is a neuropeptide secreted by the central nervous system in response to chronic pain. For a long time, basic scientists believed that only acute pain produced the palpable neuroendocrine response, which they termed 'fight or flight response' or 'stress response'. Later it was shown that patients who suffered from moderate to severe chronic pain – regardless of whether it was nociceptive or neuropathic – secreted a very small amount of a neuropeptide in response to chronic pain. The scientists aptly named it algoneuropeptide (*algos* = pain). It is secreted from thalamus in response to chronic pain stimulus but not to acute pain. Algoneuropeptide is secreted depending on the duration, intensity and frequency of the pain.

The actual function of this peptide in the body is still unclear. Some preliminary animal studies showed that it sensitised the nervous system and augmented the pain response. They also showed that blocking this neuropeptide reduces the severity of pain. Clinical use of this method is still unclear.

As this neuropeptide is secreted in a very small amount, it had so far eluded the scientists' attention. With the advent of more sensitive analytical methods, we can now identify this neuropeptide. By measuring and tracking change in the level of algoneuropeptide, scientists and clinicians are able to track the frequency and intensity of breakthrough pain attacks along with background pain in chronic non-cancer and cancer pain patients. By getting the real picture of the pain, clinicians are able to control it effectively.

Algometer

An algometer is a portable, continuous pain-monitoring device – like a continuous electrocardiography (ECG) and blood pressure monitor. It constantly tracks the frequency and intensity of background and breakthrough pain. An algometer looks similar to a transcutaneous electrical nerve stimulation (TENS) machine – two electrodes and a base unit. The electrodes and the base unit communicate wirelessly. The electrodes, which are similar to the ECG electrodes with an adhesive side, have sophisticated electronics with a sensor built in. This sensor constantly monitors the change in the algoneuropeptide in the body. It also monitors muscle movements and tension, galvanic skin response, respiration and heart rate.[7]

In addition to the electrodes, the base unit can also communicate with any smartphone through NFC technology and transfer the captured data. With the help of a purpose-built app, the smartphone uploads encrypted patient pain data to the hospital database 'over the air'.

AlgoTracRelease 1

AlgoTracRelease is a device similar to an intrathecal infusion pump, but much smaller in size. This device is so small that it is implanted (injected) under the patient's skin. The device has a drug chamber and a micro-electronic unit. Similar to the algometer, this device constantly tracks the amount of algoneuropeptide in the patient's blood and also monitors muscle movements and tension. Depending on information gathered from the above data, the device injects drugs using an iontophoresis mechanism through a semipermeable membrane.[vi]

Auropeptides

Auropeptides are group of neuropeptides that are secreted minutes before any breakthrough pain. Scientists believe that these peptides are secreted in anticipation to prepare the body for the breakthrough pain. These peptides are also believed to be the primary reason for the muscle tension and spasm associated with the pain attack. The release of auropeptide is similar to the

phenomenon of 'aura'[vii] (strange sensation of light and smell) before a migraine attack. As these peptides are the 'aura' for breakthrough pain, they are called auropeptides. Drugs that block these neuropeptides are currently undergoing phase 1 trial. There are some promising molecules in the pipeline as well.

AlgoTracRelease 2

Second-generation AlgoTracRelease is released with a new technology called AuraTrac. AuraTrac tracks auropeptides. By sensing the release of auropeptides, this device can release ultra-short-acting analgesics and muscle relaxants pre-emptively. The clinical effectiveness of this mechanism is still questionable.

AlgoCam

AlgoCam is an advanced camera system that is used to map the patient's pain. It is similar to the 40-year-old infrared thermography. AlgoCam uses a combination of infrared thermography and digital light processing (DLP) hyperspectral imaging technology. By using infrared thermography technology, the camera can 'see' hot and cold parts of the body.[viii] DLP hyperspectral imaging technology uses optical semiconductor technology.[8] In plain English, it 'sees' the chemical composition of the tissues. By mapping out the algoneuropeptide and auropeptide in the body, this camera 'sees' the patient's painful area. The camera is also used to assess the effect of interventions on patient's pain by showing the difference (or no difference) in the AlgoCam picture after the treatment.

Virtual video clinic

Virtual video clinic uses a special camera called Algovideocam. Algovideocam is a purpose-built high-speed, high-definition and medical-grade web camera. It also has built-in AlgoCam technology, which can be turned on if needed. The output video data are scrambled and encrypted for security.

Oh, one last thing…

To my knowledge, none of the above technologies are available for clinical use. Referenced technologies are in the early phases of development. Others are from my wild imagination. Every referenced technology mentioned above is patented. Those from my wild imagination are not. If you would like to use them, please feel free to use them without my prior permission. But, please give me some credit somewhere in your project.

Notes

i. Further information on NFC is available online at http://www.nearfieldcommunication.org/
ii. Further information on open world is available online at http://en.wikipedia.org/wiki/Open_world
iii. Further information on virtual reality in pain management is available online at http://player.vimeo.com/video/48078035?badge=0; http://tedxtalks.ted.com/video/TEDxAmericanRiviera-Diane-Groma and http://www.blogtalkradio.com/painwavesradio bypainbc/2013/02/14/emerging-technologies-in-chonic-pain-management
iv. Images of 3-D metamaterial are available online at http://www.qmed.com/mpmn/gallery/image/holey-metamaterial
v. Images of Oxford electromagnetic acoustic imaging are available online at http://www.qmed.com/mpmn/gallery/image/high-clarity-ultrsound
vi. Further information on iontophoresis is available online at http://en.wikipedia.org/wiki/Iontophoresis
vii. Further information on 'aura' is available online at http://en.wikipedia.org/wiki/Aura_(symptom)
viii. Further information on thermography is available online at http://en.wikipedia.org/wiki/Thermography

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Professional perspectives

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SAGE

Visceral pain – challenges to effective inpatient treatment

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Inpatient pain teams are frequently involved in the management of visceral pain in the post-surgical setting. In this, the International Association for the Study of Pain (IASP) global year against visceral pain, it would seem appropriate to review the pathophysiology of pain originating from the internal organs. Although visceral pain may arise from the thorax, abdomen or pelvis, I will focus on abdominal pain for the purposes of illustration.

Post-surgical abdominal pain comprises somatic pain arising from abdominal wall structures, visceral pain from injured internal organs and peritoneal pain due to chemical irritation. Although complex in nature, the management of acute post-surgical pain is often straightforward. However, achieving a satisfactory outcome for post-operative patients with pathological pain states such as chronic abdominal pain or pain associated with functional gastrointestinal disorders can be far more challenging. It is also important to consider that the prevalence of chronic pain following gastrointestinal surgery is in the order of 18–30%, and the effective management of acute post-surgical pain is crucial in reducing the ongoing suffering.[1]

Anatomy and physiology

Our knowledge of the anatomy and physiology of the pain nervous system has been largely based on the study of animal and human skin and muscle. The visceral nervous system has been less thoroughly studied, but clear similarities and differences between somatic and visceral nociception are apparent. [2]

The clinical features of visceral pain reflect the underlying neurobiology. Pain tends to be poorly localised and referred to somatic structures, usually the abdominal wall. For example, pain due to nephrolithiasis is felt in the loin, lower abdominal and inguinal regions. Another common feature of visceral pain is the association with autonomic symptoms such as sweating, vasoconstriction and nausea.

The poor localisation of visceral pain is due to the relatively low density of visceral nociceptors and widespread mapping of visceral afferents onto brainstem and cortical structures.

Unlike skin and muscle, sensations from the viscera are conveyed via autonomic sympathetic and parasympathetic fibres. Sympathetic fibres travel with the major intra-abdominal nerves and join the sympathetic chain in the thoracolumbar regions. Parasympathetic afferents either travel to the brainstem in the vagus nerve or to the lumbosacral spinal nerve roots and cord.

Afferent fibres are almost entirely small myelinated $A\delta$ fibres or unmyelinated C fibres. These fibres convey both conscious sensations and regulatory functions such as gut motility. In contrast to somatic structures, where innocuous stimuli are transmitted via $A\beta$ fibres, visceral afferents may convey a range of stimuli from the innocuous to noxious. There is also a population of silent or mechanically insensitive afferent fibres, which may become activated by inflammatory processes to convey nociceptive signals.

Visceral afferents project to the brain via a number of ascending pathways, including the spinothalamic tract and dorsal columns. Fibres from the spinothalamic tract project to the insular and somatosensory cortices, providing information about the location and type of pain sensation. There are also significant ascending connections to areas of the brain involved in affect, such as the amygdala and anterior cingulate cortex.

Neuroplasticity and visceral pain

As Melzack and Wall first suggested in 1965, the responsiveness of the pain nervous system may change, becoming more or less sensitive to stimuli, depending upon the action of interneurons and the balance of activity in excitatory and inhibitory pathways.[3]

Ongoing noxious ascending or excitatory descending input may result in central sensitisation whereby there is a gain of function of the nociceptive pathway. This results in an increased response to further noxious stimuli, clinically apparent as visceral hyperalgesia.

Such an increase in the sensitivity of the visceral nervous system commonly occurs in chronically painful abdominal conditions. This may involve clear pathology in conditions such as inflammatory bowel disease, or there may be no peripheral pathology such as functional disorders including irritable bowel syndrome. This would suggest that central sensitisation may by driven by both peripheral noxious stimuli (bottom-up) and centrally driven processes such as anxiety and depression (top-down).[4] In these conditions, post-surgical pain is often severe and response to opioid analgesics is limited.

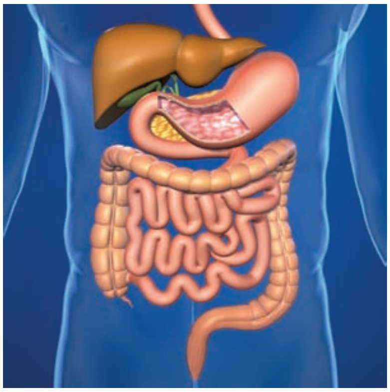
Sensitsation of one viscus may also affect pain processing in related organs, sharing a common spinal innervation. For example, the uterus and hind-gut are both innervated by the S1-S4 segmental levels and sensitisation of the nerve supply of one organ may result in visceral hyperalgesia of the other. This is known as viscero-visceral sensitisation.[5,6] Clinically, this presents as a worsening of symptoms originating from both organs. For example, patients with both gallbladder disease and coronary artery disease, structures with a shared T5 spinal cord segmental level, may experience worse symptoms of angina and cholecystitis than those with disease of one organ alone. Interestingly, treatment of one organ disorder will also improve symptoms from the other, presumably by reducing the state of central sensitisation at the shared spinal cord level.

Similarly, ongoing nociceptor input from viscera may result in viscero-somatic sensitisation of body wall structures sharing the same spinal cord level (viscero-somatic convergence). Clinically, secondary hyperalgesia may develop in abdominal wall skin and muscle. If a state of post-operative central sensitisation does not resolve, this is likely to result in chronic post-surgical pain.

Preventing chronic post-surgical pain – are we getting there?

Visceral hyperalgesia, viscero-visceral sensitisation and viscero-somatic sensitisation all occur in chronic pain states, but the clinical significance of these neuroplastic processes in the perioperative setting is uncertain. Nonetheless, it is well known that poorly controlled acute pain is a significant risk factor for the emergence of chronic post-surgical pain.[7]

There are several pharmacological approaches that may act to specifically reduce central sensitisation. These include the $\alpha 2\delta$ ligands gabapentin and pregabalin, NMDA antagonists and α_2 agonists.[8] Sub-anaesthetic infusions of ketamine have been shown to reduce the area of secondary hyperalgesia around the abdominal wounds by at least 75% for the first seven days post-operatively.[9] Intravenous ketamine has also been shown to reduce the incidence of chronic post-surgical pain following colonic resection.[10] However, such promising results have not been consistently replicated, and there are many negative trials of preventative analgesic techniques.[11]



Recently, there has been a trend for local anaesthetic infusion catheter techniques to replace epidural infusions as the gold standard for analgesia following major abdominal surgery. This change in practice may be due to increased pressure for early mobilisation and discharge with the introduction of enhanced recovery protocols, concerns about the potential serious complications of neuraxial analgesia, or cost and manpower issues.[12–14] Epidural analgesia effectively blocks autonomic fibres, including visceral afferents as well as somatic spinal nerves. Abdominal wall catheters may prevent nociceptive input from somatic structures, but they do not impact on visceral pain, which is usually managed with additional opioids. What is not yet known is the impact this may have on the prevalence of chronic post-surgical pain. However, controlled trials and clinical experience to date have shown that these techniques are effective, at least in the short term.[15]

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Professional perspectives

Targets in health care – a necessary evil?

THE BRITISH PAIN SOCIETY

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SAGE

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The Editor thanks Peter Wemyss-Gorman for his help in transcripting the lectures from the Philosophy and Ethics SIG meetings; the next three articles are transcripts of these lectures.

The ethics of funding are relevant to the ethics of care because without funding you cannot do very much caring.

History

At its inception, the National Health Service (NHS) was not only supposed to be self-funding by keeping the masses in good health and therefore full employment, but would actually generate money for the country. Clearly that was not going to be the case. When Tony Blair introduced his plan for the NHS in 2000, it was at that time being funded by about 3% of gross domestic product (GDP), but patients were waiting too long for treatment and there were unacceptable variations in care both around the country and for different patient groups. In exchange for the five Ps – *Partnership, Performance, Professionalism, Patient care and Prevention* – the NHS plan made a deal that would significantly increase funding. Expenditure that had remained at about 3% of GDP between 1974 and 2000 was increased to the European average of about 8% GDP. In 2011, with a change in government, the funding also changed and there was no further increase, and taking health care inflation into account there will actually be a reduction in funding for the next few years. So I am going to examine which of the five Ps were delivered as a result of the 2000 deal.

Targets

The increase in funding was accompanied by some imposition of targets, so that the government could ask if there had been a corresponding increase in output. Most people hate these targets. They are becoming increasingly broad, covering more and more aspects of primary, secondary and specialist care. They are becoming increasingly challenging and lacking in wriggle room. As people have become more cunning at finding ways around the targets, they have closed down all the loopholes that used to exist, like putting referral letters or admission cards in a drawer and 'forgetting' them for months.

But have these targets done any good? There are two types: *Quality improvement targets* – things like hospital-acquired infection, mortality and single-sex accommodation; and *Access time targets* – including referral-to-treatment time, delay in diagnostic imaging and delay in emergency departments. These are quantitative measures; some more qualitative assessments (although they are usually converted to numbers) have been introduced more recently, including Patient Reported Outcome Measures (PROMS) and patient and staff surveys.

Targets have undoubtedly been successful in reducing Methicillin-resistant Staphylococcus aureus (MRSA) infection. We used to accept it as inevitable but the quarterly incidence has come down from nearly 1,400 in 2007 to a stable 350 or fewer since mid-2010, and in Portsmouth we now have on average about three per quarter; so it has almost disappeared. We do not know which of the measures – hand washing, patient isolation, naked below the elbow – changed things; perhaps it was just awareness that we could do something about it. As well as benefit to patients, there have been big financial savings. There has been similar progress with *Clostridium difficile*.

There has also been a sharp drop in mixed-sex accommodation, which a lot of people feel very strongly about. But it is interesting. In primary care if you want general practitioners (GPs) to do something, you pay them with Quality and Outcomes Framework (QOF) points. They get paid for doing something right, but in secondary care we get fined if we do something wrong. We get fined £250 for every breach of the single-sex accommodation rule – and if you have a four-bedded room and you put one man in with four women you make *four* breaches of the rules and get fined £1,000. So you sort that out pretty quickly.

When we were first given targets for access to outpatients and for operations, they were separate. You were told that you had a certain number of weeks to see the patient in the outpatient department and if they needed an operation they would have to be admitted within, say, six months. So by the time the patient had been seen, sent off for a test and seen again it might have been a year before you first told them they needed an operation. Then we were told that every patient had to complete the pathway within 18 weeks from referral, regardless of how many tests were needed or how complex their problem. And this has been done – over 90% of patients are getting their treatment started in 18 weeks. Although there has been an increase in activity in diagnostic imaging from 2008 to 2012, apart from holiday times, the waiting time has remained hovering around two weeks – so we are getting a good service.

Of course, it does not cost any more to provide a timely service than one that is six months out of date. If your secretary is typing up the clinic letters the day after the clinic, it does not take any more activity than waiting six months; it is easier, more efficient and more effective to do things in a timely fashion. So, the NHS may have become more efficient, but you have to balance this against the question: *Does shorter access alter demand?*

Our accident and emergency department has been given 98% as a target for patients waiting no longer than four hours; currently about 95% of patients are seen within this limit. This is a great improvement but it may increase demand because it might be tempting to admit someone so that ED is not breached, rather than wait a little longer to be sure they are stable and send them home. The way to deal with this is to make sure that the first assessment is done as early as possible.

Real NHS expenditure has grown; targets largely have been met, mostly in ways that are of benefit to the patient rather than just to manipulate numbers; and in some ways quality has improved. The old methods of demand management involved rationing by waiting list, which was a dreadfully dishonest and inhumane way of controlling health care expenditure, in effect telling the patient that they can go private, die or decide not to have the treatment, or wait until they eventually got to the top of the waiting list. We cannot do that any more and have introduced new ways of managing demand that are more honest, even if some are still rather manipulative, such as using a body mass index (BMI) limit for orthopaedic surgery or requesting that patients stop smoking. Primary care trusts (PCTs) have introduced the categories of Procedures of Limited Clinical Value (PLCV) and Procedures not Normally Purchased (PNNP), which are becoming more common. In my patch, we do not operate on varicose veins unless the patient has an ulcer or the veins have been bleeding for at least eight years. Neither do we remove cosmetic lumps and bumps.

Mismatch of demand and funding: The dilemma

Sir David Nicholson, chief executive of the English NHS, says that we can save about £20 billion by efficiency, but there is not much evidence to support this. If in the present state of the UK economy, we carry on spending no more than 8% of GDP, it is going down with it. We can try to reduce the demand but the old methods no longer work and the 'new' methods are somewhat discredited. We are in danger of reverting to 'postcode lotteries'. We have demographics that are altering demands for health care upwards all the time. The expectations of patients and their relatives continue to increase.

Can we improve productivity? As far as elective care is concerned, planned care is pretty efficient even if patients sometimes feel that they are on a conveyor belt. In Portsmouth, 99% of elective surgical patients go home within six days; planned discharge for joint replacement and Caesarean section patients is three days. We cannot make that much more efficient.

Can we make the staff any more efficient? Can the same staff do more activity or fewer staff the same? The ratio of output to input in the NHS has in fact declined by 0.2% between 1995 and 2011. The Nicholson plans to save £20 million over the next seven years will demand a 5% improvement in this ratio. No health service in the world has achieved that sort of efficiency gain.

The future

I am anxious: we have less funding and no evidence of an efficiency gain. We have achieved a lot, but where are we going? I do think that the scheduled care at the moment wastes money. The purchaser/provider split rewarded failure in some ways: for example, in primary care, if a patient with diabetes is not managed very well and they get diabetic ketoacidosis they have to come to secondary care and we get paid for it. Obama's health care reforms involve a managed purchased year of care so there is no reward for failing; the cost of purchasing secondary care because someone has fallen through the net has to be paid for out of the same budget. The demands on secondary care from things like out-of-hours set-ups, nursing home admissions and deferred transfer of care of people who do not need to be in hospital involve too much expense.

There is a breakdown between health care, social care, welfare and employment that may seem to work completely separately but are in fact intimately related. If we can do something about integrating these rather than rewarding the secondary care financially for picking up the failures, perhaps we can get somewhere. But the NHS has not become dramatically more efficient and we are not getting a great deal more output for the amount of money that is being put in.

Points from discussion

The talk was mainly about very important improvements in service, but it asked what improvements if any had been seen in the quality of care. The focus has been mainly on service in the acute sector, but the burden of the financial demands on the health service is increasingly from chronic care, such as outpatient pain services, mental health services, care of the elderly and care in the community. Care is difficult to quantify and is probably something that needs more qualitative assessment.

A recent survey has suggested that there has been a significant drop in patients' opinions of the NHS, but contrary to impressions given by the popular press the vast majority of patients do experience pretty good care.

There is managerial resistance to redesigning the service with breakdown of barriers and better integration of primary and secondary care. There is money wasted in introducing untried and untested new technology but without disposing of the redundant technology.

There seems to have been an imbalance between administrative/managerial and clinical costs, but managers are there to facilitate what only clinicians can do and good management can actually save money. There is a need for better-paid high-quality managers. Managerial imperatives of improvement in 'productivity' may be incompatible with the need to give pain clinic patients enough time. A narrowly defined cost/throughput model of productivity is often inappropriate in the context of health care.

Secondary care can learn lessons from general practice as regards efficiency. There is a huge need for breaking down barriers between different sections of the health services, such as between doctors and allied professions. Parts of the Health Services and Social Care Act may help in this way.

The NHS cannot continue to be a free-at-the-point-of-use universal all-singing all-dancing service for the foreseeable future, and the need for rationing, especially of technology, cannot be ignored. Care must never be rationed, but we have to manage patients' expectations realistically.

Professional perspectives

Difficult Patients and the ‘Victorian Values’ Narrative

The British Pain Society
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SAGE

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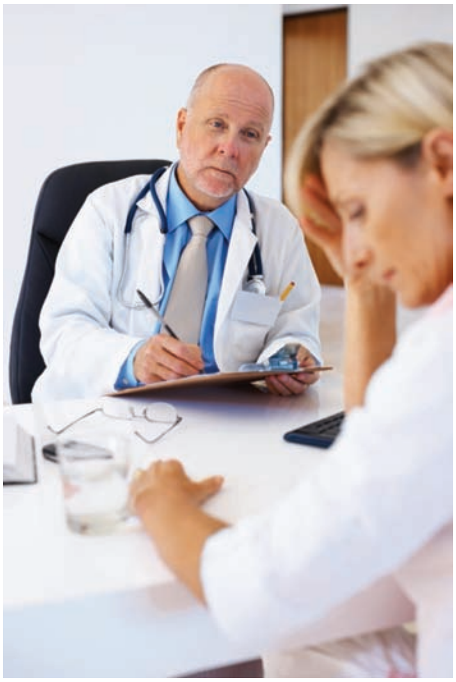
As the majority of patients in hospital experience pain, why are some patients rather than others selected to be referred to the specialist pain team? Most are of course referred simply because their pain is proving more difficult to manage than expected, but in a minority of cases it is not simply because of pain management issues, although this might have been a focus of the patient’s dissatisfaction, but because staff have found the person personally difficult to manage for some reason. When these patients are referred the staff are very careful to avoid saying “this is a difficult patient”, but they greet you with huge relief when you arrive on the ward and you meet a patient who is angry, dissatisfied, and with whom it is difficult to establish effective communication.

Although every clinician seems to know what the term ‘difficult patient’ means, there is little systematic *research* about this topic. When I undertook a literature review for my dissertation, I was only able to find thirteen relevant articles in the previous ten years. Of these, some focused on chronic pain patients’ reports of their experiences of stigmatisation (some even reporting how they had had to *become* ‘challenging’ in order to obtain the service they felt they deserved). Other papers were by clinicians trying to explain what made patients ‘difficult’, and a few attempted to look at the subject from both sides. There was however a preponderance of ‘grey’ literature: clinicians writing, usually in a judgmental fashion, about those patients who make them feel inadequate, angry, or frustrated. As far back as the 1970’s, Stockwell published a study describing how some patients were liked and some disliked by staff. A lot of the discussions about ‘*difficulty*’ are still very personally judgemental today, based on how patients act and how they make clinicians feel, and how for both those involved these conversations can develop into a negative cycle hard to escape.



When people talk about ‘difficult’ patients they can actually mean a wide variety of things: the patient may be confrontational; it may be that just as you think you’ve sorted their problem they move on to a different complaint; they keep coming back despite expressing dissatisfaction with past service; they expect priority and seem to think they are your only patient, even though it is clear there are others awaiting your attention; they get cross because they are seen late, but don’t mind keeping others waiting. Repeatedly seen in the literature are words such as ‘ungrateful’, ‘noncompliant’, ‘disobedient’, ‘dislikeable’, ‘demanding’, ‘aggressive’, ‘rude’, and even ‘smelly’. Some patients may be pigeonholed by staff by the use of labels such as ‘people on long-term benefits’, ‘drug-seeking behaviour’ and ‘compensation-seekers’.

Many of our patients with chronic pain and disability and experiencing social disadvantage are victims of such labelling: we assign them to groups that mark them out as somehow immediately knowable as a ‘type’. Despite various labels, everybody seems to understand what makes for a generically ‘difficult’ patient.

Anyone working in healthcare will know that there are many ways of handing over so that the next clinician is ‘pre-warned’ – be it only the way “Mr Bloggs in room 6 …” is said. Even before they meet Mr Bloggs people have already decided he may be ‘difficult’ and erected barriers. However we need somehow to move away from language which perpetuates negative impressions, towards a language of relationships involving genuine two-way communication and which promotes improved insight and understanding.

Victorian values

The framework for my MSc study involved examining the limited literature about 'difficult' patients in relation to theories of stigmatisation and labelling and the socio-political narrative of 'Victorian Values'. I think current debates about welfare entitlement are interesting in the light of this work, which I will discuss here.

Margaret Thatcher is the most famed modern proponent of *'Victorian Values'*: the idea that there are 'right' ways of living and behaving (hard work, independence, self-reliance, demonstrating filial duty and conventional ideas of what constitutes a 'family') and that living or behaving otherwise is by implication therefore reprehensible.

There is an ongoing narrative in the media regarding proposed changes to the disability and incapacity benefits. As a point for discussion, I feel it could be argued that, just as there are perceived to be 'deserving' and 'undeserving' poor, so we may also have developed a common understanding of who is deserving or undeserving of healthcare and welfare. Typical of recent newspaper headlines include '*Beat the Cheat*' and '*75% of Incapacity Claimants are Fit for Work*'. Media stories describe 'scroungers', 'rights and responsibilities', people who aren't 'really' disabled, how 'easy' it is to get disability benefits, and people with lots of children 'enjoying a life on 30 grand a year' etc. It is commonplace for phrases like 'scrounging families' and 'work shy' to be used. It is often implied that many people in receipt of benefits are either lying, manipulative or lazy, and are therefore undeserving, and that *most* of the people who are dependent on benefits are in some way cheating the system, 'hardworking families' and 'genuine' claimants.

So what does this mean for patients in pain? I think it would be quite astounding if the dominance of this narrative combined with pressures in the NHS and social care didn't influence us all in some way. However we have to try to ensure that we don't just dismiss those we find 'difficult' because we don't understand them and their responses or how they have got to where they are: those people you haven't been able to help, are resistant to your efforts, or are challenging or exhausting. Such action would imply we feel that somehow our failure to help is entirely *their* fault. We see many patients who have chronic illnesses and chronic pain, but many also live in complex, unhappy psychosocial worlds, which are worsened by their perception of being judged by both the general public and the many professionals they meet. As we want to help, we have to move beyond how uncomfortable such situations make us feel.

In summary, as clinicians our feelings of self-doubt and insecurity, personal affront, and threat to our own personal beliefs and boundaries, contribute to the cycle of mistrust and non-compliance and overall poor communication that constructs a 'difficult patient'. We need to practice reflection on our own actions and responses in order to deconstruct this label, and work towards discussion of and trying to resolve 'difficult *situations'*, rather than blaming individuals.

Points from Group Discussion in the meeting

It was acknowledged that the image of the 'difficult' patient covers a huge range, including every patient that makes us feel uncomfortable. Each 'difficult' patient is unique, but often this has not been acknowledged and they are treated as if they are all the same. A few actually are unpleasant, but the trouble for many seems to be that they have never had anyone prepared to listen to them and attempt to get to the bottom of their problem. People come to us, who have already been made to feel 'difficult'. When clinicians can't make people better and don't even know what the matter with them is, we can feel helpless, and blame the patient. We can sometimes work with patients to understand why they have had such a bad experience with doctors who are not used to seeing people with chronic pain.

But we have to acknowledge our own weakness and recognise that it is our own heart that sinks because we are feeling a loss of power to help. ***If you start thinking badly about a patient you need to start thinking about yourself****. But all this takes time, which may be limited, and training*.

We also discussed the economic pressures which drive patients to behave in a 'difficult' fashion, including the ATOS assessment procedure which may deprive them of benefits, and the potential for reverse incentives for people in poverty with health issues in times of high unemployment and low wages, when being recognised as disabled may seem to be the only way of protecting a limited income.

Jumbulance and the Ethics of Care

THE BRITISH PAIN SOCIETY
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SAGE

Chris Chisholm, *The Jumbulance Trust*

The Jumbulance Trust is a small national charity dedicated to taking people on holiday who would otherwise be prevented by serious illness or disability… known to us as VIPs. Apart from the drivers and a part-time secretary, it is run entirely by volunteers. We have affiliated self-funded groups throughout the UK; I now organise the Hampshire group, and we run four holidays a year. Other groups only run one holiday a year, and some are specifically for disabled children or parents and their disabled children. My background is in palliative care and about a third of our clients have palliative care needs, but over the years there has been an increasingly large group of long-term disabled people, with long-term conditions like MS, cerebral palsy and polio who have got to the stage when they have enormous care needs and nobody else will take them on holiday. They enjoy it so much they want to come again and again so we have had to increase the number of groups and we have to accommodate the increased repeat bookings. Referrals come from GP's, district nurses and social workers, and people do self-refer.

We have three Jumbulances (part coach part ambulance) equipped with platform lifts and a floor that is completely flat. On one side there is a row of seats which have leg-rests and more room than normal and on the other there are beds which can be taken out at our destination (we go all over Europe) and replaced by wheelchairs instead for days out. We only take 20 or 22, so we have a lot of space. There is a kitchen and a disabled loo which is big enough for three people so there is room for two assistants. There is resuscitation equipment by each bed with oxygen and electrical points for nebulisers ventilators etc. We offer 24-hour care, given by volunteers including nurses, doctors, physios, OT's and lot of helpers who have no professional caring background but give excellent social care. Although caring is the domain of women, we do get a lot of men applying; We need male carers as we pair up our clients and our volunteers one-to one, men with men and women with women; VIPs who need a nurse are paired with one but if you need less care, you are paired with a helper and the nurse will go in only when needed.

Ethical dilemmas

Some groups only want to take people from their own area where they have fund-raised, but in Berkshire and Hampshire, we will take VIPs from elsewhere (the Jumbulances are based in the North and if necessary, we can send a nurse to accompany them). Sadly there is a lot of disparity of provision throughout the country: there are lots of groups in the south but only one group in Wales and nothing north of South Yorkshire. Last year, we did a fund-raising 12 day coast-to-coast walk and whilst the sponsored walkers walked, we took a Jumbulance to demonstrate what we had to offer, and visited hospices and schools across the country. Earlier this year I followed this by taking a Jumbulance to an international conference on palliative care in Gateshead and then a tour of hospices in the north of England. Sometimes, we are blocked from ever meeting the people who most need a holiday; one Cheshire home didn't even want me to come to talk to them as they said their patients weren't interested – so people are denied the opportunity even to learn about us. After the northern tour, not one hospice or organisation has come back to us. Sometimes people will say "*we want our council to organise this*" or "*why don't the health authority offer this*?" – Well, they are not going to, that is the reality! We rely on volunteers and it is very difficult to get things going in the north of England.

I find it very frustrating that when I go out every spring to give talks to patient

groups, social workers and even medical students - a mixture of recruiting and trying to find new potential clients who don't know about us - to hear again and again, that the day centre for the long term disabled or the hospice day centre is closing or has been closed, or the respite budget has been stopped. People who live on their own are deemed not to need respite because there is nobody caring for them. We enable someone looking after an aged relative or a young person needing a lot of care to go on holiday themselves without feeling guilty and this is a win-win situation for everyone.

A lot of disabled or sick people say "*I'd love to go but I haven't any money*". Whenever possible I go and see them at home to assess their care needs, and if they say they can't afford it, I can look for funding. There can be difficulty in getting help for older people: everybody wants to give money for children or hospice groups but it is sometimes difficult to get funding for long-term disabled older people who desperately need what we can give. We have never failed getting help but it is getting harder. The funding organisations tell me that whereas they had an enormous pot and were getting lots of interest on it, that the available funds have diminished; whereas they were giving out £60,000 grants per quarter they now only have £6,000 to give away. But it's not too difficult to find money if you know where to look. There are some very generous people who help our charity. They say "*if you need some money, Chris, just let us know*" - nobody else knows who they are, and I can always rely on them. We are very lucky – there are people who can afford to do that but I appreciate that isn't always so elsewhere in the UK.

People have to give me their trust and we have to trust them, which may be difficult if people aren't completely honest, for instance about their weight: there is a maximum of 20 stone imposed by the platform lift, which has to accommodate the wheelchair and the driver as well as the patient.

I nearly left Jumbulance in the 90's over the issue of AIDS: the Across Trust who were then running the Jumbulances refused to take a gentleman with AIDS on a pilgrimage to Lourdes although there were places available. I was so angry – I had the distressing task of telling him why he couldn't go. I pointed out to the Across Trust that they only knew the HIV status of people who were honest enough to tell them and in any case it wasn't an issue as although we don't wear uniforms, we are professional nurses and use universal precautions when we deal with body fluids. Shortly after that the Across Trust went bankrupt! I became a trustee of the new trust and we now take people who are HIV positive.

Our volunteers

We have to match up the VIPs with appropriate volunteers; these include every kind of nurse – District nurses, Palliative care nurses and Cheshire Home nurses are particularly good with people with long-term disabilities. The doctors who come are all GP's and palliative care doctors. We try to give lots of opportunities: we subsidise young people under 25 including medical students and nurses, but also disadvantaged young people from the community who may not have the opportunity to travel. We are sometimes asked to take people with learning difficulties or even mental health problems, who may be sponsored by a Rotary Club or a church. This is asking quite a lot of the group leader as they are likely to need a lot of support themselves. We took a young man with drug and alcohol problems, who said he couldn't stay up late or get up early to help because of his medication…these are busy times in our day. We put up with this for a couple of days and then my daughter who is an OT in forensic rehabilitation took him in hand and within 24 hours, he had knuckled down and was doing everything! It was wonderful to watch him blossom into a carer – something previously quite foreign to him. He gained in confidence and has already signed up for another trip next year.

Making a difference

We never use the word 'patient' and refer to all our clients as VIP's. Some of our long-term VIP's are heavy on care, or heavy emotionally to be with. We have one lady who can only move one hand and lies in her room for 350 days a year and has eight days with us, when she actually gets out and does something. Some people are in bed for 22 hours out of 24, and we have to replicate that level of care. But we make sure they can get in a wheelchair to socialise at dinner, go to a theatre or the pub or even go up Snowdon or on a lake in the Italian Tyrol. It will exhaust them but if they want to do it we make sure they do it.

A lot of our VIP's feel they don't belong, that they are the victims of prejudice and that the system has let them down. When they are referred to us they are very much at the end of the road. But after the trip many of them say it's enabled them to get back a sense of fun, that they had forgotten what it was like to feel joyful, that they feel alive again, and that they belong again. This can't be measured and it's something very difficult to get across to people when you apply for funding. Some will say that when we first met them in the hospice they were very near to giving up, but *we have opened a door*. And that's what we try to do – to open doors for people who have lost most of the choices in life. They feel it's all over and we say "*no, it isn't!*" It's not just about the holiday, they need people who will go on supporting them, and often new friendships continue afterwards. Once a year, we have a reunion lunch.

The VIP's get a lot out of these holidays but the helpers get just as much. It can be life changing for both. In our discussion, a GP volunteer described how much he had learned from the experience of being with a VIP for a whole week compared with the brief encounter he normally had with his patients – and how he had never believed it is possible to be so happy and laugh so much in such a situation! He also noted that people on high dose opiates didn't seem to mind missing doses - "they don't seem to have time to have pain"!

The description of Jumbulance holidays resonated with experience of Lourdes, where the pilgrims, very sick people, are treated as if they are very special – the most important people there - which never happens in the rest of their lives.

This was described as 'assisted living' (in contrast to assisted dying which we were due to discuss later in the conference). There were anecdotes of people who had seriously considered availing themselves of Dignitas but for whom the experience of a holiday, with renewed hope and choice, had banished all such thoughts.

For more details, please visit www.jumbulance.org.uk

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

Informing change

Phantom limb pain after spinal anaesthesia

The British Pain Society

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SAGE

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We would like to report a case of phantom limb pain (PLP) recurring after spinal anaesthesia in a patient with previous lower-limb amputation. This phenomenon was first reported by Moore in 1946[1] and has been reported since. There is controversy among authors: some have concluded spinal anaesthetic to be a contraindication to amputees as it is quite an awful experience and impossible to treat, while others consider the pain to be transient and a rare phenomenon.

Case report

A 72-year-old, 80 kg, male patient, a retired builder, was scheduled for left femoral end arterectomy. Relevant points in his medical history included non-insulin dependent diabetes mellitus for six years with HbA1c of 7.6, and mild background diabetic retinopathy. He had hyper-cholesterolaemia, moderate left ventricular impairment due to ischaemic myopathy and his exercise tolerance was limited by claudication distance of about 50 yards before he developed constant rest pain in the previous two weeks. He had smoked for more than 30 years before stopping two years previously and there were radiological features consistent with mild chronic obstructive pulmonary disease. His drug history includes gliclazide 80mg bd and metformin 500 mg bd, simvastatin 40 mg OD, aspirin 75 mg and amitriptyline 25 mg OD. His past surgical history included right femoral end arterectomy and femoro-popliteal bypass graft in May 2001 under general anaesthesia (GA). He had had a fem-femoral cross-over graft in September 2001 again under GA and epidural. The graft subsequently failed and he ended up one month later with a below-knee amputation under GA and epidural. He developed mild PLP, which did not require treatment, and he underwent uneventful right above-knee amputation under spinal anaesthesia in January 2002 due to a non-healing ischaemic ulcer on the stump. He had experienced very little pain from his amputation.

In the pre-operative visit, the anaesthetic was discussed with the patient and the choice of spinal anaesthetic was made. Intravenous (IV) infusion dextrose 5% and IV insulin sliding scale was started in the morning of surgery. In the anaesthetic room, IV infusion of normal saline solution was commenced and baseline non-invasive arterial blood pressure, electrocardiogram and haemoglobin saturation monitoring were recorded. The spinal anaesthetic was introduced with 24 G Sprott needle at the L3-4 interspace using 3.5 ml of bupivacaine in 5% dextrose in the sitting position. Loss of temperature sensation was quickly elicited up to T6. However, on the way to the operating room the patient started to complain of severe PLP, which was described as a nail through the big toe, coming every two minutes and lasting for one minute. The pain persisted for 20 minutes before it subsided, after which the operation was completed. The patient stayed in recovery for 20 minutes before he returned to the ward completely free of pain. He stayed in hospital for five days with no record of any further PLP.

Discussion

The incidence of PLP after spinal anaesthesia is unknown. One study of 17 patients[2] with previous lower-limb amputation who underwent spinal anaesthesia estimated the incidence to be less than 5%. Most amputees report awareness of and sensation referred to the missing body part. Painless phantom limb sensation occurs commonly in normal patients during spinal anaesthesia, lasting only for the motor and proprioceptive blockade, and does not require any treatment except psychotherapy, supplemented if needed by tranquillisers.[3] PLP may occur during the onset or regression of the block and has been reported in patients who have been symptom free for as long as 40 years. The exact pathophysiology behind this bizarre phenomenon is poorly understood. In general, it is believed that PLP is initiated by changes arising in the periphery that alter the afferent input that the central nervous system receives, leading to central reorganisation.

Three mechanisms are postulated:

Peripheral: spontaneous ectopic discharge from afferent nerve in the amputation site and the dorsal nerve root ganglion (linked to up-regulation of voltage-gated sodium channels).

Spinal cord: the myelinated Aβ-fibres normally involved in touch, pressure and proprioception sprout connections from lamina 3 and 4, where they normally synapse, into lamina 1 and 2, which is normally occupied by unmyelinated C-fibres. This results in previously non-painful stimuli experienced as painful. In addition, a state of hyper-excitability resulting from central sensitisation of the dorsal horn cells, occurs in response to an increased barrage of painful stimuli from the amputation site, leading to development of hyperalgesia. Excitatory amino acids such as glutamic and aspartic acids may be involved, as well as calcitonin gene-related peptide and substance P.

Supraspinal: loss of afferent segmental input to the brain stem mechanism normally exerting an inhibitory influence on the sensory transmission, which may allow upward transmission of abnormal neural activity. The cortical remapping process (sensory information) from different areas of the body synapse at adjacent areas in the somatosensory cortex.[4]

A range of treatments has appeared in the literature but they lack evidence to support their efficacy and performing well-designed study is difficult in this condition. Tessler[2] claimed midazolam to be effective in reducing PLP. Mackenzie[8] reported a patient who did not respond to diazepam but was comfortable enough for surgery after 20 minutes. Koyama[9] found a sub-anaesthetic dose of thiopental to be effective in treating PLP. Fiddller[10] reported immediate relief of PLP after IV 100 IU Calcitonin. Sellick used transcutaneous electrical nerve stimulation after postponing surgery. Some authors[5–8] have concluded that a history of lower-limb amputation should be considered as a contraindication to spinal anaesthesia as it is excruciating and almost impossible to treat, while others have concluded that it is infrequent[2], transient[2,10] and treatable.[2,9,10]

PLP after spinal anaesthesia is a rare condition but it can happen and there is no approved guideline for its treatment. It is time to think of an agreed approach to this condition.

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Informing change

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SAGE

A case for Guinness book of records?

Bilateral hip replacement surgery “Dr Salem’s personal experience”

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Joint replacement surgery is for pain relief, improvement of joint stability and mobility. Careful pre operative assessment, peri operative anaesthetic management and adequate post operative pain relief technique can enhance success rates and prevent complications. Dr Salem was scheduled for bilateral hip replacement surgery due to degenerative osteoarthritis. Pre operatively he was involved in strenuous physical exercise with a high level of fitness.

Anaesthetic technique comprised of subarachnoid block with local anaesthetic and diamorphine in combination with general anaesthetic; periarticular infiltration of local anaesthetic (Chirocaine 20mls of 2.5mg/ml) was provided for analgesia of the area of surgical trauma.

Paracetamol 1G I.V QDS and diclofenac 50mg orally TDS were prescribed for post op pain relief. Pain was assessed using VAS of scale 10. For the first four post operative days the score was 0 – 1. Mobility commenced on day one post operatively for four days and was aided.

Discharge home was on the fourth day and physical exercise was encouraged. Full mobility with minimal support was achieved by day nine. Normal mobility and activity was resumed after three weeks, returning to work by the fourth week.

Conclusion:

It appears pre operative physical exercise helped reduce length of hospital stay, reduce post operative complications and enhanced recovery.

I would like to ask your readers if they have similar successful outcomes to Dr Salem’s experience after bilateral hip replacement surgery or could this be a case for Guinness book of records?

Further reading:

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Informing change

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Does the internet present a useful and accessible source for chronic pain sufferers?

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In a recent Pain News article, Dr Charles Pither highlighted a roadblock in developing the online pain management programme "Pathway through Pain". He wrote *"…naysayers immediately came up with a number of problems and pitfalls, mostly related to the percentage of patients with access to the internet who would have the necessary skills to negotiate their way around such a package…"*; an argument that, as a former media developer, I've heard more times than I care to imagine, but is it really a current concern? When the internet was in its infancy, and only usable by the tech-savvy this obstacle was definitely real, but in the highly user-friendly, technology-centred world of 2013, is this still the case? Do those suffering from long-term pain have the skills and the technology to access health information online and, just as important, do they have any interest in doing so?

The internet is constantly expanding, and the amount of people using it increases every year, but to gain some understanding of its importance to people with chronic pain, we need to consider whether or not these individuals are likely to have internet connections. On top of this, there has to be interest – even if everyone had an internet connection, if none were willing to use it to search for health information, those naysayers may be right. Not only this, but as the internet expands, the skills needed to use it are constantly changing. Because of this, it's important to assess whether people with chronic pain have these skills.

Access

In order for the internet to be a viable platform for pain-related information, there would have to be sufficient people with access to an internet connection. Whilst calculating the exact numbers would be near to impossible, we can look at the current spread of internet access across Britain. According to the Office for National Statistics, in 2012 around 80% of households had internet access, the vast majority of which were fast, dedicated lines. It is important to remember that "landline" connections aren't the only method of surfing the net anymore. With the mobile technology boom in the mid to late "noughties", the internet suddenly became available on smaller devices, such as tablets and smartphones. In late 2011, OFCOM reported that the amount of adults (over the age of 18) with an internet-ready "smartphone" was at 27%. Many people may not have an internet-ready mobile device or a home internet connection for many reasons (such as finance, interest or perceived usefulness), however this still doesn't mean internet access is beyond their reach. Many local libraries now have bookable PCs with internet access, so that people who do not have home internet connections are able to access the wealth of knowledge that the internet provides.

Interest

Since its initial development, the use of the internet has commonly been associated with the "computer whizz" and, more recently, with younger people. The average attendee on a team-led pain management programme is around 51 years old, which would suggest that, were this stereotype true, internet-based health information may not interest our target audience. Recent findings by the Office for National Statistics, however, prove that this definitely is not the case. According to data collected at the end of 2012, whilst internet use does show some decline as age increases, a staggering 92% of individuals within the 45-54 age-bracket had "surfed", with 97% reporting going online recently (within the previous 3 months). The same report indicates that almost two thirds (64%) of adults over the age of 55 had used the internet, 98% of whom had gone online in the last 3 months.

Just because people use the internet, does it necessarily mean that they would use it to find out more about their health? A study conducted in U.S. reported that, between January and June 2009, 51% of adults had used the internet to research health information, and that women were more likely to do so than men. In Britain alone, research in 2010 indicated that 65% of people asked were more likely to search the web for healthcare-related information than consult with their GP. Existing advice on chronic pain management is already a popular search term; the Pain Toolkit website (www.paintoolkit.org) offers advice and support to those suffering from chronic pain, and receives around 10,000 hits per day.

Ability

As mentioned earlier, the internet is often seen as the domain of the young – those born into a world where you can hardly move for twitter tags or pop-ups, but that by no means suggests that your average 50-year-old is clueless when it comes to navigating the World Wide Web. Gauging the skill with which people can use the internet can be tricky as any objective measure of "surfing skill" would be influenced by too many other factors to have any real meaning, however the skills needed to run specific searches are common place and, even if people have no experience with "Googling", if they have the desire to, there are many different ways that they can overcome this lack of experience.

For those with absolutely no experience of the internet, they may well find not just internet access, but also training at their local library. Not only do county and city councils offer free internet access in libraries, but many also offer free individual assistance to those individuals who either have limited experience browsing, or are struggling to find the information they are looking for. For example, within Gloucestershire, there are 18 libraries offering a volunteer-run "internet buddy" scheme, removing another barrier between chronic pain sufferers, and access to health-related information. Once people are up-and-running on the Web, accessing information about healthcare and their specific conditions is simple, thanks to numerous user-friendly sites created specifically for these purposes. As part of their "Webwise" site (www.bbc.co.uk/webwise/), the BBC offer comprehensive, printable guides on how to handle all basic aspects of the web, from searching for information to setting up your own site.

In conclusion, there is a vast amount of information on the internet, and it is very important that patients who wish to utilise this are directed to reliable resources, and that those who don't have access to the internet but wish to learn more are signposted to the services and facilities designed to help them get online. No medium will ever appeal to all individuals – many will not pick up patient information leaflets supplied by hospitals, many will not ask their GP or consultant questions that they really want to know the answers to. The internet is one of the largest media of healthcare information, and gives patients the opportunity to access information both anonymously and discreetly. We will always need different ways to give people information, but with the sheer amount of information available, the internet should be at the heart of any strategy.

From this, we can see that there is definitely the need for a solid, accurate online presence for health information regarding chronic pain. With more people than ever accessing the vast wealth of knowledge that the internet provides, it is important that sufficient accurate information is available. On one search engine alone, the current estimate for hits on the search "chronic pain" is 54.9 million pages and, as we have seen from the Pain Toolkit site, some of these pages receive around 10,000 hits per day. When looking at the availability of internet access and training in how to use it, combined with the current demand for health-related information (especially in the management and treatment for chronic conditions), the internet is no longer a medium which can be overlooked for chronic pain information.

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SAGE

Painful Bladder Syndrome by Philip Weeks, Singing Dragon 2012, ISBN 9781848191105

Reviewed by
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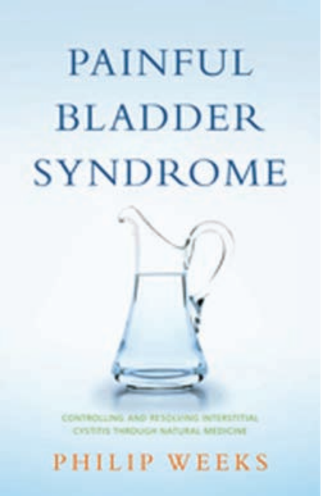
'Painful Bladder Syndrome' (PBS) has a very readable style, is well set out, with a clear, logical progression through the chapters and is practical. Surprising to me was the author's choice of language, using metaphors of 'war' and 'weapons' (from natural medicine) against 'chronic inflammation' instead perhaps of soothing or healing, but maybe this reflects my own prejudices. Unfortunately Weeks repeatedly calls a chronically painful bladder 'inflamed', 'damaged' and 'injured', intensifying the myth that it is and that all of orthodox medicine doesn't know why people have a painful bladder or that it must represent a chronic inflammation and/or autoimmune condition. The book would really benefit from a simple explanation of chronic pain mechanisms. It has good descriptions of symptoms and although the author says he doesn't want to go into lots of medical 'jargon', he does in parts, such as to explain the anatomy and function of kidney and bladder, which is useful. There are also easy to understand descriptions of urological tests and diagnoses and a sound section on preventing urinary tract infections and the problems with taking repeated antibiotics, with alternatives.

More challenging for the holistic pain doctor than the chapter on the elusive 'adaptogens', is Chapter 4 which 'explains' the causes of PBS. This is because Weeks mixes in good material with his own potential theory on how people develop PBS. He correctly identifies links with the gut, but doesn't know or mention the mechanism of viscero-visceral hyperalgesia. He then launches into his theory of the aetiology which has some facts mixed in (e.g. about yeast overgrowth) so it is all very plausible which leads the reader to the fact that he or she must have a 'leaky gut' as well as a 'leaky bladder'. Paraphrasing for you to illustrate -'bad bacteria are allowed to run riot' due to all the 'damage' putting the 'liver, kidneys, bladder and other organs under pressure'. I'm not sure how the reader will feel learning this; all the possible effects on all the body systems are quite terrifying, and may, I suggest, not be helpful for the patient prone to catastrophising. Paternalistically I think it might have been better if he had stuck to remedies which seem easy to try, and could help, with minimal risk. He has particularly strong opinions about mercury amalgams and other aspects of dentistry, which I confess to knowing nothing about, except that one of my patients told me a year ago that they felt better after having them removed. A personal survey of dentist colleagues (with mercury amalgams in situ) and PubMed suggests that the issue is perhaps not as imminently dangerous as the author would have us believe.

Weeks covers many subjects to show how interconnected our systems are. The material on stress is particularly relevant but there is a tendency to expand into areas which readers may pick up on, but I'm not sure adding value. For example there is box on Caesarean section and non-breast feeding which whilst explaining how important gut flora are, also condemns those not born naturally to a life of leaky gut problems unless probiotics are taken. This is written without balancing by perhaps saying that Caesarean section can save lives, or that not every one is affected (I wouldn't know). There are times on the other hand that I found Weeks' approach too narrow, such as describing how stress can be held in the psoas muscle, but missing out that it can be held in so many other muscle groups, such as the shoulders, buttocks or pelvic floor, which are particularly important in this pain syndrome.



It was interesting to read of the various herbal remedies, which are presented without an evidence base. So much like many treatments in chronic pain then, except that I would not claim that anything I prescribed had 'a strong rejuvinative effect' on any organ, or that 'ghee…increases longevity' unless this had been demonstrated with scientific rigor. I do believe in the validity of the trial on an individual however, so think seeing a qualified herbalist as recommended is sensible, as is the approach to exclusion i.e. biggest offenders first - gluten, sugars, fruit juices, caffeine, alcohol etc, and taking probiotics. Confounding factors seem less considered by the author which left me with questions like 'If I take an Epsom salt bath, how much magnesium will actually be absorbed?' Maybe Diana's migraine cure was just as much in taking the relaxing baths than the salts she put in them and so on.

There are chapters on flare ups, acupuncture and Weeks' seven point protocol is straightforward. The book is sporadically referenced, missing some important evidenced based guidelines e.g. from the European Association of Urology on chronic pain and many statements are unreferenced and potentially alarmist.

Overall I think this book suffers from the same fate as many patients who have PBS – neither has encountered multidisciplinary pain services that might assist in a difficult to manage pain syndrome. For instance there is a lack of explanation and inadequate description of the use of amitriptyline ('prevents pain from travelling between the spinal cord and the brain'). There is no mention of any other neuropathic analgesics and he stops short of saying that the long term benefits of intravesical treatments are not proven. I'm left feeling I'd like to talk to Weeks to see how we could learn from each other. For my patients I might tell them to try the exclusions and techniques but to consume the pseudoscience with a pinch of chronic pain mechanisms salt.

Despite my criticisms, this book is complimentary to what a holistic pain service committed to self management would promote, and I believe people deciding for themselves to make their life healthier on reading it, will be more successful than health professionals suggesting they identify triggers and that a regular routine, eating, sleeping and exercising well plus reducing stress will improve their pain. So go forth and attack naturally!

Book reviews

The Mystery of Pain, Douglas Nelson
Jessica Kingsley Publishers, ISBN 978 1 848191525

Reviewed by
Austin Leach

This is an ambitious book that, while it makes a number of points extremely well, falls short of the mark in other areas.

The first consideration is: "who is this book for?"

Although it is broadly accurate scientifically, most of the explanations are too simplistic for the practising pain clinician, who should already have an understanding of the phenomena and mechanisms described. It is interesting reading about someone else's take on what we already know, but if no new knowledge is imparted it is not a particularly rewarding experience.

It is too technical for the lay reader who has no knowledge of neurological processes or psychology, so as a guide for patients with painful conditions who seek enlightenment, I would only recommend it if there is some previous, and reasonably in-depth, knowledge of brain biology and anatomy.

There may be healthcare professionals who do have some basic understanding of neurological processes, how humans behave in adverse situations and exposure to the type of patient who suffers from a painful condition who will gain some new insights into how we think pain "works". I suppose it is towards these individuals that this book should be directed.

Medical students on a pain medicine attachment, or who have a basic knowledge of neurology and who wish to improve their understanding of pain might enjoy Mr Nelson's approach.

It is written in a distinctly North American upbeat style which may grate on some European sensibilities; others may find the optimistic tone agreeable and easy to read. There is some criticism of the way healthcare professionals may interact with patients in pain. While this may be a fair point, and there are numerous examples of badly behaving doctors, nurses, and other therapists, I hope it wouldn't encourage the lay reader to adopt an adversarial approach when dealing with healthcare providers.

The reader is left in no doubt as to the complexity and the elusive nature of pain. Some chapters are more informative than others: the chapters on placebo and phantom limb pain were well-researched and coherently written with admirable brevity. Others are more speculative – the rather lengthier chapter on fibromyalgia made some good points but I suspect the author spends much of his time treating fibromyalgia and thus seemed inclined to wax a little more lyrical on the topic.

The earlier chapters in the book attempt to rationalise pain as nociception with some important ‘bolt-on’ goodies. This is a conventional view of how the human experience of pain developed (in evolutionary terms) but the weaknesses in this model (we still don’t know why humans have consciousness, are capable of abstract thought and appreciation of aesthetics) are also exposed.

There are some truly clunky bits of prose. Chapter 8, talking about the role of the amygdala and fear in pain perception, refers to noradrenaline as “the brain’s adrenaline”. Given the detailed neuroanatomy and behaviour descriptions elsewhere, the same attention to detail in sections such as this would have improved the book overall.

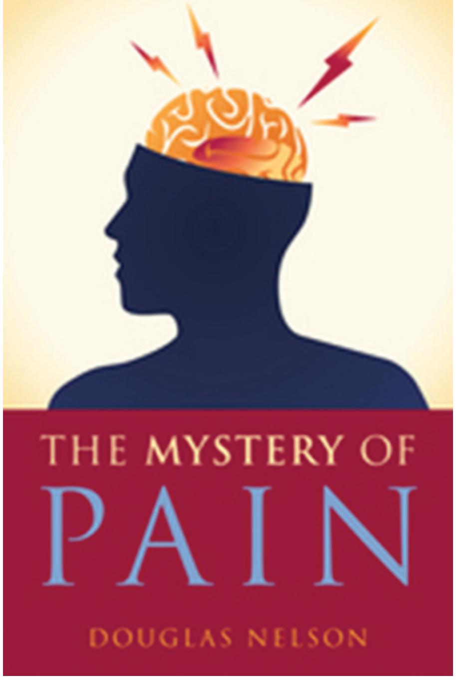
I am a pain physician, and while I enjoyed reading parts of this book, I didn’t learn anything new, nor did I gain any new insight into mechanisms or treatments that I had previously struggled to understand. However, I do not wish to judge Mr Nelson’s book unfairly, and I think the people who are most likely to gain from reading it are interested healthcare professionals who have read some basic science texts, and have a pre-existing understanding of pain and pain mechanisms but found them rather heavy going. I feel that patients with little understanding of the science involved would be rather at sea, and the book presupposes a level of knowledge and insight that only a well-educated patient might be expected to have.

I was somewhat perturbed to read on the back cover that among the target audience are “alternative medicine practitioners and massage therapists”. In the UK’s National Health Service we are encouraged to practice evidence-based medicine, which tends to exclude input from such individuals, simply because there is little or no evidence to support what they do.

I suspect that Mr Nelson is a skilled and experienced practitioner who has treated many patients with pain. I commend him for the concluding words in his volume, which any budding pain practitioner would do well to follow:

“Good providers listen and observe carefully, withhold initial judgement and enlist the patient’s involvement in the treatment possibilities. As a result the patient feels heard (sic) and validated in the process. That alone is powerful medicine”

Seven out of ten



Reviewed by
Colin D. Preece

The central theme running through this book is that greater understanding of pain, results in increased power to affect it in a positive manner. The book attempts to cover a vast area in its relatively small size. Chapters cover areas such as: Pain definition, measurement, sensitization, meaning, fear, placebos, phantom limb pain and fibromyalgia.

A book of this type often runs the risk of being a ‘halfway house’ failing to contain sufficient detail for the expert and yet being over complicated with research findings to engage a less specialist reader. The author himself identifies this difficulty referring to it as a ‘struggle’ between ‘complexity and oversimplification’ (p10). I am uncertain if the final balance in this book is a perfect one. I enjoyed many of the analogies given, which the author has clearly drawn from his own extensive practice in America. However I found the use of past research findings in the text insufficient in detail. This resulted in me wanting to find out more, to gain further detail and situational relevance.

Perhaps this is what the author ultimately wants; to encourage the readers to explore further and to increase their own understanding of pain?

I am sure that the book will appeal to many readers but the majority, I feel, will come from the less specialised audience. I hope that, like myself, the book will motivate the reader to research further.

The Mystery of Pain *by Douglas Nelson is published by Singing Dragon (RRP £ 15.99, ISBN: 9781848191525). Copies can be bought with a special discount of 20%, and free Postage & Packing, by visiting http://www.singingdragon.com/, or calling +44 (0)20 7833 2307 and quoting the code* **NELBPS**. *Offer is valid for 6 months*.

The British Pain Society

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SAGE

Website review

Sheffield Aches and Pains website

http://www.sheffieldachesandpains.com/

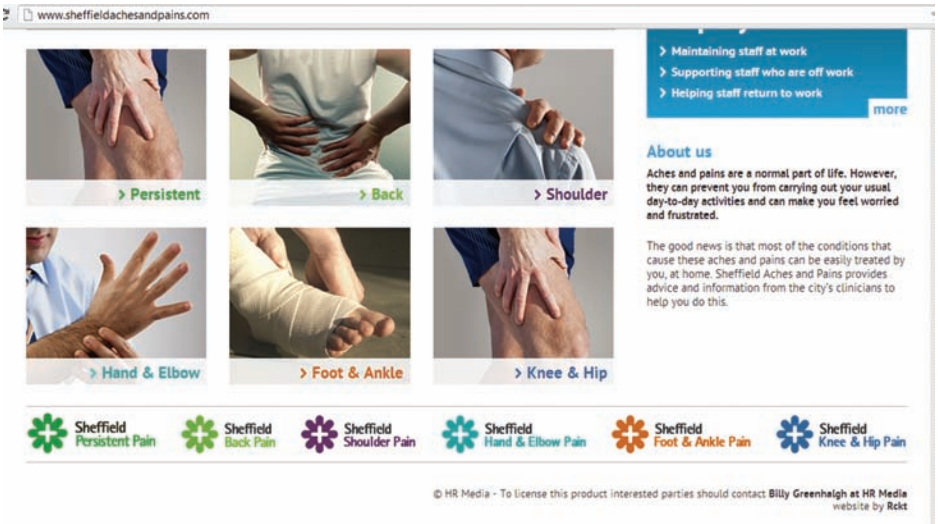
By Liz killick, Patient Member, Patient Liaison Committee

This new website has been put together by Sheffield hospital consultants, GPs, physiotherapists and clinicians with a special interest in managing musculoskeletal pain. It provides their agreed approach to managing patients in the city with common conditions affecting the joints, muscles and surrounding tissue. It takes into account the latest national and international best practice guidelines on pain management.

It is intended to be used in conjunction with advice given by GP's, physiotherapists or specialists.

It aims to be '*a one-stop advice site for people in Sheffield to find out about musculoskeletal pain, how they can manage it and what they can do to prevent further problems*'.

The site has a simple layout, uses plain English, and straightforward advice is clearly presented.



About us

Aches and pains are a normal part of life. However, they can prevent you from carrying out your usual day-to-day activities and can make you feel worried and frustrated.

The good news is that most of the conditions that cause these aches and pains can be easily treated by you, at home. Sheffield Aches and Pains provides advice and information from the city's clinicians to help you do this.

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website by **Rckt**

A section on Advice for Employers covers maintaining employees at work, supporting absent staff, helping staff return and providing fit notes. This would also be helpful for employees who need to negotiate with employers about managing incidents of pain.

The section on General Health Advice focuses on diet, pain management and chronic pain.

The website includes individual sections giving advice on managing pain in specific areas of the body - shoulder, back, hand and elbow, foot and ankle, knee and hip. There are explanations of the types of pain, advice for managing pain and tips on how to avoid provoking pain.

The most extensive section is on persistent - or chronic – pain. It is well constructed and comprehensive. An eye-catching circular graphic illustrates the cycle of pain, which captures well the need for patients to address chronic pain issues on a number of fronts. Each separate aspect of managing pain is explored, and users can access well-chosen links for further advice.

I particularly liked the short interviews with people who were learning, or had learned, that their normal coping skills as a well person were leading to anguish and increased pain. They reflected on their success once they had mastered pain management techniques. As a chronic pain sufferer, I found these injected a powerful human element.

I guess that my reservation is that in an era of cuts and financial restraint, patients with chronic pain may be directed to this website as a route for understanding their condition - and it certainly provides excellent resources to do this. But as a patient who was fortunate to attend a residential pain management programme, the contact with other patients who had had similar experiences was a vital part of the healing process. The shared knowledge of chronic pain as a daily experience was a powerful complement to the tools we learned to manage the condition which, by its nature, tends to isolate sufferers. I hope, therefore, that it will be used as intended, as a complement to, rather than a replacement for, personalised treatment and advice.

I really liked this website, and would recommend it to anyone who is living with pain. It is ambitious in its concept, and I feel it has succeeded in its aims of delivering a large amount of information in a well structured and clear way.

New Members

THE BRITISH PAIN SOCIETY

Pain News
11(2) 127–128

SAGE

Ratified at the April 2013 Council Meeting

Name	Position	Institution
Miss Muna Adan Hag Hersi	PHD Student, Social Research in Medicine	University of Nottingham
Dr Rajesh Aggarwal	ST6 Anaesthetics	St. Thomas' Hospital
Dr Angies Alamgir	Lead Pain Psychologist	Mile End Hospital
Mr Hamza Alshuft	PhD Student	Nottingham University Hospital
Dr Madhu Balasa	Pain Fellow	James Cook University Hospital
Mr David Barrett	COO & Managing Director	White Pharmacy Ltd
Mr Alenjandro Barroso	Clinical Research Fellow	Imperial College
Mrs Wendy Geinor Bean	Lecturer Msc Pain Management	University of Wales
Mrs Jackie Beck	Pain Management Nurse	Lister Hospital
Mrs Heather Margaret Buckley	Chronic Pain Specialist Nurse	Worcestershire Royal Hospital
Dr Janet Bultitude	Junior Research Fellow	John Radcliffe Hospital
Mrs Jane Louise Bushby	Clinical Nurse Specialist	East and North Hertfordshire NHS Trust
Miss Felicity Joanna Erica Carter	Student Bsc (Hons) Biomedical	University of Plymouth
Dr Bret Claxton	Consultant in Anaesthesia & Pain Management	Bradford Royal Infirmary
Dr Enrique Collantes Celadom	ST4	Royal London
Miss Pippa Collins	Senior Physiotherapist (Also an intern on the Clinical Academic Training Pathway for AHP)	Poole Hospital NHS Trust
Mr Craig Kevin Crawley	Clinical Specialist Physiotherapist 8A	West Middlesex University Hospital
Dr Katrina Dick	ST5 Anaesthetics	NHS Lanarkshire
Dr Kirsten Fehrmann	ST7, Anaesthesia	University Hospital Aintree
Dr Alireza Feizerfan	Consultant in Anaesthesia	Walsgrave General Hospital
Dr Jon Albert Gjerlow	Consultant in Anaesthesia	Norway National Health Service
Dr Juan Graterol	Specialty Registrar 7, Anaesthetist	Cheltenham General Hospital
Dr Pradeepa Gunawardane	Consultant Anaesthetist	Nottingham City Hospital NHS Trust

Name	Position	Institution
Dr Lis Dreijer Hammond	Counselling Psychologist (B7) - Part Time	University Hospital of North Durham
Miss Lee Harrison	PhD Student	Bristol University
Mr Robin Hunt	Psychology placement student, Pain Management	Gloucestershire Royal Hospital
Mr Ashish Khiloshiya	Clinical Lead, Chronic Pain	Staffordshire & Stoke -on-Trent Partnership Trust
Dr Jeena Binu Mathew	Pain Fellow	Ulster Hospital
Mrs Suzanne Miller	Specialist Physiotherapist	NHS Fife
Miss Rosemary Morland	PhD Student	Chelsea & Westminster Hospital
Miss Andrea Murless	Senior Clinical Nurse Specialist	Lister Hospital/QEII
Dr Elaine O'Shea	Consultant in Anaesthesia	Royal Bournemouth & Christchurch Hospital NHS
Dr John Onimisi Ogendengbe	Lecturer, Human Physiology Dept	University Of Abuja, Nigeria
Dr Nishi Patel	Anaesthetic ST4	Frenchay Hospital
Dr Sally-Anne Shiels	ST3 Anaesthetics LTFT	John Radcliffe Hospital
Miss Diane Smith	PhD Student	Keele University
Dr Victoria Tidman	Advanced Pain Training ST5	National Hospital for Neurology & Neurosurgery
Mrs April Dawn Woodward	PhD Student	Keele University
Dr Mei Foong Yeoh	Doctor	Bristol Royal Infirmary