

JUNE 2017 VOLUME 15 ISSUE 2

# PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



*Credit: mattjeacock*

**Transition - not just a paediatric issue**  
**Opioid prescribing guidelines**  
**MDT approach to manage sickle cell disease**

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THE BRITISH PAIN SOCIETY  
PAIN NEWS

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PAIN NEWS JUNE 2017

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

**Next submission deadline : 30th June 2017**

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<https://www.britishpainsociety.org/for-members/pain-news/>

# Editorial



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I remember the days (long time ago) when, myself, as a Pain Management Consultant, had to persuade general practitioners (GPs) to try

morphine on patients for their uncontrolled chronic severe pain which did not respond to any treatment. We believed that opioids were as effective in chronic pain as it was in acute pain. We also persuaded ourselves that the chronic use of opioids was not associated with any major concerns. This led to a sharp and rapid increase in prescribing and usage of opioids to treat chronic pain. I have even listened to experts in this field giving lectures that addiction with opioid usage in uncontrolled chronic severe pain was unheard of or almost impossible because of the antagonistic effect of pain on opioids. Over the years we have learned that it was not correct. It has been shown that the steady increase in use of opioids associated with similar increase in opioid dependence,

addiction, opioid-related hospital admissions and death. The United States had the worst possible opioid addiction epidemic. Even though the United Kingdom does not have similar issues, 2014 data showed that there were 22.75 million prescriptions written in England with a total cost of nearly £305 million to the National Health Service (NHS). There are now unquestionable data to prove that the use of opioids in uncontrolled chronic severe pain is associated with numerous problems. It is proven that, in addition to well-known complications like nausea, vomiting, sedation and constipation, chronic use of opioids for medical purpose is associated with opioid-induced hyperalgesia, hormonal and immunological complications. Because of these issues, various national bodies have developed guidelines for opioid use in chronic pain conditions. In the March 2016 edition of *Pain News*, Roger Knaggs wrote about Opioid Aware, a guideline developed with major contributions from the British Pain Society and the Faculty of Pain Medicine. There were several medical royal colleges, the Royal Pharmaceutical Society, the Public Health England, NHS England, the National Institute for Health and Care Excellence (NICE), the Care Quality Commission (CQC) and the NHS Business Services Authority involved in

this guideline to ensure that Opioids Aware is relevant for everyone including different disciplines and specialities involved in the decision to prescribe and take opioid medicines.

Opioids Aware is a web-based resource, funded by Public Health England and hosted by the Faculty of Pain Medicine, Royal College of Anaesthetists and can be found at [www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware](http://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware)

In this issue, Sandeep Kapur is looking at this guideline in his article 'Opioid prescribing guidelines: the road back from perdition?' In the same article, he also looks at the guideline from United States Centers for Disease Control (CDC) which was published in 2016. There are a few important messages in his article about opioid usages. I would like to draw your attention to morphine equivalents (MME) per day. It is recommended that not more than 120 MME per day of opioids should be used in managing chronic pain. The reason for this warning is because of the risk of overdose is in excess of nine times at 100 MME compared to 20 MME! Fentanyl 25 µg/h patch is apparently 90 MME! I am thinking of the that little old lady of 96 years referred to me with shoulder pain who was on Fentanyl 150 µg/h patch.

## British Pain Society Calendar of Events

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

[www.britishpainsociety.org/mediacentre/events/](http://www.britishpainsociety.org/mediacentre/events/)



**THE BRITISH  
PAIN SOCIETY**  
EXPERTISE WHERE IT MATTERS

### 2017

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#### **Living Well Right to the End Philosophy & Ethics SIG Annual Meeting**

26<sup>th</sup> to 29<sup>th</sup> June 2017

Rydall Hall, Cumbria

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#### **Gonnae no dae that! – exploring patient and clinician fears**

#### **Pain Management Programmes SIG Biennial Conference**

14<sup>th</sup> & 15<sup>th</sup> September 2017

Glasgow Caledonian University, Scotland

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#### **Cancer Pain Study Day**

27<sup>th</sup> November 2017

Churchill House, London

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### 2018

#### **Trainee Study Day**

7<sup>th</sup> February 2018

Churchill House, London

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#### **Pain in Military Veterans & Pain in Torture Survivors Study Day**

26<sup>th</sup> February 2018

Churchill House, London

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Further details for all our meetings can be found on our events listing page:

[www.britishpainsociety.org/mediacentre/events/](http://www.britishpainsociety.org/mediacentre/events/)



## Dr Andrew Baranowski



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### **Celebrating 50 years ...**

Our first major event celebrating 50 years, the Annual Scientific Meeting (ASM) has passed and our teams (Secretariat, Scientific Committee and

Council specifically) will be reflecting on what worked and what needs further development. Thank you to all of those that provided feedback – this is so important to enable us to build on what is valued for these meetings to be a success.

At the British Pain Society ASM, it is was my great pleasure to welcome our members, guests and the fantastic faculty (both international and home grown), as well as loyal and new exhibitors, to what was widely acclaimed as a successful 50th celebration of meetings.

The Intractable Pain Society of Great Britain and Ireland (IPSGBI) was formed in 1967, making our Society probably the oldest Pain Society in the world (International Association for the Study of Pain (IASP) was founded in 1973). Their first meeting was in Manchester with 17 attendees. Since that meeting, we have grown in strength and we had over 600 attendees at this year's meeting in the Birmingham International Convention Centre.

### **The ASM underwent further modernisation ...**

Over the years and particularly recently, we have made changes to the meeting

format to meet more modern needs and challenges. As always, I am grateful to Professor Kate Seers and her Scientific Programme Committee, but particularly for the professional manner they have taken matters forward with so much ongoing change. Similarly, I would like to thank the British Pain Society Secretariat that have supported them.

### **Guest and plenary speakers at the 50th ASM ...**

This year our British Pain Society Pat Wall Lecture was by Professor Frank Porreca from Arizona, United States. There has been a lot of discussion on the role of opioids in chronic pain and Professor Porreca provided us with further insight through his talk on, 'Molecular and circuit basis for the use of opioids in pain treatment'. Another international speaker, Professor Liesbet Goubert gave the British Pain Society Lecture, tackling the difficult area, 'A resilience approach to chronic pain – challenges for pain research and practice'.

This year, we had Plenary Sessions by Dr Jane Ballantyne (Seattle, US), Professor Lance McCracken (London, UK), Dr Nicole Tang (Warwick, UK), Professor Sam Eldabe (Middlesbrough, UK) and Sir Muir Gray (Oxford, UK). Our new conference App facilitated interaction, questions and feedback. Some special thanks here to the Secretariat that worked with the new technology so we could see it's true potential. The App has also given us a further means to enable industry to support the Society.

The sessions were organised for the first time in themes to try and ensure all

participants could maximise their learning and interaction. This appeared to be successful and I hope will be continued.

### **British Pain Society Annual General Meeting**

The British Pain Society Annual General Meeting was held on Thursday 4 May. This was an ideal time for the Executives to update members on the plans to move the Society forward over the next few years, but also time for members to discuss with us their views on where we should be going. Please also make sure you look out for the minutes when they are published.

### **Honorary Members 2017**

The Annual General Meeting is also our time to behold on those that have contributed to pain medicine Honorary Membership. As always there are so many of you out there achieving great things. This year, the Honorary memberships went to

Professor Maria Fitzgerald, Ms Heather Wallace and Professor Paul Watson.

Please read the citations within the forthcoming September edition to understand why we considered these as worthy recipients.

### **Medal of distinction 2017**

No nominations were received, so there was no medal presented in 2017. The medal is for outstanding work in the field of pain medicine and is not awarded every year.

### Thankyous, goodbyes and welcomes ...

At the 2017 AGM, we were very sorry to be saying goodbye to the following members of Council; Dr William Campbell, Immediate Past President and Drs Austin Leach and Ann Taylor, Council Members. We give them our most sincere thanks for all of their assistance, commitment and time in supporting the Society.

We were also pleased to welcome a new Council Member, Dr Ayman Eissa, and congratulate both Dr Eissa on his new appointment, and also Dr Arun Bhaskar for being appointed for a second term of office.

### Less serious but as vital ...

Every time I think of the ASM, I drift in to memories of parties past. As I have indicated before, many of us missed the party and dinner that the Society was so famous for but was not able to support long term. Over the past few years, the concept was returned to the ASM and, to make those that did not attend jealous, this year we danced the night away at Nuvo; 'a lavish, trendy VIP cocktail lounge'! What does next year hold?

### The Next British Pain Society ASM

The 2018 ASM will be held in Brighton 1st to 2nd May 2018. We have had much discussion based on members' feedback, also taking into account shrinking income from industry. Many have missed the smaller more intimate meetings of the past which facilitated greater opportunities to interact and we are trying to get back to an environment suitable for a big family gathering as well as recognising the need to have top quality presentations. I hope that as many of you will attend as possible, and we will do what we can to keep costs down and for the meeting to be as effective as possible.

### What progress have we made since my last newsletter?

There are so many things that are ongoing, there are so many people to recognise. I am grateful for all that have provided time, effort and dedication to the Society. Below are a few things that I am monitoring closely.

### The National Awareness Campaign

The National Awareness Campaign (NAC), guided by Paul Wilkinson, has made steady progress with 12 posters signed off and the prospectus being complete. The Social Media Team and Media Team have been embedded into the Communication Committee and with the ICT Special Interest Group (SIG) are supporting the launch of the posters. Meetings with prospective supporters, advisors and trustees have occurred and we are all trying to learn quickly what needs to be done to make this venture successful. Formal appointments are still to be made. The National Art Competition has several world-renowned artist sponsors declaring interest, and we work towards finding financial partners and those that can provide an 'electronic platform' for works to be submitted to for ranking and potential prizes. It's a mammoth task, but great to see progress and thank you to all of those involved.

### Quality Standards National Institute for Health and Care Excellence Guidelines and outcome measures

The British Pain Society and Faculty of Pain Medicine, Royal College of Anaesthetists have now agreed the Terms of Reference for a small working group to produce agreed outcome measures that we would consider 'a must for all services'. The measures will be well established and freely available – there is no intention to re-invent the wheel. The team will be as follows:

## From the President

Dr Andrew Baranowski

Andrew Baranowski, BPS President (Ex Officio)

Barry Miller, The Dean FPM (Ex Officio)

Ganesan Barani, FPM Representative (Chair)

Paul Cameron, BPS Representative

Amanda C de C Williams, Psychology

Sarah Wilson, Physiotherapy

A representative from NICE

Dr Martin Johnson is setting up a similar group to look at outcome measures for primary care.

### Membership review

There is a lot going on; however, there is one change that will have now already happened:

We have removed the current need for 2 existing member signatures on the application form as this slows process down. Instead applicants will be asked to provide 2 referees along with their CV. The intention is to only go to the referees if the application is not clear. The addition of the professional body number is a further change to be made.

### Joint Parliamentary Meeting between the Chronic Pain Policy Coalition, Faculty of Pain Medicine and British Pain Society

This year all three organisations are celebrating anniversaries, British Pain Society 50 years, Chronic Pain Policy Coalition (CPPC) and Faculty of Pain Medicine (FPM) both 10 years. There will be a parliamentary meeting, and it is agreed the agenda should cover standards (FPM) and the Commissioning of Pain Services, using the recent British Pain Society survey conducted by Dr Zoey Malpus and Dr Tim Johnson, British Pain Society members.

# Professor Roger Knaggs



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One of the issues with writing a column several months prior to publication is that it can be very difficult to predict what is going to be topical and relevant. As I am writing this column, the general election has just been

announced, and we will have a new government by the time you are reading this issue of *Pain News*. No doubt the political parties will have suggested new health policies and priorities, and there will have been much debate and discussion about the healthcare, then National Health Service (NHS) and funding. Policy making will inevitably be slow and will give us a period to concentrate and focus on the daily routine and perhaps issues that impact us more locally.

## Membership

All members will be aware that the process for collecting subscriptions by direct debit moved to a twice-yearly collection (November and May) last year. The articles of association (see the new look British Pain Society (BPS) website if you wish to read) have been updated so that membership lapses if more than 60 days in arrears with your subscription. After the first collection of subscriptions

with the new timings, 107 (8.6% of member at the time) subscriptions were lapsed or cancelled.

So, if you are reading *Pain News* from a colleague and were a member previously do consider re-joining. In addition, at the last Council Meeting in February 2017, the application process was simplified so that new applications for membership do not need to be approved by two current members but instead require the names of two referees to be supplied.

## Elections for Council members

Although there were three vacancies for elected Council members this year, there were only two nominations and hence no elections were required. Congratulations to Dr Ayman Eissa from Sheffield who was elected and Dr Arun Bhaskar who will continue as an elected Council member for a second term of office.

The Society relies on the commitment and dedication of members in order to ensure the smooth running on a daily basis, so when nominations are next open do think about whether you have the time and vision to contribute to the further vision and development of the Society.

## 50th (and 51st) Scientific Annual Scientific Meetings

By the time you read this, our 50th Annual Scientific Meeting (ASM) will have been and gone and planning will have already begun for the 2018 ASM. One of the first priorities is to identify plenary speakers, and there will be the opportunity for

members to submit proposals for topical workshops. Please do consider nominating a good or engaging speaker that you have heard at other conferences or contributing to a workshop proposal to make the ASM programme next year as good as this year.

## Congratulations

I have just heard that Felicia (Flick) Cox has been awarded Fellowship of the Royal College of Nursing. As all readers



will know Flick has been editor of the *British Journal of Pain* and has masterminded its transformation over the last few years. As well as being involved in the work of the BPS, Flick previously chaired the RCN London Pain Interest Group for nurse specialists but was able to see the larger potential to promote pain management to the nursing profession. Since 2012, she has chaired the national RCN Pain and Palliative Care Forum, a group of over 15,000 nurses across the country. In this role, she leads a group of experienced senior nurses working in pain, palliative care and end-of-life care to promote high-quality education and professional standards. Congratulations Flick. Very well deserved.



# Spotlight - Margaret Dunham



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## 1. What first brought you into contact with the BPS?

I was first interested in pain

management while doing my nurse training, witnessing the variability in quality of pain management. I was first introduced to the BPS many years ago by Prof. Pat Schofield and Dr Richard 'Dick' Atkinson. I remember my first ASM was in York.

## 2. What is your role within the BPS? What is exiting about this role?

I am currently Associate Editor of *Pain News*, working with Dr Arasu Rayen to produce the quarterly BPS newsletter. I am also involved with the

Pain in Older People Special Interest Group (SIG) trying to raise awareness of older people's needs. I am excited to think that through publishing mine and other people's work, I might make some little change to people's lives and improve pain management practice.

## 3. What are/were you best known for professionally?

I hope I am known for my interest in older people's pain experiences, the importance of the patient voice in expressing their needs and in developing appropriate research. There is a neglected personal account, in the midst of complex patient assessment, that can contribute to wellbeing and maintaining independence in older people in particular.

## 4. How do you think the BPS has changed from when you first joined?

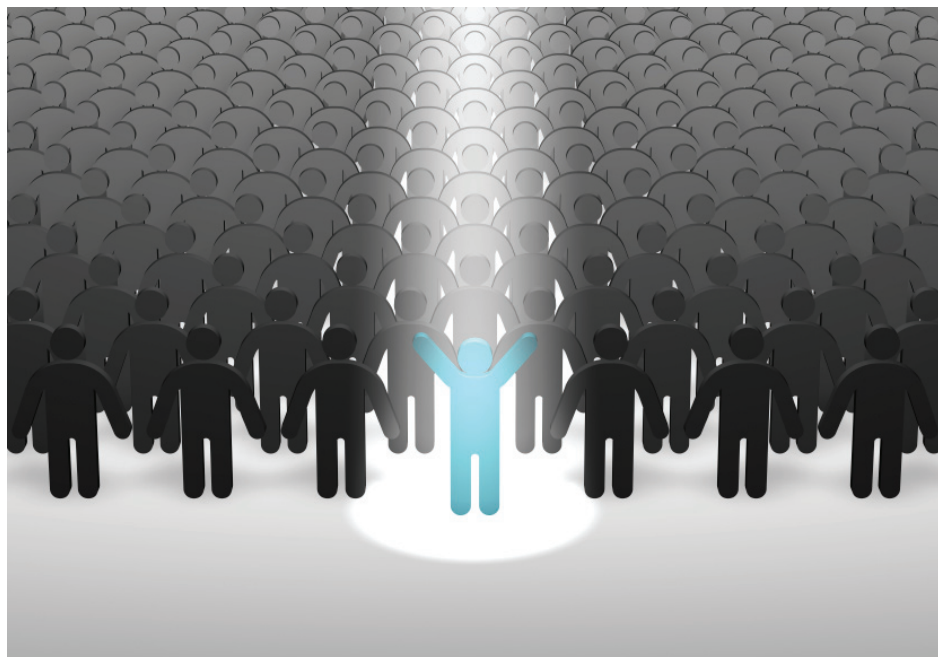
The BPS has changed enormously; it is much more about MDT contributions and definitely not just chronic pain. I have seen all of us grow older (hopefully wiser) and more experienced.

## 5. If you were President of the BPS for the day, what would you do?

I would probably panic. The enormity of the role and the responsibility seems truly daunting. I would however, try to lobby parliament with the need for legislation to protect the rights of people in pain, particularly those disadvantaged or non-verbal groups whose voice is not heard. I remember wishing hard that the then PM Tony Blair would get back pain so that it would get as much media coverage as when he had the SVT episode.

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

Gardening and singing are generally good for the soul and your mental health. In my spare time I love gardening, I have a good collection of sempervivum and other hardy semi-succulents and an evolving herbaceous border. But I am also a chorister, a mezzo soprano, in my local church choir and usually sing every Sunday morning at Mass and occasionally at weddings. I also love cooking a big Sunday dinner for the family after which a walk is always nice.



**7. What would it be impossible for you to give up?**

I like a drink, not as much as in my youth, but now I don't think I could ever give up hot chocolate, having been re-introduced by my daughter to the modern variety with whipped cream and marshmallows.

**8. Any life achievements you are particularly proud of?**

I suppose getting my PhD was a massive milestone for me but I suppose my best achievement will always be having three reasonably well-balanced adult children alongside surviving 32 years of marriage.

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

I love science fiction and absolutely adore the *Star Wars* and *Star Trek* series of films but also I love to read murder mysteries, when I get time to read fiction.



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

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

**Thank you for supporting the BPS!**



## Have your say and contribute to *Pain News* today

*Pain News* is the newsletter for members of the British Pain Society and we welcome member and non-member contributions to share your news with the wider membership and beyond.

*Do you have a news item to share?*

*Perhaps a professional perspective, or informing practice piece?*

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

We'd love to hear from you so drop the Editor an email today at: [pns.raven@gmail.com](mailto:pns.raven@gmail.com)

Upcoming submission deadlines:

Issue	Copy deadline
September 2017	30 <sup>th</sup> June 2017
December 2017	29 <sup>th</sup> September 2017



# Interventional Pain Medicine Special Interest Group

Dr Neil Collighan *Chair, Interventional Pain Medicine SIG*

The Interventional Pain Medicine Special Interest Group (SIG) held its Annual Scientific Meeting (ASM) last September. This time it was the turn of the Radisson Blu at Manchester airport to host the meeting as we try to divide the meeting between north and south every other year. The SIG committee comprising myself, Ashish Gulve and Sameer Gupta spent many a long hour creating a wide and diverse programme, and we hope all those who attended had an interesting and thoughtful day.

We started with a presentation by Dr Vladimir Gorelov and his work on bipolar radiofrequency lesioning of the cervical medial branch. He was able to show radiographs outlining his treatments completed so far and thought provoking outcome data which challenged previous treatment modalities and established a new approach to the management of facet-related neck pain.

Following on was Dr Ron Cooper. There had been, prior to the meeting, much online debate as to the differences between thermal radiofrequency, cooled radiofrequency and pulsed radiofrequency. Dr Cooper produced a presentation outlining the different modalities, comparing the different situations for use and outcomes. He was able to provide specific examples to further help with his explanations and helped answer some of the questions previously raised.

At a previous meeting, we had had a presentation on the use of genicular branch blocks for the treatment of knee

pain. Dr Tom Haag delivered a presentation on the use of ultrasound guided genicular branch blocks. Following this, he then was able to use a live model to show the genicular branches and the landmarks/guide points he used for the procedure. This was so well received it went far into the coffee break and had to be actively broken up for us to move onto the next session!

We were expecting by the time of the meeting that the new National Institute for Health and Care Excellence (NICE) guidelines on Low back pain and Radicular pain would have been released. I had planned a discussion piece on these guidelines, but due to delays, I was only able to examine the draft guidelines at this point. This still managed to create a lively discussion on the points made but also on the future of pain services and the impact the guidelines would have. We also debated future management of possible outcome decisions by local Clinical Commissioning Groups.

We then followed this with some case reports by Dr Simon Thomson, Dr Sameer Gupta and Dr Ron Cooper, each enabling further lively debate on the various management options.

Following lunch, we organised 2 experts to discuss the conundrum between shoulder and neck pain and the various aetiologies which can cause confusion between the pain source diagnosis and management. First, Mr Daniel Fagan, Consultant Spinal Orthopaedic Surgeon, discussed neck

pain and radicular pain. Of note, he produced diagrams of different referral patterns of pain related to the cervical spinal level involved. Following, Mr Simon Lambert, Consultant Orthopaedic Surgeon, delivered a fine presentation on Shoulder Pain: Causes, Differential Diagnosis & Management for Pain Physicians. The level of information provided by both surgeons was superb in answering the puzzle set by ourselves.

To finish the meeting, Dr Kavita Poply delivered the latest data from St. Barts hospital on studies relating to the treatment of sacroiliac joint pain. Dr Roman Clegg then closed the meeting describing his thoughts on how he assesses and chooses the different interventions available when treating chronic pelvic pain.

Overall thoughtful and diverse meeting which enabled lively debate on a variety of topics. The only downside was a problem with the local train network causing us to bypass our usual business meeting to ensure attendees could get back to the South of England!

As ever, we are planning a London-based meeting later in the year (date and venue yet to be confirmed), but I hope some of you managed to attend the to the 2 workshops we held at the British Pain Society (BPS) ASM in Birmingham. We held a joint workshop with the headache SIG and also a radiofrequency denervation workshop looking at the physics behind it and the evidence for its use. Rather apt considering the very recent NICE guidelines.

# Essential Pain Management – to Medical Schools and beyond!

**Helen Makins** *Consultant in Pain Management, Gloucestershire Hospitals NHS Foundation Trust and EPM Working Group, Faculty of Pain Medicine, Royal College of Anaesthetists*

**Mike O'Connor** *EPM Working Group, Faculty of Pain Medicine, Royal College of Anaesthetists*

Readers with an interest in education know that there has been a drive to increase undergraduate education in Pain Management over the last few years. A recommendation to improve pain education was incorporated into the Chief Medical Officer's Report in 2008 and the inadequacies were confirmed by work from the British Pain Society (BPS) Education Special Interest Group (SIG), led by Emma Briggs et al.<sup>1</sup> This survey concluded that undergraduate training in Pain Management across eight healthcare professions was inadequate, and the SIG continues to work on an important document to provide guidance on how this may be incorporated into undergraduate education for a range of healthcare professionals.

The Essential Pain Management Course (EPM) was developed in Australia and New Zealand to address inadequacy in the teaching of Pain Management to healthcare workers in lower and middle-income countries. The Australia and New Zealand College of Anaesthetists (ANZCA) support this programme and have resourced courses in Asia, the Pacific Islands and Mongolia, among others. Since the initial course in 2014, a comprehensive EPM programme has been implemented in India and is run by The Traveling Pain School, a local voluntary, not for profit organisation (<http://travelingpainschool.com/>). This impressive organisation has taught the

course to 1,300 Doctors and 410 Undergraduates to date.

Since 2013, the Faculty of Pain Medicine of the Royal College of Anaesthetists (FPM) have been involved internationally, setting up a UK EPM working group to provide courses in Africa, with more than 8 countries reached to date and several more in the pipeline. The emphasis is on sustainability, with several one-day courses run by the visiting team but also a 'Train the Trainers' day for local workers.

Drawing from the international experience, our Southern Hemisphere colleagues developed a slightly abbreviated half-day course (EPM Lite) and introduced this into medical student teaching locally. In 2014, it became apparent that a similar approach might start to address the inconsistency of training in Pain Management here in the United Kingdom, and over the last 3 years, we have reached the point where the course is incorporated into 14 of the 34 medical schools in the United Kingdom. There is more work to be done in this respect and we continue to work with existing and potential leads within Medical Schools around the United Kingdom.

We are pleased with our progress so far but realise that the best trained students will only be able to practice the principles they have learnt in an environment where others speak the same language. The course centres around an acronym –



Running an EPM group discussion session on the Mercy Ship, Benin

Recognise, Assess, Treat (known affectionately as the RAT approach!) which provides a framework for the consideration of a multidisciplinary, biopsychosocial approach to the management of patients in acute and chronic pain. The next phase of our project involves going beyond medical schools, to reach undergraduate and postgraduate doctors, nurses, physiotherapists and indeed any healthcare professional who has patient contact. We aspire to a time when a patient with pain is approached in a standard (RAT) manner, in the way that a resuscitation always follows ABC.

## A challenge indeed – where to start?

Small local surveys we've carried out in the South West have highlighted a need for general practitioner (GP) education, with only 4/20 of the GPs questioned ever

## Essential Pain Management – to Medical Schools and beyond!

having received formal training in pain medicine. Only 4 of 14 specialist nurses surveyed had received formal training in multidisciplinary Pain Management, despite all having a significant role in teaching doctors, nurses, physiotherapists and patients. Both GPs and specialist nurses who responded could see the benefits of the RAT model and were keen to incorporate the EPM Lite principles into their own teaching.

### What we have learnt so far

One of the joys of teaching is the opportunity to provide a clear explanation of a previously mystifying concept. In this respect, we are never disappointed when running the course, making each session hugely rewarding. Medical students find the opportunity to discuss how the pathophysiology and pharmacology theory they have spent so many hours learning translates into patient management. They enjoy the chance to spend time in small groups discussing patient management with experts. Our Core Anaesthetic Trainee pilot in Kingston Hospital highlighted various misinterpretations, particularly surrounding the use of opioids for cancer pain, for example, it became clear that concerns regarding addiction were clouding management of pain in terminal disease. Across the board, discussing the tricky concepts of differentiation between nociceptive and neuropathic pain, addiction and dependence are appreciated.

EPM Course Logo:



### Where next?

We are running a 'Train the Trainers' course in late March and will use this opportunity to teach the course to a group of nurses, physios and junior doctors. Our aim is the use a snowball effect to spread the EPM Lite word, particularly focussing on trust-wide approaches. A GP trainee pilot is planned for the Summer.

The course materials are freely available at <http://www.rcoa.ac.uk/faculty-of-pain-medicine/essential-pain-management/epm-lite> and include the student and instructor manual, slide set and evaluation form. To maximise the benefit of the course, these resources are ideally adapted by the trainer to suit the attendees. We prefer to minimise the didactic element and focus on small group discussions around clinical cases, as this has universally been appreciated according to feedback. The patient scenarios are often altered to reflect the clinical practice of those attending the course.

### The Future

We have 3 ongoing parts to the project:

1. Incorporation of EPM Lite into all UK medical school curricula
2. The GMC are in a consultation process with the Royal Colleges currently, to decide on the format and content of a Fitness to Practice assessment, which will be taken by all

medical students before qualification. We will put forward the case for Pain Management to be included in this assessment.

3. Progress the use of the EPM Lite format for all healthcare professionals, via a Trust-wide approach, using locally identified leads, trained through a Train The Trainers scheme.

This is an opportunity to shape the future of Pain Management by ensuring standardised teaching throughout multidisciplinary staff. It is a huge job and needs local engagement at every level. If you are interested in incorporating the EPM Lite course into your medical student teaching or for any other healthcare professionals within your Trust, please do get in touch. We'd be delighted to help you to institute EPM Lite in your locality.

Contacts:

Ms Jyoti Chand, Faculty Administrator,  
Faculty of Pain Medicine, Royal College  
of Anaesthetists ([jchand@rcoa.ac.uk](mailto:jchand@rcoa.ac.uk))



**FACULTY OF PAIN MEDICINE**  
of the Royal College of Anaesthetists

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Overview of Course Content from official slide-set:

#### Workshop Plan

- Pain basics
  - What is pain?
  - Why should we treat pain?
  - Classification of pain
  - Physiology and pathology
  - Pain treatment
- RAT approach
- Case discussions

1.3



The RAT approach acronym:

#### Approach to Pain

- Recognize
- Assess
- Treat



1.6



# Headache Special Interest Group

Dr Ajoy Pandit

The Headache Special Interest Group (SIG) is the youngest SIG in the British Pain Society (BPS). The second Headache SIG Annual Meeting was held on 16 November 2016 at Churchill House, London. The day was conducted and attended by an excellent multidisciplinary faculty and included a wide range of topics relevant to clinicians with an interest in managing head and face pains. Attendees included neurologists, maxillofacial physicians, pain physicians, psychologists, nurses, general practitioners (GPs) and so on.

The morning sessions were chaired by Vivek Mehta and Karin Cannons. Justin Durham, Senior Lecturer and Hon Consultant in Oral surgery and Orofacial pain, started the day in style with his signature '007' walk across the podium and screen! He presented a detailed overview of temporomandibular joint disorders (TMD) and the Orofacial Pain Prospective Evaluation and Risk Assessment (OPERRA) study. He was followed by Consultant Neurologist, Anish Bahra, who gave a comprehensive account of headaches, facial pains and neuralgias. Pathophysiology of headaches and migraines was extensively covered by Farooq Maniyar's talk.

Pain trainees Peter Keogh and Kavita Poply presented challenging clinical cases, including chronic migraine with idiopathic stabbing headache, and cluster headache and the role of sphenopalatine ganglion stimulation, respectively.

A highlight of the day was the interactive sponsored session including hands on demonstration on Botox injections by Dr Giles Elrington. All delegates had the opportunity to attend this hands demo on the day. The delegates were split into smaller manageable groups. This informal session included practical tips and informal question and answer session on Botox and its safe use for headaches.

The post-lunch session was chaired by Anish Bahra. Anna Cohen presented an overview of Medication Overuse Headache and its Management. This was followed by Sarah Love-Jones followed with a succinct account of the role of Percutaneous Electrical Nerve Stimulation. Vivek Mehta provided a detailed account of the role of Neuromodulation in Headache with a focus on evidence base for use of occipital nerve stimulation.

The stimulating day ended with a panel discussion on the 'Role of MDT in assessing patients for headache interventions' where the experiences of the Barts and Bristol MDT were shared with the audience.

All presentations were followed by active audience participation with questions and answers at the end of the session. The day was purposefully structured to be interactive and informal with ample time to network and discuss with colleagues and faculty. Coffee breaks and lunchtime gave an opportunity to network with other attendees and visit sponsor stalls.

The day ended with an informal social gathering of some of the faculty and delegates for further networking and refreshments at a local venue nearby!

This second headache SIG study day was well attended and followed the interest and success of the first annual meeting in November 2015. This is planned to be an annual event in November with more multidisciplinary working and input from various specialties involved in management of head and facial pains at future headache SIG study days.



Percutaneous Electrical Stimulation: Sarah Love Jones



## Headache Special Interest Group



Neuromodulation in Headache – Commissioning Pathway:  
Vivek Mehta



Informal social gathering

## Follow the Society on twitter



Please follow the Society on twitter **@BritishPainSoc**  
We will be sharing relevant information and updates from the Society.

# Rochdale fundraiser to take on charity cycling challenge to help fund life-saving heart research

Harriet Southwood *Media Officer, written on behalf of and taken from the British Heart Foundation*

A local resident is taking on an adrenaline-fuelled bike ride for the British Heart Foundation (BHF) to help fund life-saving research, in memory of her husband, Mike Gregory, who passed away unexpectedly in November 2015 from a heart attack aged just 58 years. He passed away just months after participating in the very same event.

Jo Gregory, 55 years, will be a member of Team MG and will take on the iconic Prudential Ride London–Surrey on 30 July to raise money for the BHF's life-saving research. She will be cycling alongside her children Siobhan, Ciaran and Aoife and family friends Brian O'Gorman and Yara Ali Adib. Around 500 cyclists take part for the BHF each year, raising over £300,000 in the fight against heart disease.

Mike, a well-renowned Pain Consultant, was playing squash when he started noticing symptoms of a heart attack. Going into cardiac arrest in the car on the way to hospital, Jo administered cardiopulmonary resuscitation (CPR) on the roadside, and although he managed to be revived, his heart stopped again in the ambulance and he passed away in the same hospital he worked at. Each year, 30,000 people in the United Kingdom have an out-of-hospital cardiac arrest, but the survival rate is less than 1 in 10.

Jo explains, 'A doctor for over 30 years, Mike knew the symptoms of a



heart attack. But never did I think that as we calmly made our way to the hospital, he would have a cardiac arrest. He was healthy, active and worked full time as a Consultant at the Royal Oldham Hospital.

'Just months before we had celebrated our 30th wedding anniversary with the family skiing holiday. In July we also completed the Prudential Ride London–Surrey in just under 8 hours. I'm just grateful that I was with him at the Royal Oldham Hospital so I got the chance to say goodbye.

'We always said that when we retired, we would spend more time cycling around the British countryside but sadly that will never happen. It's terrifying how life as you know it can change in an instant. Heart disease really can strike anyone at any time and it's only through research that we can end this devastation.



*Mike would have been 60 this year and I know he would have wanted to do the ride again to see if he could have beaten his time. So this year, alongside my children and some family friends, I'm cycling the same course to keep his memory alive. I'm sure he will be extremely proud.*

The Prudential Ride London–Surrey takes riders through the London Olympic 2012 cycle route, all on closed roads through central London and the Surrey countryside. It also includes a 46-mile course, and the stunning views and amazing atmosphere will allow you to see for yourself just how much fun can be had on two wheels.

The ballot for the Prudential Ride London–Surrey cycling event is now open. To ride for the British Heart Foundation, visit [bhf.org.uk/ridelondon100](http://bhf.org.uk/ridelondon100) or contact the events team at [events@bhf.org.uk](mailto:events@bhf.org.uk) or 0845 130 8663.



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THE BRITISH PAIN SOCIETY'S  
ANNUAL SCIENTIFIC MEETING

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

VENUE: **HILTON BRIGHTON METROPOLE**  
DATES: **01 – 02 MAY 2018**

We look forward to seeing you



# A multidisciplinary (MDT) approach to managing sickle cell pain

**Jenna Love** *Clinical Psychologist, Red Cell Pain Management Service, St George's University Hospitals NHS Foundation Trust, Tooting, London; SCDpain@stgeorges.nhs.uk*

**Oliver Seyfried** *Consultant in Pain Medicine, Red Cell Pain Management Service, St George's University Hospitals NHS Foundation Trust, Tooting, London; SCDpain@stgeorges.nhs.uk*

This article is based on a workshop presented at the 2016 ASM by the authors along with Dr Elizabeth Rhodes (Consultant Haematologist) and Ms Rebecca McLoughlin (Specialist Physiotherapist), also at St George's Hospital.



Jenna Love

Pain is the hallmark of sickle cell diseases (SCD), with episodes of acute pain reflecting blockage of blood vessels (a vaso-occlusive 'crisis') and potentially life-threatening sequelae. However, with increasing life span, we are becoming more aware of the existence of chronic pain in people living with SCD, but often this may not be well recognised or understood. Furthermore, it is not clear whether people with SCD are able to access mainstream pain management services. In this article, we provide an overview of the medical aspects of SCD and what is known about chronic pain in SCD and describe the service we have developed specifically for people with



Oliver Seyfried

sickle-cell-related pain. We hope that by generating conversations and building expertise, this might drive improved access to pain management for people living with sickle cell pain around the United Kingdom.

## Overview of SCD

SCD are lifelong, life-limiting genetic conditions where a single point 'AA mutation' causes abnormal haemoglobin production, leading to haemolytic anaemia, multi-organ dysfunction and life-threatening acute events. There can be a marked difference in disease progression and severity due to  $\beta$ -allele heterogeneity (with HbSS being the most severe genotype) and other factors, including the level of foetal haemoglobin.

The complex pathophysiology is grounded in red blood cell (RBC) abnormality. Haemoglobin, a protein found in the RBC, is vital for oxygen transportation around the body. Those with SCD produce abnormal haemoglobin S, hence the RBCs suffer accelerated denaturation and breakdown as well as decreased solubility allowing the haemoglobin to precipitate. The rigid sickle-shaped cells are unable to travel through capillary beds, which lead to vaso-occlusion of blood vessels which can cause ischaemia, infarction and pain. These episodes, known as 'crises' and characterised by significant amounts of sudden onset pain, can be life threatening and require urgent medical attention.

Over recent years, the medical management of SCD has led to a dramatic increase in life expectancy. However, there remains a limited number of disease modifying treatments. Some patients have undergone bone marrow transplants, which if successful can lead to production of healthy RBCs and 'cure' from SCD, although this is a procedure with considerable risk and requiring a suitable donor. A more widespread treatment is the use of hydroxycarbamide, a medication which stimulates the production of healthy foetal haemoglobin which can reduce

### A MDT approach to managing sickle cell pain

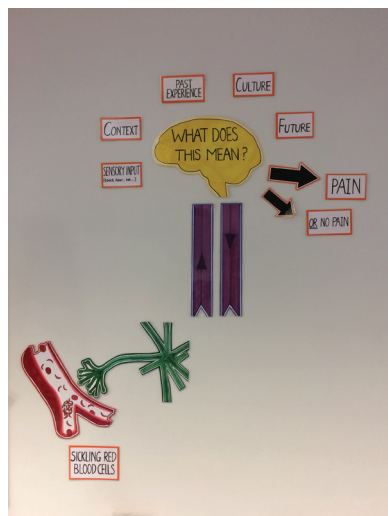


Image of the nervous system

symptoms and prevent future complications, though some experience side effects. Blood transfusions and RBC exchanges have shown a significant benefit for many at risk of complications, though they do require attendance at hospital on a regular basis.

SCD are most common in those from African, Caribbean, Asian and Middle Eastern backgrounds. The high incidence of the condition is thought to be due to the historical survival advantage that heterozygotes had over haematologically normal individuals when infected with malaria. In the United Kingdom, there are thought to be at least 12,500 people living with SCD and around two thirds of them live in London, with other areas of high population in cities like Birmingham and Manchester. SCD is the fastest growing genetic condition, and it is likely that the geographical distribution is likely to spread in future decades.

The population with SCD live with a severe and largely incurable disease that occurs in an ethnic minority whose members tend towards lower socio-economic status. They are often educationally disadvantaged due to the neuropsychological sequelae of the condition as well as poor school

attendance due to frequent ill health. This may lead to a wide social gap between health care provider and a receiver, who may have negative associations with the health service; many people with SCD will have experienced perceived disbelief about their condition and can be mistrusting of new people. Awareness and respect of these complex factors can be important to understanding an individual's presentation and developing a good working alliance with them.

### Pain in sickle cell

Pain is the primary symptom of SCD. It may be nociceptive or neuropathic, somatic or visceral. The acute pain of SCD is more recognisable and consists of vaso-occlusive crises, acute chest syndromes, bowel infarction and hand-foot syndrome amongst others. Acute pain is often intermittent and recurs unpredictably in all areas of the body.

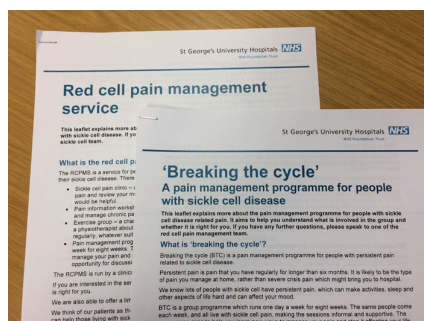
Chronic pain in SCD can have a recognisable aetiology, avascular necrosis and arthropathies, and leg ulcers are relatively common and may be increasing as survival with SCD increases. It is also helpful to remember that the causes of pain present in the population at large also affect those with SCD. Often there may be no identifiable aetiology and here changes in the nervous system may well be important. In a population where frequent episodes of acute pain are experienced, often since childhood, where pain presents real and significant danger, it is perhaps reasonable to assume that the nervous system may begin to change in similar ways to those with other types of chronic pain and there is some evidence supporting the development of central sensitisation in people with SCD (Campbell et al. 2016). This is one area where pain specialists can have an important role in supporting those affected by SCD, and their clinicians to understand that a lack of identifiable

cause does not mean pain is any less real or difficult.

The prevalence of chronic pain in SCD in the United Kingdom is not known. One author suggests pain between crises may be present in approximately 50% of the US population with SCD (Ballas et al. 2012). Similarly, the PiSCES study suggests those with SCD experience pain on 55% of days, but they did not differentiate between chronic and acute pain. In our service in South London, we are increasingly becoming aware of significant levels of chronic pain in our patient group. Many individuals' descriptions of the impact of pain are similar to chronic pain of other aetiologies and sometimes severe enough to prevent people from living functional lives. The cost of chronic pain in SCD is significant, on a personal, social and economic level.

SCD pain, similar to cancer pain, often necessitates the use of strong analgesics. Opioids are often needed for management of vaso-occlusive crises, including subcutaneous injection during hospital admission and are also often prescribed for management of crises at home. In our experience, people with SCD may not always be well supported in understanding the difference between acute and chronic pain and the appropriate use of opioids. Coupled with a lack of access to other methods of managing chronic pain and a desire from clinicians to change the historical under-treatment of sickle cell pain, it is not unusual to see SCD patients on long-term opioid medication. An individual with SCD can experience pain as young as 6 months, and their exposure to opioids can be lifelong. Minimising the sequelae of this treatment pattern is a priority, as is providing individuals with information about the long-term side effects of opioids and their appropriate use. Physicians are often apprehensive due to the potential for tolerance, dependence and addiction. This is not routinely borne out in clinical practice but is frequent





Leaflets

enough to suggest that an expert and multidisciplinary approach is vital.

Despite its potential prevalence, chronic pain receives only brief mention in the key standards of SCD care, with little guidance on management. It is difficult to ascertain whether those living with SCD are able to access pain management services; certainly in some services, SCD are explicit exclusion criteria, and it may be that in many others links between haematology and pain management are not well developed. This represents a health inequality and a rationale for improving access to pain services for people with SCD.

### The red cell pain management service

The red cell pain management service (RCPMS) is a small multidisciplinary specialist service for adults (aged 16 and over) living with pain related to SCD. The service was established in 2013. It aims to optimise pain management and help individuals to develop self-management skills to reduce the impact of pain. Following are the services it currently offers:

- **Sickle cell pain clinic.** A monthly medical clinic that provides assessment and treatment of SCD-related chronic pain, led by the Consultant in Pain Medicine. The psychologist or physiotherapist is also present and can introduce the self-management elements of the service if appropriate. Formal

evaluation has suggested attendees valued the sole focus on pain and found the consultation itself therapeutic.

- **Pain information workshops.** Stand alone workshops that provide information about pain science (e.g. biopsychosocial model, acute vs. chronic), and an introduction to self-management. All people with SCD currently under the care of our haematologists have been invited, along with their friends and family. Twelve workshops have been run, with 48 people attending. Feedback has shown 97% were mostly or very satisfied with the content of the session and many have subsequently attended further sessions with the service.
- **'Circulate', an exercise group for people with SCD:** A weekly group led by our specialist physiotherapist, where participants are shown simple exercises they can continue at home that can support them in working towards valued goals. A particular value of this group is supporting those who want to move more but who are unsure where to start or have had experiences of exercise causing crisis or flaring up pain.
- **'Breaking the cycle', the pain management programme (PMP) for SCD pain:** An 8-day programme, based on evidence-based PMP guidelines, adapted to be appropriate for SCD pain. Some of these adaptations will be explored more below.
- Individual psychology and/or physiotherapy sessions covering the above content for those not able to attend group sessions.

### Applicability of pain management principles to sickle cell pain

There is very little research exploring pain management in SCD; as far as we know

no PMPs have previously been provided for people with SCD specifically. Preliminary work by the team at St. Thomas' Hospital, London, explored incorporating people with SCD into group PMP for other types of pain (Knight et al., 2012), which seemed to be acceptable to participants and staff; however, this pilot does not seem to have been continued. Important work has also been carried out by psychologists working in SCD, notably Nicky Thomas and Kofi Anie, who have looked at using cognitive behavioural therapy (CBT) skills for pain management; however, this has not been a multidisciplinary approach.

Our clinical experience, from working in non-sickle pain services, is that many of the components of acceptance based and cognitive-behavioural PMPs are very relevant and helpful for sickle cell pain. In our PMP, we include identification of valued goals and techniques to work towards these, including pacing, discussion about exercise and movement, working with thoughts and feelings and approaches such as mindfulness. Communication and friends and family sessions have been particularly important in helping others understand chronic pain.

The key areas of difference we have noticed include the following:

- In many PMPs, a key message is often that pain is not harmful, which is not necessarily true for people with SCD. Crisis pain is an indicator of a potentially serious problem. Helping participants understand and recognise the difference between acute crisis pain and a flare up of chronic pain can be complex. However, it can also be very important as the responses in the situations are often different; in a crisis, medical attention, rest and medication are all helpful and appropriate. Chronic pain does not necessarily need (or benefit from)

### A MDT approach to managing sickle cell pain

these actions but benefits from continuing with paced activity, managing anxiety-laden thoughts and compassionate self-care. In our experience, many people are unaware of the different types of pain and believe ongoing pain is a sign of ongoing damage/crisis and so discussion about the nature of acute and chronic pain can be very helpful.

- Linked to the above, it is important to recognise pain in the context of a life-limiting illness. Many other pain conditions are incredibly distressing but usually are not life-threatening, whereas people living with SCD not only have pain but also the knowledge that they are likely to have a shorter life expectancy and that health can often deteriorate rapidly. Many have known family members or friends who have died suddenly from SCD. There can be a lot of anger at having the condition, and there can be complexities due to the genetic heritability, for example, a person whose child also has SCD may be very conscious of how they cope with pain in front of their child.
- People with SCD almost always have a long history of pain experiences and yet conversely to non-sickle pain, they do have a diagnosis for their pain and they often expect to have pain. In some ways pain in SCD may

be taken less seriously than in other conditions as it is seen as an inherent part of the condition.

Sickle cell clinics often experience high non-attendance rates due to a number of factors, including sudden onset of crisis, neurocognitive problems affecting prospective memory and planning, difficult relationship with hospitals and medical professionals, financial or mobility difficulties. We have needed to be much more flexible and proactive in our approach, including attending medical clinics and sending reminders before appointments. We have been heartened to see excellent attendance rates at our PMPs, which show that with support, individuals with SCD are able to engage well in a flexible service. A more flexible approach would need to be considered if people with SCD are seen in a mainstream pain service where strict rules of attendance apply.

Alongside a lot of individual work, we have completed three PMPs to date and so our experience is still in its infancy. We have not formally evaluated the PMP data yet as our numbers are too small, but we are collecting outcome data (including health economics data) to allow us to evaluate the service. Our experience has been of very rewarding work where pain management principles can bring great benefit to a new and

often underserved population. The qualitative feedback from participants who describe the impact of a better understanding of pain, being able to exercise and feel confident with movement, feeling less depressed and returning to valued activity has been incredibly satisfying. It is not unusual for the perception of people with SCD to be heavily dominated by the minority who can be challenging when admitted to hospital or in acute pain and it has been a privilege to work with such resilient and resourceful individuals and to support them in developing ways to reduce the impact of pain on their lives.

While there are many advantages in offering a specialised service specifically for people with SCD, this is unlikely to be possible or necessary in other parts of the country and we would hope that people living with SCD would be able to access the expertise of specialist pain management services around the United Kingdom. By sharing our experience of translating pain management principles, we hope this supports others doing similar work. We would like to see closer relationships between the haematology and chronic pain departments, to allow a sharing of expertise and to develop a network of pain specialists working with people with SCD to develop an evidence base for pain management work.

# Opioid prescribing guidelines: the road back from perdition?

Sandeep Kapur *Consultant in Pain Management & Anaesthesia, University Hospital Birmingham*

In 'Trump-speak', we all know that opioids are 'Bad, sick guys'. However, exactly what makes opioids 'Losers' is nebulous to most people, so the facts are worth restating:

Most randomised controlled trials on opioid therapy drew their conclusions based on trials lasting 6–12 weeks. The few studies that did look at opioid efficacy for longer than this time scale reported consistently poor results.<sup>1</sup>

A large cross-sectional observational study in Denmark showed higher pain intensity, pain interference and worse quality of life for patients treated with opioids than those not treated with opioids.<sup>2</sup>

In a longitudinal study of 67,963 postmenopausal women with recurrent pain, women reporting prescription opioid use at baseline were more likely to report lack of improvement in pain and worsened physical functioning 3 years later.<sup>3</sup>

The prevalence of opioid dependence may be as high as 26% among patients in primary care receiving opioids for chronic non-cancer-related pain. Compared with doses of less than 20 mg morphine equivalents (MME) per day, the overdose risk is doubled at 50–99 MME per day and increases up to 9 times at doses exceeding 100 MME per day.<sup>4</sup>

A cohort study using healthcare records of 32,499 individuals who commenced chronic opioid therapy for non-cancer pain in Ontario, Canada, found that 1 of every 550 patients started

on opioid therapy died of opioid-related causes a median of 2.6 years after the first opioid prescription; patients prescribed high-dose opioids (200 MME or higher) for chronic pain were 24 times more likely to die of opioid-related causes than patients taking lower doses. Men are at higher risk than women for escalation to high-dose opioid therapy and death from opioid-related causes.<sup>5</sup>

According to data published by the Office for National Statistics, in 2015 (the latest data currently available), over half of all drug-related deaths in England and Wales involved an opioid (excluding co-codamol). Between 2012 and 2015, deaths from heroin or morphine doubled from 579 to 1,201. The highest rate of drug misuse deaths was seen in 30- to 39-year-olds, followed by people aged 40–49, with Wales suffering 58.3 deaths per million compared with 42.9 per million in England. In England, the North-East had the highest mortality rates.<sup>6</sup>

To combat the opioid epidemic, the United States Centers for Disease Control (CDC) published (in 2016) a guideline for prescribing opioids for chronic pain.<sup>4</sup> In the United Kingdom, the Faculty of Pain Medicine, Royal College of Anaesthetists launched the *Opioids Aware* web-based resource in January 2016.<sup>7</sup> Developed in collaboration with medical royal colleges, the Royal Pharmaceutical Society, the British Pain Society, Public Health England, National Health Service (NHS) England, National Institute for Health and Care Excellence (NICE), the Care Quality Commission, the *Opioids Aware* guideline enjoys broad support.



Credit: smartstock

The US guideline is quite similar to the UK one, indicating a rare trans-Atlantic consensus of opinion. The CDC guideline very sensibly advocates non-opioid therapies (including exercise therapy, weight loss, psychological therapies such as cognitive behavioural therapy, sleep improving interventions, and interventional procedures) are to be preferred over opioid therapy for chronic non-cancer pain. Both advocate that opioids should be added only when their expected benefits are likely to outweigh the substantial risks inherent in their use. When opioids are commenced, the golden rule should be to 'start low and go slow'. Prescribers should think about the risk–benefit ratio when increasing a dose to 50 MME or more per day, and only used when carefully considered and justified. According to the Opioids Aware resource, doses above 120 MME or more should be avoided, as the risk of harm far outweighs any potential benefits. This cutoff dose is a stark warning of the potency of most available opioid formulations: a 25 µg/h Fentanyl patch is approximately 90 MME!!

## Opioid prescribing guidelines: the road back from perdition?

Both guidelines advocate that it is important to establish realistic treatment goals for improvement in pain and function, including discontinuation of opioids if benefits do not outweigh risks. Additionally, co-prescribing of 'risk multipliers', such as benzodiazepines should be avoided as far as possible. It is also important to discuss secure storage of opioids to prevent diversion and accidental use by other household members.<sup>1,4,7</sup>

The opioids aware resource also states that, while formal opioid contracts have no legal validity, it is recommended that prescribing clinicians document the agreed doses, treatment outcomes and the circumstances for withdrawing opioid therapy, if deemed unsuccessful. Pertinently, a 2- to 4-week opioid trial is suggested as enough time to gauge benefit: if patients fail to benefit appreciably from opioids within this period, it is unlikely they will benefit in the long-term. A minimum of 30%

improvement in pain, or improvement in sleep or function are useful yardsticks to gauge efficacy.<sup>7</sup>

In addition, the opioids aware resource also identifies patients at risk of opioid dependence: these include patients with previous or current psychiatric illness, those with a history of past or present drug or alcohol overuse and patients on long-term opioid therapy. Signs such as patients demanding higher doses, running out of prescribed medication early, or reporting lost/stolen medication must also trigger alarm bells, the guideline advocates.<sup>7</sup>

In my view, the *Opioids Aware* ought to be mandatory reading for anyone prescribing opioids. The one quote I found most useful is worthy of verbatim reproduction:

Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high dose opioids, a very detailed

assessment of the many emotional influences on their pain experience is essential.<sup>7</sup>

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*A collaboration between The Faculty of Pain Medicine, The British Pain Society and e-Learning for Healthcare*



# Transition – not just a paediatric issue!

**Alison Bliss** *Consultant in Paediatric Anaesthesia and Pain Medicine, Leeds Children's Hospital*



For those of us whose practice is centred within paediatric services, our involvement in the care of children often has a finite limit; as

the child grows through adolescence and into young adulthood (see Table 1 for definitions), their ongoing care will be transferred to the relevant speciality within adult services. How we manage this transfer of care, the transition process, has been a hot topic within paediatric specialities for some time.<sup>1–6</sup>

Adolescence is recognised as a transitional life stage during which further development and maturation occur in distinct areas. Alongside the physical changes of puberty are psychological and social changes related to personal identity, independence, responsibility and the establishment of relationships. As they mature emotionally, the young person transforms during this phase, from a more dependent child to a more independent adult.<sup>7</sup> The needs of this specific patient group of young people differ from both those of children and those of the older patients; neither the toy-filled waiting rooms of children's outpatients nor the more clinical adult settings, offering 'information about incontinence and mobility aids', provides an appropriate or engaging environment for a teenager accessing healthcare.

Table 1. Definition of common terms describing young people.<sup>7</sup>

Term	Definition
Adolescent	A social construct describing young people as they move into the adult world
Teenager	The period of life between 10–19 years
Youth	A person aged 15–24 years
Young person	A person aged 10–24 years

Table 2. Selection of recommendations for transition planning.<sup>9</sup>

- Planning for adulthood should begin in school year 9 (age 13–14 years)
- Each young person should have a single practitioner (nurse, youth worker, allied health professional, general practitioner or other) as a 'named worker' to coordinate and support their transition
- Young people should be involved through peer support, mentoring, advocacy and the use of mobile technology
- Young people should determine the extent that parents and carers are involved during and after the transition process
- Young people should see the same health care practitioner for the first two appointments after transition to adult services
- Establishment of local, integrated youth forums for transition

Transition has been defined as 'the purposeful, planned movement of adolescents & young adults with chronic physical and medical conditions from child-centred to adult-orientated health care systems'.<sup>8</sup> Transition planning rose to the top of the healthcare agenda at the start of 2016 with the publication of guidance on transition planning from National Institute for Health and Care Excellence (NICE).<sup>9</sup>

The NICE guidance opens with an array of overarching principles for planning transition, including factors such as involving young people in

service design, ensuring that support for transition is developmentally appropriate, that plans are person-centred and include the General Practitioner and that all services have appropriate responsibility for safeguarding and confidentiality.<sup>9</sup> The NICE guidance then makes a multitude of recommendations, a selection of which is presented in Table 2.

It is easy to see how the principles and recommendations will apply to those services caring for chronic illnesses such as diabetes, congenital heart disease, cancer and asthma, but how easily do



### Transition – not just a paediatric issue!



they apply to our young patients with chronic pain?

The Pain in Children SIG hosted a parallel session at the Society's 2016 ASM which focussed on the topic of transition and as a prelude to this, the SIG undertook a survey of the Society's members to ask how aware and how prepared practitioners and services would be to implement the recommendations on transition put forward in the NICE guidance.

A simple electronic questionnaire (Survey Monkey), comprising 6 questions and the opportunity to add free text comments, was sent electronically to all members of the Society in the months prior to the ASM. The questions covered simple demographics, awareness of the recent transition guidance, any local provision for transition and an estimate of the ease with which recommendations could be implemented.

The survey was completed by 104 members. In all, 39% worked in facilities which catered only for adult patients aged 18 years and over and 1% only saw children under 16 years. In all, 27% worked with adults including young people aged 16 years and over, and 10% worked in paediatric facilities which included young people up to the age of 18 years. A total of 23% worked in combined adult and paediatric units spanning all ages.

In all, 58% had no plan in place for the transition of young people into or out of their service, and 16% felt this did not apply to their practice.

Only 33% of respondents answered

that arranged links were already in place with local adult or paediatric services as appropriate. The extent of these local arrangements varied widely as described in the free text comments. Most described informal or ad hoc arrangements and some identified a named contact with their speciality counterparts within a multi-disciplinary team, for example, therapist to therapist. Only a few described combined multi-disciplinary meetings, transition clinics or named clinician contacts.

Prior to receiving the survey, only 30% of respondents were aware of the NICE guidance published at the start of 2016; after completion of the survey, this rose to over 75% – a positive step towards raising awareness of the need for transition planning.

The majority of respondents (79%) felt that their team members had appropriate

training in both safeguarding vulnerable people and application of the Mental Capacity Act, to encompass the care of the young people transitioning into and out of their service.

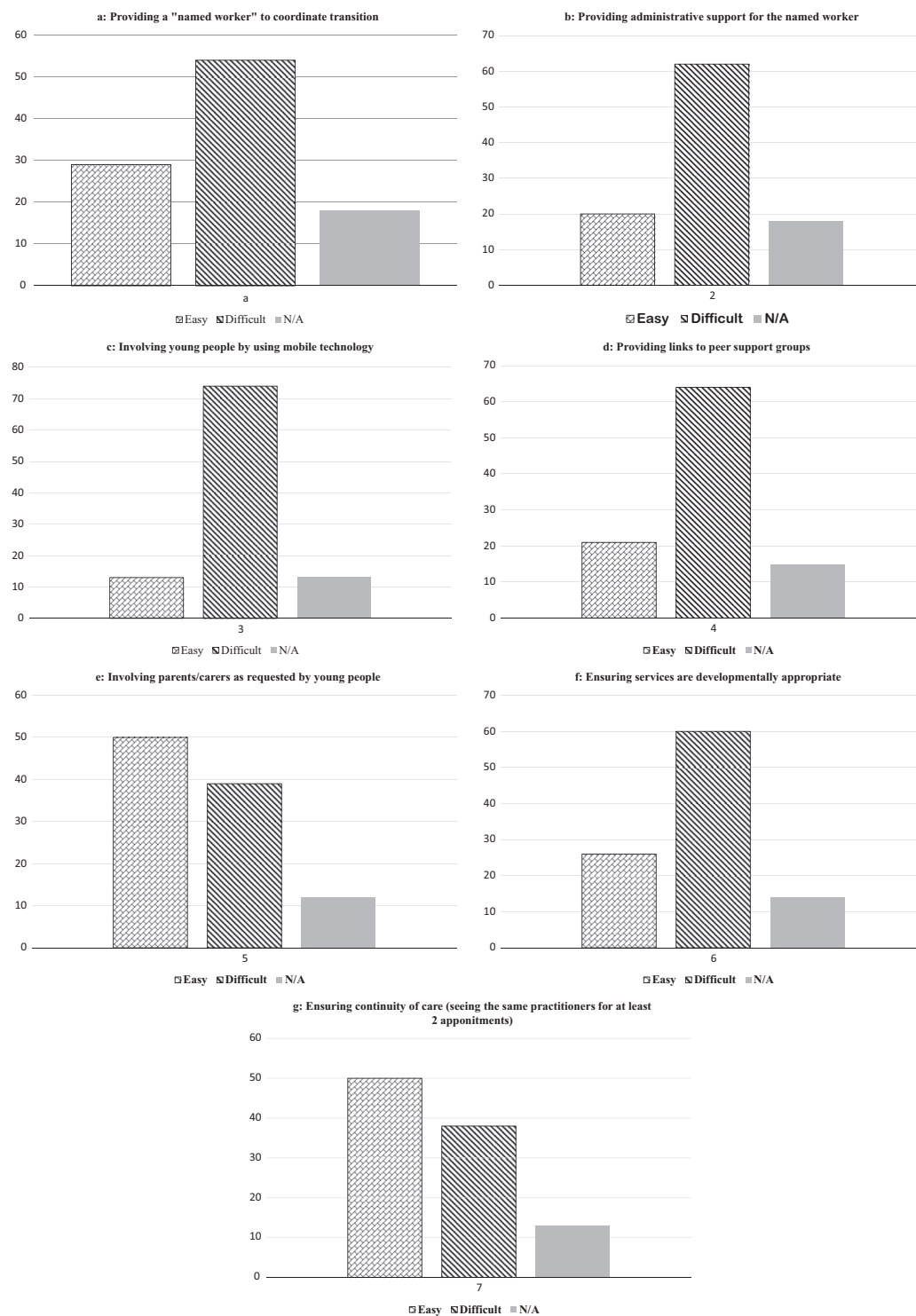
The final question of the survey asked respondents to grade how prepared they felt their service was to implement a selection of seven of the recommendations made in the NICE guidance. Respondents could indicate a recommendation would be 'easy' to implement, defined as achievable within the capacity of the existing service or 'difficult' to implement, defined as requiring additional resource. The results are shown in Graphs a–g.

Most respondents felt it would be difficult to provide a 'named worker' to coordinate transition, to provide administrative support for a named worker, to engage young people using mobile technology, to provide links to peer support groups and to ensure their services were developmentally appropriate. Conversely, it was considered to be easy to involve parents and carers, as requested by the young people, and to ensure continuity of care by providing reviews with the same practitioner for at least the first two appointments.

The comments provided by respondents focused on a small number of specific themes. These themes were echoed in online discussion forums on paediatric pain, at the time and also in the discussions held within the parallel session at the 2016 ASM.

The majority recognised the plight of those aged 16–18 years presenting with chronic pain, who often found themselves in a care void – too old for paediatric services and too young for adult ones. It was highlighted that many adult chronic pain units are located within healthcare trusts which provided no paediatric services at all. The provision of paediatric pain services is only available in a smaller number of units and this inevitably leads to large geographical

**Graphs a–g.** Results of survey question: ‘How prepared is your service to implement some of the recommendations made in the NICE guidance?’



Easy to implement = capacity within the existing service; difficult to implement = would need extra resource.

### Transition – not just a paediatric issue!

distances for many patients between their adult and paediatric units. This was identified as a barrier to easy liaison between tertiary centres and local services by some respondents. Other acknowledged barriers to good transition practice included lack of local knowledge about service provision, lack of expertise and a predictable lack of funding. One respondent in particular identified a core difference in ethos between paediatric and adult chronic pain provision within some areas. They described positive discouragement from providing long-term follow-up of adult patients with chronic pain in a commissioning model where secondary specialist support provided only brief episodes of care for patients, with general practitioners providing regular review.

On a more positive note, comments and discussions recognised that the numbers of young people requiring transition into adult services for ongoing pain problems were very small. For these

individual cases, any formal didactic pathway may not be easy to follow.

There are currently several streams of work taking place nationally which have the potential to improve the transition process for these young people with chronic pain; these include the provision of information about paediatric chronic pain services within the country and a review by the Faculty of Pain Medicine to address the training requirements for pain medicine practitioners who may be involved in the treatment of adolescents with chronic pain. Both of these avenues, by raising awareness and knowledge, increase the likelihood that any young person needing that ongoing support will pass more smoothly from the paediatric into the adult setting.

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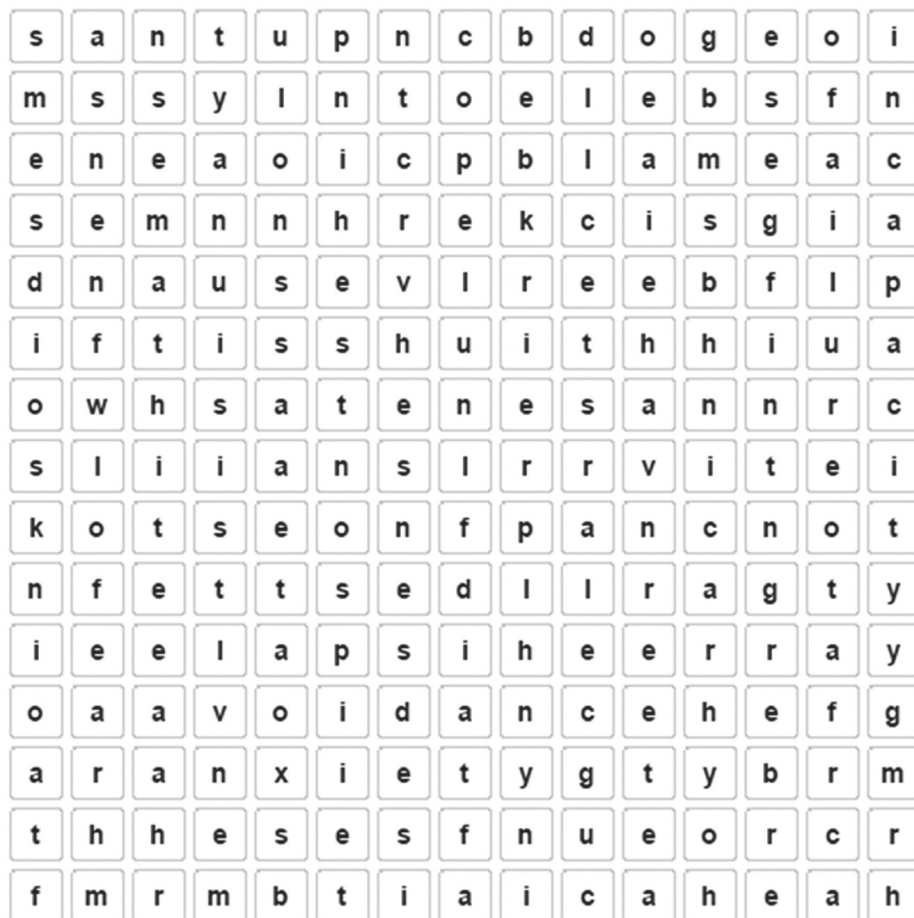
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## New members ratified since March 2017

Name	Current post	Place of work
Ms Ann-Maria Ahern	Clinical Specialist Physiotherapist	St Thomas' Hospital
Miss Alia Ahmad	Trail Coordinator	St. Bartholomew's Hospital
Dr Amelia Arasaratnam	ST5 Anaesthetics	Dorset County Hospital
Ms Alexandra Ballantine	Medical Student	University of Liverpool
Mrs Claire Bamber	Specialist Pain Physiotherapist	Chapel Road Clinic
Ms Tamar Beck	PhD Student	Canterbury Christ Church University
Ms Katy Benneworth	Senior Specialist Physiotherapist	St Thomas' Hospital
Mrs Elisabeth Bird	Rotational Pharmacist	University Hospital of Wales - Heath Hospital
Dr Fiona Bull	Specialty Registrar Anaesthesia	Ninewells Hospital
Dr Helen Chester	Specialty Doctor, Palliative Care	St. Richard's Hospice
Mrs Clare Clark	Advanced Practitioner	Powys Teaching Health Board
Mrs Rosie Cruickshank	Highly Specialist Physiotherapist	St Thomas' Hospital
Dr Sunil Dasari	ST6 Anaesthetics	University Hospital of Wales
Dr Thomas Daubeney	ST5	Hampshire Hospitals
Mrs Sue Dennis	Acute Pain Nurse	Leicester Royal Infirmary
Mr Alex Deutsch	Senior Physiotherapist in Pain	Dudley Group of Hospitals NHS Foundation Trust
Ms Lucy Edgar	BSc Biomedical Science	Leeds Beckett University
Dr Anna Everatt	Clinical Psychologist	Birmingham City Hospital
Dr David Gronow	Medical Director	Sydney Pain Management Centre
Dr Beth Guildford	Clinical Psychologist	St Thomas' Hospital
Ms Jessie Hill	Pain Specialist Nurse	Royal Cornwall Hospital
Mrs Jinny Holden	Nurse Specialist	Leicester General Hospital
Ms Ana Howarth	PhD Student	St George's, University of London
Dr James Huddy	GP and GPSI in Gastroenterology	Perranporth Surgery
Ms Clair Jacobs	Lead Physiotherapist INPUT Pain Management	Guys & St Thomas' NHS Trust
Dr Gulam Hadi Kadiwal	Retired	

Name	Current post	Place of work
Dr Ahmed Kafafy	Pain Medicine Consultant	The Royal Orthopaedic Hospital
Dr Lori Lindsay	Pain Fellow	The Walton Centre
Dr David Magee	ST5 Anaesthetic Doctor	Northwick Park Hospital
Dr Jane Mills	Advanced Pain Trainee and ST7 Anaesthetics North West	Royal Preston Hospital
Dr Suresh Narayanan	ST-6 Anaesthesia and Pain Medicine	Royal Victoria Infirmary
Mrs Julie Oz	Clinical Nurse Specialist	QE Gateshead
Ms Clemency Palmer	Head of The Psychology Service and Pain Service	The Pain Service
Ms Emily Phillis	Pain Management Specialist Nurse	Great Western Hospital NHS Foundation Trust
Dr Karthik Ponnusamy	Consultant in Pain Management	Kent and Canterbury Hospital
Ms Robyn Quinn	Manager	Sydney Pain Management Centre
Mrs Caroline Roan	Pain Nurse Specialist	Stoke Mandeville Hospital
Dr Judith Sergeant	Counselling Psychologist	Ashford & St Peters NHS Trust
Dr Adele Springer	Perioperative Medicine/Pain Management	Tragaret X-Ray centre
Ms Louise Sweeney	PhD Student	King's College London
Mrs Kate Thompson	Senior Physiotherapy Lecturer	Leeds Beckett University
Ms Rachel Townsend	Specialist Nurse	Royal Surrey County Hospital NHS Foundation Trust
Dr Rebecca Williams	ST5 Anaesthetics Registrar	Great Western Hospital
Ms Georgina Wilson	Research Assistant	Barts Health NHS Trust
Dr Theresa Wodehouse	Scientist	Barts Health NHS Trust
Mrs Victoria Woolger	Specialist Nurse Pain Management	Ashford & St Peters NHS Trust

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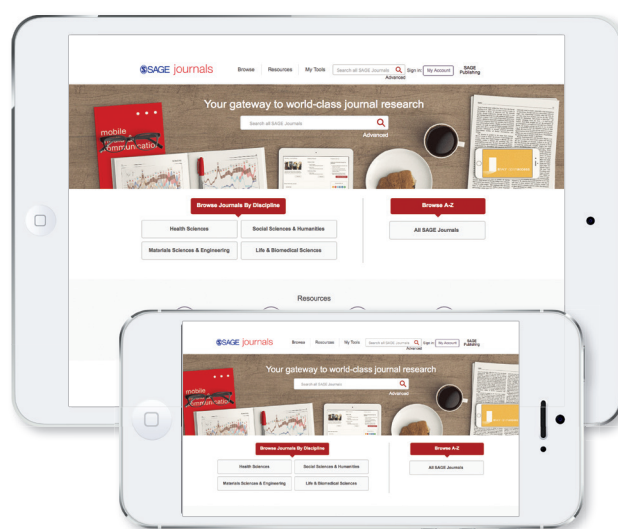


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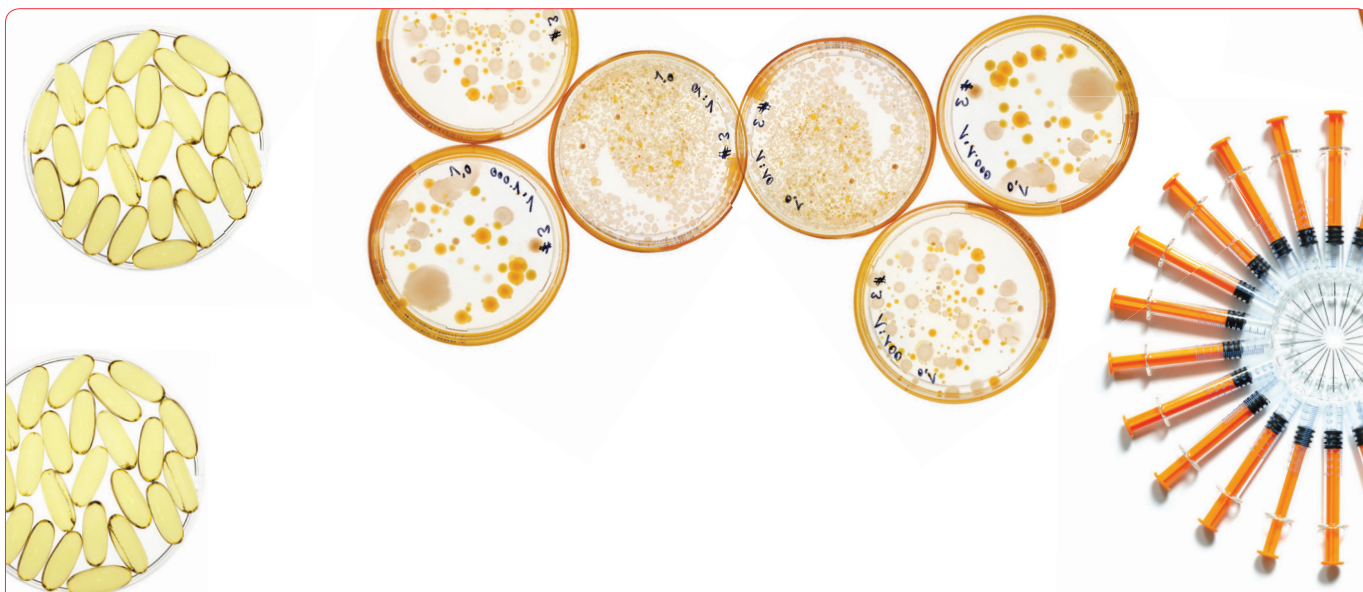
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