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PAIN NEWS

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Pain Apps – are they useful?

Pelvic pain support network

Faculty of Pain Medicine History

A Rare Case of Facioscapulohumeral syndrome (FSHS) with Widespread Chronic Pain

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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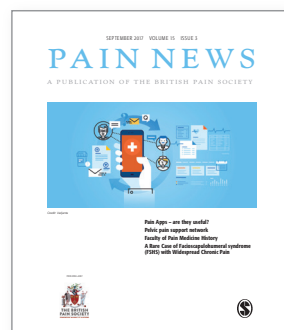
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<https://www.britishpainsociety.org/for-members/pain-news/>

British Pain Society Calendar of Events

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

www.britishpainsociety.org/mediacentre/events/



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

2017

Interventional Pain Medicine and Neuropathic Pain SIG's Joint Meeting

BMA House, London

20th September 2017

Medicolegal Study Day

21st November 2017

Churchill House, London

Cancer Pain Study Day

27th November 2017

Churchill House, London

In this study day, we will field a faculty of eminent expert speakers from each area – basic science, oncology, and pain/palliative medicine. Within each theme, there will be not only a keynote lecture, but also short presentations from PhD and other researchers. Each topic will end with a 'debate with a difference'. What that means is that the subject of the debate will be set during the day by the delegates – so that the debaters will have to think on their feet rather than present set arguments.

2018

Trainee Study Day

7th February 2018

Churchill House, London

This is an excellent opportunity for those who have an interest in Perioperative Anaesthesia and Management of patients with Chronic Pain. Speakers -experts in their field will cover:

- Neurobiology of the transition of acute on chronic pain
- Perioperative management of the chronic pain patient,
- Management of patients on long-term opioids, and the
- Role of regional anaesthesia

Pain in Military Veterans & Pain in Torture Survivors Study Day

26th February 2018

Churchill House, London

Treating pain in people with post-traumatic stress symptoms: survivors of torture and of war

This day will be run in two halves, and participants are welcome to sign up for either or both. The morning will cover medical, psychological and physiotherapeutic principles and practices of treating chronic pain in military veterans, from an experienced team at the King Edward VII Hospital. The afternoon will cover medical, psychological and physiotherapeutic principles and practices for treating chronic pain in survivors of torture, in a pain clinic, with teaching from clinicians from a variety of settings.

Annual Scientific Meeting

1st & 2nd May 2018

Hilton Brighton Metropole

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

www.britishpainsociety.org/mediacentre/events/

Dr Arasu Rayen



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It has been 3 months since we have had our 50th Anniversary Annual Scientific Meeting (ASM) in Birmingham.

It was a huge success. Scientific programme was excellent. Of course, social programme was top class. Everyone whom I spoke with was not only appreciative of the ASM and the social programme but also most importantly appreciative of the ASM app. It was so useful – instant updates and reminders, ease of use and less wastage of paper! Hats off to the ASM

scientific committee for making the 50th anniversary a memorable one.

Throughout this issue of *Pain News*, you will find lots of articles, snippets, photos and feedback from the ASM.

Apps are everywhere now. We had the app for the BPS ASM this year. Apps are being used more and more in medicine. In this *Pain News*, Rebecca Brierly discusses Pain Diary Apps and debating whether they are useful or not? (Pain Diary Apps – Are they useful?). Rebecca is a lay member of the Patient Liaison Committee. There are comments at the end of the article by Dr Austin Leach. Rebecca reviews three apps – Catch My Pain, Nanolume and Chronic Pain Tracker Lite from App Store. Catch my Pain is also available in Google Play Store but Nanolume is available as Pain Tracker and Diary (Nanolume LLC).

Chronic Pain Tracker Lite is not available in Play Store; instead, there is Manage My Pain Lite. Rebecca looks at these apps and gives a review of three apps from a patient's perspective.

In the last issue of *Pain News*, we looked at the history of the British Pain Society. In this issue, Dr Barry Miller, Dean, Faculty of Pain Medicine, is looking at the history of the Faculty of Pain Medicine in his article 'The Faculty of Pain Medicine in context – A personal view'. In the same article, he also looks at the function of the faculty.

By the time you read this, you would have had a good summer, fabulous holiday and break, and be getting ready for Autumn and Winter. I've got to get on to my bicycle before it gets colder and darker. I will see you in the December issue. Happy Reading!

Dr Andrew Baranowski



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I said it in the June edition, but need to say it again.

50th Annual Scientific Meeting in Birmingham

It was a great honour for me to

be President of the British Pain Society (BPS) during our year when we had our 50th Annual Scientific Meeting (ASM) in Birmingham. The event was a team effort but I am particularly grateful to Prof. Kate Sears and her Scientific Programme Committee for putting on such an amazing event.

This year, the Pat Wall lecture, our first plenary session was given by Prof. Frank Porreca who travelled from Arizona in the United States and we were also honoured to have Prof. Lisbet Goubert from Ghent in Belgium presenting the BPS lecture.

Honorary members for 2017 were Prof. Maria Fitzgerald, Ms Heather Wallace and Prof. Paul Watson. Please read the citations within this edition to understand why we considered these as worthy recipients.

Acute Pain Special Interest Group meeting

Prior to the ASM, there was an Acute Pain Special Interest Group meeting. This was strongly supported with 83 attendees. It was such a success that there has been a proposal that a similar event should occur next year. On behalf of all our members, I would like to thank Ruth Day for organising this event.

51st Annual Scientific Meeting in Brighton

I look forward to welcoming you at Brighton next year. The format of the ASM will change for next year; the aim is to have another acute pain day to proceed the main meeting. There has also been an interest shown by the neuromodulation companies to run workshops on the same day. Therefore, as well as keeping the dates of 1–2 May 2018 available for the main meeting, we need to keep 30 Monday April also free.

NICE guideline on persistent pain

As I write this, NICE (The National Institute for Health and Care Excellence) is in the early stages of scoping this guideline, and in due course will go through the usual steps of formal consultation on the draft scope, and probably a stakeholder workshop in September.

The BPS and Faculty of Pain Medicine (FPM) have been asked to give their views on the areas where a NICE guideline could best add value and Council have been asked to comment on the minutes of a meeting held with representatives of the BPS and FPM in June 2011. This work has been completed. It is fascinating to see that progress has been made since then, but other aspects have moved slowly.

For instance, there are more education resources available with the FPM/BPS/e-Learning for Healthcare e-Pain resources as an example as well as the Royal College Nursing Pain Knowledge and Skills Framework for the nursing team.

The development of stratified treatment pathways has been supported by the joint project with Map of Medicine and the BPS that produced guidelines

that we still have to inform the process, despite funding to maintain on the Map of Medicine platform being too expensive. NICE and NHS England have produced guidance and/or pathway of care documents as well as the Scottish Intercollegiate Guidelines Network clinical guideline on the Management of Chronic Pain.

Supporting self-management continues to be an area of importance, with several groups being involved – including our Honorary Member Mr Pete Moore.

Outcome measures

The BPS and FPM, of the 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. Outcome measures and NICE guidelines are key to Quality Standards and the BPS needs to be central to these discussions.

Children and young people

There is a strong support for pain services for this group within NHS England Specialised Services, but the number of services is small resources limited.

Other news

Patient members

As a part of ensuring that we have our feet on the ground as a Society, Martin Johnson, Roger Knaggs and Antony Chuter have been considering a membership package for patients and their carers. The process has involved discussions at

Council but the final proposal will be shared to members for their opinion.

Discussions with IASP

Since the IASP (International Association for the Study of Pain) World Congress, I have been having discussions with members of IASP Secretariat as to how we can collaborate more with them and other IASP Chapters.

We have agreed that more informal discussion groups between the leaders of the Chapters and IASP with the aim of increasing sharing of information, collaborative work and possibly saving money would be a positive way forward. How we do that is another issue!

Joint membership has been raised; we have discussed looking at how that might work. IASP and the American Pain Society are in ongoing discussions to look at trialling this, possibly for trainees in the first instance, possibly working to a shared social media approach with IASP and other chapters to increase awareness World Wide.

Joint Parliamentary Meeting between the Chronic Pain Policy Coalition, FPM and the BPS

This year, all three organisations are celebrating anniversaries, BPS 50 years,

Chronic Pain Policy Coalition (CPPC) and 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 BPS survey conducted by Dr Zoey Malpus and Dr Tim Johnson of BPS members.

National Awareness Campaign

Paul Wilkinson and his team are continuing to look at how to maximise the impact of our posters on Social Media. At the time of writing, we have had a slight delay as we ensure we are getting this right. There is a significant amount of work ongoing as we look at all aspects of increasing publicity, income generation, who and how to engage, the roles for Patron, Ambassadors and Trustees. What I started several years ago has become a huge project beyond belief and I thank all that are involved on your behalf.

National Art Competition

At the time of writing, discussions are ongoing with several Royal Academics of Art, several professional bodies, a range of media teams and a number of academics. The Patient Liaison Committee is involved. Certain principles have been agreed. For instance, a

patient reference group people's panel will probably have a role in short listing – patient's choice.

Restructuring Council

As you may remember we restructured the Society's working groups to match the BPS Values. How these groups were supported and their relationships were also developed. As well as this, we have reviewed the way your elected members work and how Council works. To try and ensure we are in the best position to obtain outcomes from our meetings and activities, Council is trialling a new focused working group approach. Small groups of Council members are discussing specific issues that need to be addressed and then reporting their suggestions back to Council as a whole. We are working more with IT such as Google groups and Google documents. It is this approach that has enabled us to focus on Patient Membership, the way we work and the National Awareness Campaign. Please see the minutes of our Council meetings that are available in the members section of our website.

Thank you every one for your support and as always, please contact us if you feel the need.

Professor Roger Knaggs



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I began my column in the last issue of *Pain News* by stating it can be extremely difficult to predict what was going to be topical around 8 weeks after writing. Since

then, the General Election has been and gone. Now, summer seems definitely to have arrived and Britons are doing well in several sports, ranging from cricket, rugby and tennis. Long may it continue – certainly a distraction to Brexit, political debate and other tragic events that have affected our country over recent months. However, you will be reading this column in September, after most people had time for a well-earned break and refreshment, but so much may have happened by then.

Membership

As reported at the Annual General Meeting, held in Birmingham at the

ASM, the number of members has gradually increased from a recent low at the end of last year. Membership remains just over 1200. The major professional groups are doctors (589), nurses (172), psychologists (114) and physiotherapists (91).

At a Council meeting earlier this year, a change in the Regulations was agreed that removes the need for two members to approve the membership of a person requesting to join the Society. In order to streamline the application process, a brief CV outlining their association with the management of pain and supported by the names of two referees that the Society can contact instead. Please do continue to promote the benefits of membership of the largest multiprofessional professional organisation for pain in the United Kingdom to colleagues and friends.

Annual Scientific Meeting

I am sure that everyone who attended the 50th Anniversary ASM in Birmingham will agree on the quality of the plenary presentations, the wide variety of workshops available and the

excellent opportunities to catch-up with friends and network with colleagues. We really appreciate those who took time to provide feedback and opinion after the ASM. In total, there were 59 pages of comments this year which were reviewed by the Scientific Programme Committee recently. Overall, there were many positive comments but your feedback helps us refine the event to make the next ASM more reflective of your needs and opinions. Of course, it is not possible to please everyone but we will certainly continue to strive for a balance between science, clinical practice and other fields that make this such an interesting and challenging area to work.

It was pleasing to receive so many proposals from members for workshops for the ASM next year and tough decisions were required about how to create the best programme for delegates. Next year, the ASM is going to be over 2 days rather than 3 days; however, I am sure that we will all make the most of the opportunities that this will bring. Be sure to keep 1st and 2nd May 2018 free for what promises to be another great ASM in Brighton.

Spotlight – Matthew Jay

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



Matthew Jay
UCL Great Ormond
Street Institute of
Child Health; Great
Ormond Street
Hospital

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

I think my first contact with the BPS was when I attended the PMP SIG meeting on Jersey a few years ago. I can't really remember but I probably joined the Society around then.

myself as a Social Epidemiologist but really I have interests in acute and chronic pain, epidemiology, administrative data, statistics and law, so my projects to larger or lesser extents cross these fields. Some people also know me as a specialist adviser at Citizens Advice Camden, Great Ormond Street Hospital, where I work with European nationals on benefits appeals.

4. How do you think the BPS has changed from when you first became a member to now?

Difficult to say. I think I'd need a few more years in the Society before I can make a fair appraisal.

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

That really is a difficult one. We definitely need more awareness around (and research into) paediatric chronic pain. My bias is towards public health and service provision perspectives, so I would do something around that. Quite what I would do is up in the air!

2. What was your role in the BPS? What excited you about this role?

I suppose first of all I'm just an ordinary member. I thoroughly enjoy the various meetings organised throughout the BPS, especially the ASMs, and I've written the occasional piece for *Pain News*. I'm also the website manager for the Philosophy & Ethics SIG. I've not been able to attend our last couple of meetings but being able to take a step back and think about pain (and more) from entirely new perspectives is incredibly refreshing.

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

Depends who you ask! Mainly I'm a researcher. I tend these days to describe



Spotlight – Matthew Jay

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

I always try to make time for my friends so will often be found out with them somewhere – usually some pub around one of our respective work places. I also enjoy the cinema (read: I'll be at home bingeing on Netflix).

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

Egg custard tarts.

8. Any life achievements you are particularly proud of?

Winning the trainee presentation session at this year's ASM! I'm still somewhere on cloud nine about this.

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

I feel really fortunate to be part of the pain community. I came to study pain pretty much by accident but I've had some incredible support to get to where I am today.



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.rayen@gmail.com

Upcoming submission deadlines:

Issue	Copy deadline
December 2017	29 th September 2017
March 2018	5 th January 2018
June 2018	3 rd April 2018
September 2018	15 th June 2018
December 2018	28 th September 2018



Fellowship of the Royal College of Nursing

Felicia Cox *Editor British Journal of Pain*



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Felicia Cox, Editor British Journal of Pain

Recently, Felicia Cox (Flick), Editor of the *British Journal of Pain*, was awarded Fellowship of Royal College of Nursing. *Pain News* spoke to Flick about this.

What does it mean to be awarded a fellowship of the RCN? Is it something you apply for, or were you nominated by someone?

You are nominated by an individual who has had to seek three additional individual supporting statements. This entire process is undertaken secretly and the first you learn of it is when you open your letter formally offering you a Fellowship. It was lucky I was sitting

down as I was truly astounded. You are expected to keep this information secret until the actual Award Ceremony which was a challenge.

Is there any particular aspect of your work that has been recognised?

The RCN Fellowship is awarded to nurses registered in the United Kingdom who have made 'an exceptional contribution to nursing and healthcare'. I have been working as a specialist pain nurse since 1997 and was awarded an Honorary Membership of the British Pain Society in 2015 for developing and editing the *British Journal of Pain* and representing nursing as a co-opted Council member. As an editorial board member of the International Association for the Study of Pain, I have also been able to support the global year against pain by co-authoring a Pain Clinical Update.

My RCN Fellowship was awarded for a number of reasons including raising the profile of pain management through publication and editing, supporting novice writers and novice nurse

specialists, developing EasyRead pain publications and the RCN Pain Knowledge and Skills framework. I have been able to influence practice related to epidural analgesia, NICE guidance and raised the profiles of professional Forums at RCN Congress.

How do you feel to have been awarded a fellowship?

It was an unexpected honour to be recognised for my contribution to pain management which is considered a fundament of nursing care.

I know you've been off work – will you be returning soon?

Mid-June 2017.



BPS Honorary Membership Citation for Professor Maria Fitzgerald

By Dr Amanda C de C Williams

Maria graduated from Oxford in 1975 in Physiological Sciences, and then moved to University College London (UCL) where she completed her PhD in Physiology in 1978. She was already publishing papers by then and has now published well over 200. She won an MRC training fellowship to work with Patrick Wall at UCL, and has worked there ever since, starting her own research group and becoming Professor of Developmental Neurobiology in 1995.

Maria's work is brave, original and of enormous impact in reducing pain and suffering. She has built a science of pain in infants, particularly preterm infants, extending into questions about pain in foetal life and the consequences in adolescents and adults of infant pain. Her work is characterised by rigorous science applied with compassion and curiosity, but never settling for convenient answers.

Maria has navigated parliamentary committees, the anti-abortion lobby and many other perils, always intellectually honest, not least in admitting that we cannot yet answer important questions. Her work bridges the anatomy and neurophysiology of pain processing in rodents and humans, extending into the neuroscience, behaviour and clinical care of neonates and preterm infants, all in the context of development of the nervous system and brain. Maria works closely with paediatricians and other clinicians, designing research around the opportunities presented by the real pain events and medically required imaging of preterm infants.

As an aspect of all this, Maria grapples with the ethical and epistemological

difficulties of the field, trying to make best sense of questions such as 'Can an infant *feel* pain?' Among other publications and chapters, I found on the Internet a document from 1995 when the Department of Health commissioned Maria to update knowledge on foetal pain. While she made clear that foetal 'protective responses to noxious stimuli cannot be interpreted as feeling or perceiving pain until connections exist to the cortex', she emphasised 'that even reflex responses to noxious stimuli may affect the future course of sensory development and thus 'the effects of trauma of any kind to the developing nervous system should be minimised'. I think that characterises her thoughtfulness and balance.

Maria is committed to understanding as fully as possible the clinical and scientific questions in her area. When others were satisfied with behavioural ratings of infant pain, she pursued cortical recordings and showed them to be more sensitive, demonstrating a specific pain response even in the absence of behavioural signs. And when sucrose was declared to be analgesic in infants on the basis of reducing behavioural responses to pain, she showed that brain activity demonstrated unchanged cortical responses to noxious stimuli: sucrose was palliative but not analgesic. She also raised concerns about the amount of sucrose that routine use as analgesic would entail.

Maria has won many awards, both for contributions to basic science and to medicine. She was made a Fellow of the Academy of Medical Sciences in 2000 and elected to the Royal College of



Anaesthetists Faculty of Pain Medicine in 2013. The American Pain Society awarded her the Jeffrey Lawson Award for Advocacy in Children's Pain Relief in 2011, and she was the first basic scientist to receive it. Most notably, Maria was made a Fellow of the Royal Society last year.

She is held in considerable affection and admiration, and, indeed, awe, by her students and ex-students. Several ex-PhD students sent me comments about how she inspired creativity and scholarliness; about her kindness as a mentor; her 'almost uncanny ability to get to the root of a problem and think critically about it, often coming into discussion in journal clubs with 'yes, but what is the QUESTION?'; her red pen and high standards of clear expression.

Maria reminds me of Pat Wall, who was very proud of her: particularly her capacity to formulate the crucial questions, her courage in the face of criticism, and her lucid and compassionate writing about pain in humans. Like him, she represents the best of pain science: world class research which extends our understanding of pain and at the same time improves clinical practice.

BPS Honorary Membership Citation for Heather Wallace

By Dr Paul Cameron



Members of the British Pain Society, it is my pleasure and honour to deliver this citation for Honorary Membership of the British Pain Society to Heather Wallace.

I am indebted to the numerous people who have sent me contributions for this citation but in particular I would like to thank Paul Evans, who has worked with Heather now for the last 6 years. When told of this award, Paul told me that he thought it was well-deserved, and a testament to the hard work she has put in over the years to get to her current role as the Chair of Pain Concern.

Quite a few number of years ago, I was approached by Heather at a pain conference, where she asked me if I would be interested in joining an Advisory Committee. Little did I know, it would be a start of a 6-year relationship with Pain Concern, with Heather Wallace at the helm. In all the time I have known her, she has been a driving force behind the Pain Concern charity, and described

as an absolute 'Dynamo', when dealing with others in an effort to improve the lives of those in pain. While witnessing Pain Concern go from strength to strength under her leadership, I have admired her tenacity and drive ever since.

Of course I'm sure, years ago, Heather would never have imagined that her life would lead her to Pain Concern. Indeed, I am sure that when she was a student, incidentally sharing a flat with the ex-Prime Minister Gordon Brown, the thought of persistent pain never crossed her mind. However, like many, she was afflicted with long-standing pain and, in the words of her current colleagues, had to give up a 'promising' career in publishing. This didn't stop Heather though as, after a spell as a patient on a pain management programme, she went on to develop a pain support group in an area of Edinburgh, and this slowly grew, and developed into Pain Concern today.

Pain Concern is a national charity, involved in a wide array of areas, all designed to help those in pain. Providing regular podcasts with interviews from subject experts, conducting research – including her important work on 'Barriers to Self-Management of Pain', providing a Pain Programme to patients in Glasgow, providing information, both online and in leaflet format, and an active Helpline that

Heather herself still works on to this day. All culminating in a charitable service that continues to help patients in their time of need at all hours of the day.

Heather is not known as someone who blows her own trumpet. Nor is she known as someone who suffers fools gladly. Married to John, with two children, a 5-year-old grandson and a 7-month-old granddaughter, Heather is an active individual with a lust for life, and a passion to help others. She lobbies continually on the subject of pain, and improving the lives of others, and is on a number of National working groups pushing for better resources, better treatment and recognition for those in pain.

I first mentioned this award to Heather at a conference in Scotland, where she had set up a stand to tell delegates about the work Pain Concern was doing, and how they would help. In response to the award, Heather simply said 'thank you, that's very nice', and continued to work on her stand, encouraging others to help those with pain. That response, to me, demonstrated the type of individual Heather is. Hard working, unassuming and dedicated to improving the lives of others.

Ladies and Gentlemen, may I commend Heather Wallace, 'the Dynamo', for the extremely well-deserved award of Honorary Membership of the British Pain Society.

BPS Honorary Membership Citation for Professor Paul Watson

By Dr William Campbell



President, members of the British Pain Society. I am delighted to be in a position to provide this citation for Professor Paul Watson, in support of the award of Honorary Membership of the British Pain Society.

Paul graduated with a Diploma in Physiotherapy at the Salford College of Technology in 1979, later graduating from University College Salford with a BSc Honours in Health Care Studies.

Five years later, Paul completed an MSc in Medical Science. This was by research at the University of Manchester, followed by the completion of his PhD, 'The determinants of low back pain disability & response to treatment to non-operative approaches'. All of this interspersed with several certificates and diplomas based on healthcare, teaching and physiotherapy!

Paul first started working in a pain clinic environment at the Countess of Chester Hospital in 1986. Six years later, he discovered Professor Chris Main in Salford, while looking for an electromyography (EMG) machine to investigate myogenic causes of persistent pain. This was to be a prolonged professional relationship with Prof. Chris Main and Dr Chris Spanswick, resulting in the collaboration for huge number of pain research studies and the associated publications.

In 2002, Paul was the first Consultant Physiotherapist appointed within the United Kingdom, and by 2008, he was the first Clinical Professor of Physiotherapy within the United Kingdom, based at the Department of Health Sciences, at the Leicester University Medical School. From 2013 until the present, he continues to maintain that link with Leicester Medical School, as Emeritus Professor of Pain Management and Rehabilitation.

Paul's research work has revolved around musculoskeletal and spinal pain, as well as rehabilitation and return to work. Apart from the many publications in this area, he has raised well in excess of £3.5 million in research grants over the past 16 years.

Paul has in well over 100 peer-reviewed articles to his name in such journals as *Pain*, *Spine*, *the Clinical Journal of Pain*, *the Lancet*, *the British Journal of Anaesthesia* and *Physiotherapy and Physical Therapy*. In addition to these, Paul has contributed to over 20 textbooks on pain-related subjects and presented at every British Pain Society Annual Scientific Meeting within the 20 years from 1993 to 2013, with the exception of 2010. He also presented at every International Association for the Study of Pain (IASP), World Congress between 1996 and 2012.

His editorial work includes the following:

Associate Editor for *Pain Reviews*, Section Editor for *Musculoskeletal Physiotherapy Journal* and being on the Editorial Board for *Spine*, *the European Journal of Pain*, *the Journal of Occupational Rehabilitation* and *the British Journal of Pain*.

Paul joined the then Pain Society of Great Britain and Ireland in 1994. Shortly after that, he developed the first MSC programme in pain management, specifically for physiotherapists, and a few years later was elected Chairperson of the Physiotherapy Pain Association.

In 2006, he was awarded Distinguished Fellowship of the Chartered Society of Physiotherapy, for services to pain management, and within the same year was appointed as one of the independent clinical advisors for NICE (the National Institute for Health and Care Excellence), reviewing the management of low back pain, chaired by a Primary Care Professor. Coinciding with this, he was an executive committee member of the Chronic Pain Policy Coalition, from 2008 to 2012.

Within 3 years of joining the Society, Paul became a Council member in 1997 and took on committee membership for the Scientific, Research, Educational, Patient Liaison and Scientific Programme committees. He continued with input to these committees for a decade, and was Chairman of the Scientific Programme Committee – for 4 years – until 2007.

In 2009, Paul's high standing in the world of pain was recognised by the BPS Membership – when he was elected as the first non-physician to be President of the BPS.

Unfortunately, within a few months, events unfolded that many of us are aware of and indeed saddened by. The events were outside of Paul's control.

As Honorary Secretary at that time, I had the unenviable task of dealing with Paul's resignation letter, and I will always remember how within that letter Paul

BPS Honorary Membership Citation for Professor Paul Watson

demonstrated his true strength of character: and I quote:

I will be available to advise and support the activities of the Society as required, and pledge my full support to the Society for the future.

Despite the huge amount of work within the field of pain, Paul does have an active social life!

He is a keen mountaineer and rock climber. He has raised many thousands

of pounds for charities, running hundreds of miles (including a 1200-mile route from John O'Groats to Land's End in 2013) with his Border Collie – Midge.

Paul also is a self-sufficient allotmentee and charcutier – producing bacon, salami, sausages, haggis, beers and cider. He tells me that he hasn't knowingly poisoned anyone (yet).

In summary, Paul is an outstanding example of what a clinical teacher should aspire to. Someone who cares enough to research his field well, in order

to bring about improvements in clinical care, as well as ensuring that his knowledge and skills are passed on to others. Anyone would be proud to have a CV such as his (most of which I have had to omit due to lack of time). Considering his major contributions, not only to the British Pain Society but also the pain community as a whole, Professor Paul Watson is most thoroughly deserving of Honorary Membership of the British Pain Society.



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Report from the Acute Pain SIG AGM – May 2017

Suchitra Kanagasundaram *Secretary to the APSIG*

This year's APSIG AGM (Acute Pain Special Interest Group – Annual General Meeting) was held on the second day of the 50th anniversary of the Annual Scientific Meeting (ASM) at Birmingham, chaired by Ruth Day. The objectives of the APSIG, as determined at the 2016 AGM were outlined as follows:

- Facilitate and dissemination of good practice in acute pain;
- Encourage multidisciplinary acute pain education, research and audit;
- Continue support for a registry for acute pain;
- Organise meetings, seminars and workshops on acute pain management;
- Establish links with other acute pain forums in the United Kingdom.

Projects completed this year included the following:

- Study day in acute pain: a day on persistent post-surgical pain was held

the day before the ASM. With special prices for those attending this and the ASM, it attracted around 80 delegates. Jane Quinlan and Felicia Cox were thanked for their role in this successful meeting. A report of this meeting was in the previous *Pain News*.

- Joint workshop with PMPSIG (Pain Management Programme Special Interest Group) on the topic of frequent attendees to hospital; a useful session and one which further raised the profile of acute pain services.
- Establishment of a web-based platform for exchange of information and to share guidelines/protocols. The Acute Pain Hub UK is hosted by the Knowledge Hub. Sailesh Mishra coordinates this, assisted by Harriet Barker. The platform is accessible to any health professional and currently has over 100 members. See details at: <https://khub.net>
- The APSIG website is maintained by Nilesch Chauhan. He welcomes

feedback as he would like to make further improvements. The complete minutes of the AGM are now available at: <https://www.britishpainsociety.org/acute-pain-special-interest-group/>

- The joint publication by APSIG and Patient Liaison BPS group was launched at the ASM, 'Understanding pain after surgery – Information for adult patients and their carers'. This is now available for perusal and can be ordered via BPS.

The second half of the AGM was an open discussion regarding clinical experience and expertise in using Lidocaine for perioperative pain management. Despite variability and inconsistency in monitoring and availability of appropriate monitoring facility to extend Lidocaine infusion into the post operative period, Dr Srivastava was able to guide us to a consensus with respect to patient selection and dosage.

ASM 2017, Birmingham - Reflective Precip



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Rhiannon Edwards

It was an honour to be a recipient of the bursary to be able to attend the Annual Scientific Meeting (ASM) 2017. As I approach the end of my PhD studies, this conference fell at a crucial time period within my studies and provided me with an opportunity to present my work, meet with colleagues and establish links external to the research team in Bath.

During the ASM 2017, I presented the latter half of my PhD studies as a poster. This was a fantastic opportunity for me to talk informally with potential colleagues and collaborators about the work I have completed at the Bath Centre for Pain Research. Bath Centre for Pain Research targeted the BPS ASM 2017 as an annual meeting because of the specialist audience.

Within this specialist pain audience, there are also a mix of researchers, clinical psychologists, physiotherapists and practicing clinicians; as my research focuses on the social aspect of pain, the variety of pain specialists that I could meet with was welcomed. Due to the range of pain specialists in attendance, I was able to receive vital feedback on the work I have done for my PhD; additionally, the poster session also facilitated discussion about future areas of research, along with some of the new research questions my work has highlighted.

The range of workshops and symposiums was also a very positive aspect of this meeting, and the emphasis that was applied to the psychological mechanisms behind pain was refreshing.

I thoroughly enjoyed attending these symposiums, as well as others, including the session on funding a pain research proposal.

This brief overview has outlined how I have personally benefited from attending the BPS ASM 2017. To be given the opportunity to present my work was invaluable, as were the discussions in the breaks with other pain specialists. Personally, I would encourage any trainee to attend this meeting, as the environment is friendly, supportive and informative which provides many opportunities to expand on knowledge and ideas. Finally, I would like to thank the British Pain Society; this could not have been made possible without the support of the Society and the financial aid they provided me with.

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ASM 2017, Birmingham - Feedback summary



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Monika Halicka *PhD Student*

Dear British Pain Society,

I would like to express my gratitude for awarding me a bursary to attend the 50th Anniversary Annual Scientific Meeting of the British Pain Society. This excellently organised conference was the first pain-specific meeting that I had an opportunity to take part in and I must admit that it exceeded my expectations. As a psychologist, I was glad to find that field very well represented, not only in the scientific programme but also in more medically focused presentations. The speakers consistently acknowledged psychological factors related to persistence of post-operative pain and transition to chronic pain. What is more, many presented studies were looking not only at the sensory aspect of pain

but also at its emotional and motivational components. I was delighted to see that kind of progress in an interdisciplinary approach to pain. Attending this conference enabled me to widen my understanding of the complex reciprocal relationship between pain and sleep, pain and trauma, the great advantages of physiotherapy in managing chronic pain and improving daily functioning, and the dangers of opioids misuse. I further benefited from learning about the current trends in Acceptance and Commitment Therapy used in the population of pain sufferers, as well as the role of resilience in explaining and predicting health and disease. All of the above are highly relevant to my present PhD programme focused on the

psychology of pain. Another aspect of this year's ASM that was of great value to me was the opportunity to get to know other researchers working in the similar field, share our ideas and make plans for the potential future collaboration. The organisers have provided great space that facilitated networking, both at the poster session and the social event. I also appreciated the possibility to present my research to the broad auditorium during the Top 5 Student/Trainee Poster Abstract session. It was a very valuable experience from the perspective of early-career researcher. I would like to thank and congratulate the Organising and Scientific Committees for making this meeting possible and I already look forward for the next edition.

ASM 2017, Birmingham - What is the use and value of attending the British Pain Society's ASM?

Clair Dempsey

I'm a PhD student at the Centre for Technology Enabled Health Research at Coventry University. I'm currently working on a systematic review investigating the effectiveness of non-surgical, non-pharmacological interventions at improving quality of life for women with chronic pelvic pain. I'm planning on designing an 8-week mindfulness-based intervention to improve the quality of life for women with endometriosis and adenomyosis.

I have a BSc (Hons) Psychology and have always made an effort to be a member and attend conferences of the British Psychological Society. I'm also a member of the Midlands Health Psychology Network. While membership of these organisations is useful for networking and presenting my work, as well as representing my university, the

conferences are often not relevant to my work. Pain research is often not well represented in psychology conferences. Attending the BPS ASM allows me to learn about up-to-date research, discuss my own research and network with those from different disciplines. This year, there was a specific session on advances in management of abdomino-pelvic pain. There were some controversial points in all three presentations, which inspired a lot of conversation and debate. There was also a theme of ACT on Thursday and Friday. The resulting discussion about resilience in pain patients was engaging and thought-provoking.

While attending the sessions in the auditorium, I realised I was sitting beside authors of papers I had recently read as part of my work. These authors were not psychologists, and I was grateful of the

chance to have a dialogue with them. I also bumped into Kate Seers in the Starbucks nearby.

I really started thinking about how I could build resilience into my intervention and how to measure for this quality before and after my participants attend the intervention. Chronic pain has a resounding impact on the healthcare system, as well as the patient. Coupled with the ongoing opioid crisis, encouraging resilience seems a necessary development in managing chronic pain.

Attending the ASM allows members to be included in the conversation about the future of pain research and management. It allows members to make a contribution as well the opportunity to learn from our colleagues from a variety of disciplines.

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ASM 2017, Birmingham - 'My experience as a student nurse attending the British Pain Society's annual scientific meeting'

Fiona Mak *Student Nurse, University of Birmingham*

How did you hear about the opportunity to volunteer at the BPS ASM and why did you volunteer?

This year I had the opportunity to attend the British Pain Society (BPS) Annual Scientific Meeting, at the Birmingham ICC as a volunteer. I heard about this opportunity through my university; I am currently a second year student nurse from University of Birmingham. Pain is something that I encounter very often with patients during my clinical placements. I was very keen to find out more about pain and the alternative treatments that are available to manage it; therefore, I took the offer and volunteered. By volunteering, it enabled me to learn from experts from a variety of professional backgrounds.

What opportunity did you have to attend plenary lectures/workshops?

Although I was helping out during the conference, I was lucky that it did not stop me from attending a variety of plenary lectures and parallel sessions that was available. What I especially liked about the parallel sessions is that they used a multidisciplinary approach, where different health care professionals shared their experiences and their findings.

What new information did you learn? Could anything you have learnt be imbedded in your current clinical practice?

Due to the fact that I'm still a student, I felt quite inexperienced in terms of dealing and managing patients who are in pain when I'm on clinical placement. This conference has helped me to learn more about pain, as the majority of the material presented during these sessions was quite advanced compared to what I was taught in university.

From the parallel session 'persistent post-surgical pain (PPP): from pain to marginal pain', I learnt that pre-, intra- and post-operative factors play a role in the development of persistent surgical pain. Furthermore, pre-assessment before surgery to identify these risk factors might reduce the chance of acute pain resulting in chronic pain. I can incorporate this into clinical practice by identifying modifiable risk factors that can cause persistent pain post-op before my patient goes for his/her surgical procedure.

In the parallel session 'Patient and professional education to improve pain after surgery', it focused on breast cancer patients and how we as health care professionals can facilitate the patient to understand and manage their pain effectively after surgery through education. During this session, the

'Understanding and managing pain after surgery: information for adult patients and their carers' booklet was introduced. Although this was only a taster version, the booklet demonstrated that it is a useful tool to guide and educate patients. For example, it contained information such as the importance of pain medication regimen and other pain management methods. I think this is an excellent idea to introduce in clinical practice as the booklet contains simple but important information that the patient can easily understand, that may help them to manage their pain more effectively.

Did you meet any pain specialist nurses? Should having one as a buddy for next year's volunteers be considered?

By attending this conference, I was able to meet specialist nurses with a variety of clinical backgrounds. As a student, I have always found it daunting to speak to specialists during placement. Although the conference broke down this barrier for me and enabled me to converse with them in a natural manner, I found it difficult to identify who is who. I think it will be a great idea for next year's student volunteers to have a health care professional as a buddy. To be truthful, I did feel lost at times during the talks and

ASM 2017, Birmingham - 'My experience as a student nurse attending the British Pain Society's annual scientific meeting'

had no idea what was going on! Having a professional buddy with volunteers next year may enable greater networking opportunities as well as enhancing the learning experience.

Has the ASM made you think differently about specialist nursing practice?

I have always admired specialist nurses; they use their knowledge and clinical judgement to provide personal care for patients. ASM demonstrated that they

are also often involved in research that finds ways to improve care that is provided for the patient.

Would you now consider that after some general postgraduate ward experience that you might consider specialising in pain management?

By attending the BPS AMS this year, it has really been an eye opener for me in terms of the different opportunities out

there in pain management. I will consider specialising in pain in the future, as there are some areas that really interest me; however, I would like to experience other speciality as well.

Once again, I want to give my thanks to Felicia Cox for giving me this opportunity to write about my experience at the BPS AMS.

I really enjoyed the conference this year; it has been a great learning and networking opportunity for me. Hopefully it won't be my last!

Join our Special Interest Groups (SIGs)

The British Pain Society recognises the importance of providing members who have specific interests with a forum (Special Interest Groups) to discuss their interest in more depth. The Society actively encourages and supports the development of such Special Interest Groups, as they are an important element of our multidisciplinary Society and are a key member benefit. There are currently 14 SIGs;

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



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

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Who are we?

We are an alliance of professionals advancing the understanding and management of pain for the benefit of people living with pain.

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The British Pain Society is the largest multi-disciplinary organisation for pain in the UK as shown by the variety of disciplines comprising our membership. The British Pain Society is also the official British Chapter of the International Association for the Study of Pain (IASP), and as such is also a member of The European Pain Federation (EFIC).

What do we do?

The British Pain Society aims to promote education, training, research and development in all fields of pain. It endeavours to increase both professional and public awareness of the prevalence of pain and the facilities that are available for its management.

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50th Anniversary ASM, Birmingham



ICC Birmingham



Professor Frank Porreca and Dr Andrew Baranowski



Dr Paul Wilkinson and Dr Zoey Malpus



Dr David Walsh and Professor Kate Seers (incoming and outgoing Chairs of the Scientific Programme Committee)



Delegates enjoying a well-earned cup of tea



Margaret Dunham, Felicia Cox and Emma Briggs



Dr Zoey Malpus



Poster Exhibition



Professor Kate Seers and Professor Sam Eldabe



Dr Zoey Malpus and Professor Lance McCracken



Dr Paul Wilkinson and Dr Nicole Tang

50th Anniversary ASM, Birmingham



Past Presidents of the BPS (L-R): Dr William Campbell, Professor Sir Michael Bond, Dr Timothy Nash, Professor Paul Watson, Dr Douglas Justins and Dr Andrew Baranowski



Top 5 Student/Trainee Poster Abstract Presenters



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Dina Almuli and Professor Kate Seers



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Cocktail Making



Enjoying the party



Cocktail Making



Bar at Nuvo



Delegates dancing the night away

A rare case of facioscapulohumeral syndrome with widespread chronic pain

Mohamed Dorgham *University Hospitals of Leicester NHS Trust*

Thanthullu Vasu *University Hospitals of Leicester NHS Trust*

Mahesh Kodivalasa *University Hospitals of Leicester NHS Trust*

Background

Facioscapulohumeral syndrome (FSHS) is the third most common muscle dystrophy first described in 1886.^{1,2} It is an autosomal dominant disorder clinically defined as progressive asymmetric muscular weakness typically of the face, scapular stabilisers, proximal arm and leg. However, clinical presentations may vary.³ It can range from asymptomatic individuals to complete loss of ambulation due to weakness.⁴ Chronic pain is a frequent and likely under-recognised complaint in affected individuals, with a prevalence as high as 77%.⁵

The prevalence of FSHS is estimated at approximately one in 20,000 individuals. However, a population-based study in 2014 in the Netherlands reported a significantly higher prevalence of 12 in 100,000.⁶ The disorder affects men and women equally. The age of onset is variable but 90% of sufferers notice some weakness prior to 20 years of age. However, FSHS can have a very insidious clinical presentation during the third or fourth decades of life also.

Prognosis is variable with 20% of patients ending up in a wheelchair and usually inversely related to the age of onset. Progression is slow and steady affecting one muscle group followed by period of stability. Life expectancy is not generally compromised probably due to spared cardiac and respiratory muscles.^{6,7}

Uniqueness of the case

Widespread chronic pain remains one of the biggest challenges in pain clinics.

Despite the wide range of the differential diagnosis of this condition including rheumatological, neurological and musculoskeletal disorders, it is difficult to answer this question in many occasions, especially when dealing with relatively uncommon conditions that are not seen in common practice.

Although the management of FSHS is mainly based on conservative measures as in any other chronic widespread pain, explaining the pathophysiology and diagnosis can play a big role in the outcome.

FSHS is difficult to diagnose and can be confused with other muscle dystrophies unless there is enough knowledge and experience in this condition.

Clinical presentation

A 51-year-old male presented with chronic widespread pain of moderate intensity (visual analogue score of 4–5 out of 10). He described a constant mixed-type pain affecting his neck, shoulders, arms, back and legs for the last 18 years. The pain had got worse in the last 2 years along with sense of generalised weakness; this was worse in both the shoulders that he was not able to lift heavy weights or undertake press-ups.

He denied any speech, swallowing or breathing problems. He described that the pain started in his lower back and then progressed slowly over years to involve both the shoulders, arms and legs. He had been examined and investigated by the orthopaedic team who ruled out structural abnormalities in

his spine, before he presented to our pain clinic.

He lives with his wife and three children and is self-employed. On detailed questioning, it was evident that this pain had an impact on his sleep, mood, stress levels, sex and participation in social and family activities.

Associated symptoms included constipation, dizziness and headaches. *Family history* includes FSHS affecting mother, brother and older sister.

Examination

He had widespread allodynia all over his body without any dermatomal pattern. He had a muscle power 4/5 MRC in both shoulders and arms, 4/5 for hip flexion and extension, and 4/5 for knee extension. He also had features of bilateral scapular winging, anterior rotation and dropping of both shoulders. He had significant bilateral muscle wasting affecting trapezius, pectoralis and some degree of deltoid and triceps muscles.

Diagnosis

Genetic testing revealed pathogenic gene rearrangement at 4q35. *EMG/NCS* showed evidence of myopathy affecting proximal and distal muscles, more severely affecting scapular and humeral regions with sparing of deltoid muscle.

Management

Our detailed comprehensive management plan used the multimodal biopsychosocial model; supportive,

A rare case of facioscapulohumeral syndrome with widespread chronic pain

symptomatic and self-management strategies comprised the main pillars of management plan.

Adjustment of patient's expectation, education of pathophysiology of chronic pain, use of metaphors to explain chronic pain, self-management (leaflets, pain toolkit), coping and pacing strategies were the initial part of the comprehensive management strategy.

Supportive measures offered included Physiotherapy, Hydrotherapy, Psychology and Pain management programme. Symptomatic treatment involved pain killers (simple analgesics and adjuvant analgesics including Pregabalin and Duloxetine). We also offered intravenous lignocaine infusion as part of the comprehensive multimodal strategy for pain relief in our day-case theatre.

Conclusion

This case report details a patient presenting with FSHS confirmed on genetic testing. This is a rare condition of muscle dystrophy presenting with widespread chronic pain before

development of FSHS-related muscle weakness. *This raises the concern of adding FSHS to the differential diagnosis of widespread pain and highlights the importance of family history in such cases.*

Having a diagnosis and understanding the nature, cause and prognosis of the disease improves the patient's attitude in terms of expectations, motivation, involvement in deciding management strategies, keeping active to avoid consequences of disease progression and eventually improve overall patient satisfaction.

As with many of the widespread pain syndromes, adopting the Biopsychosocial model along with symptomatic and physical therapy is the best way forward to minimise disability due to disease progression.

Acknowledgements

This case report was presented partly as a poster in the 50th Annual Scientific Meeting of the British Pain Society, Birmingham, May 2017.

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The Faculty of Pain Medicine in context – a personal view

Barry Miller *Dean, Faculty of Pain Medicine*



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History is not the event, but why before and after are different.

'So what does the College actually do?' This was the title of an article by the then President of Royal College of Anaesthetists in 2009.¹ This year marks the 10th Anniversary of the Faculty of Pain Medicine, created as the first child of the Royal College of Anaesthetists in April 2007, and it is still a question asked.

I think to understand its role and its complementary relationship to the British Pain Society (BPS), it is useful to do a quick review of those aspects of the past that have shaped Pain Management. Sometimes, looking at the various branches in isolation makes understanding the tree as a single entity difficult.

Healthcare throughout history has been a mix of symptom relief and attempts to cure diseases. Initially, only the former was occasionally helpful, the latter rarely.

Medicine, in any form we would recognise it, came into being over a relatively short period of about a 100 years beginning in the mid-19th century. The



discovery of (largely) safe anaesthesia led to a massive increase in surgical options (read pre-anaesthetic accounts of treatment for renal stones² or breast surgery³); the reduction in complications with asepsis, aided by the discovery of the bacterial causes of infectious diseases towards the end of the century; and in the early 20th surgery, the first antibiotics (Salvarsan for syphilis introduced in 1910, the first sulphonamide in 1935 and Penicillin in 1942).

But over the same period, the philosophy of medicine had begun to change. Increasingly, the opioids were becoming viewed as a social problem (history does tend to repeat itself!), and tight worldwide control introduced, beginning with the International Opium Commission in 1909. Diagnoses became increasingly accurate, and new treatments meant that cures had become a reality. Symptoms were relegated to guides, no longer the focus of intervention. The new paradigm 'See, investigate, treat, discharge' became a working ideal.

The horrors of the Second World War had a profound influence; the obvious being the increased prevalence of acute and chronic pain related to injuries, civilian and military; but the latter had occurred after the Great War without a sea change in the perceptions of symptoms. Increasing recognition of individual human rights led to more

interest in both short- and long-term symptoms. Additionally, new medications targeting the brain (Imipramine, Chlorpromazine and Phenytoin in the 1950s) were created.

Pain Medicine followed two separate routes; for the management of cancer and palliative symptoms, it developed within a physician model, with a notable relaxation on the use of opioids. For all other chronic pains, it developed out of an anaesthetic model, where early practitioners used their knowledge of regional anaesthesia.

These two camps have remained relatively separate, though both have much to teach and learn from each other.

In the United Kingdom, the 'Pain Group' met in 1967, welcoming its first non-medical members in 1987, and ultimately becoming the BPS. The society has moved from strength to strength and long may it remain so.

So we arrive in the late 1990s. Medical Education and careers were under intense regulatory focus, with considerable interest in reform across the spectrum: from qualifications and working practices to specialist recognition.

Most medical practitioners within Pain Medicine were, and are, anaesthetists. There are many other doctors from various disciplines, but anaesthetists are the majority, and most pain services were built around them. Medicine, and the right to practice, is tightly regulated, and to be a consultant, an individual has to have completed prolonged training to be eligible for the Specialist Register, but the register only has a limited number of

The Faculty of Pain Medicine in context – a personal view

specialist and sub-specialist designations, and Pain is not one of them.

Nonetheless, it is the task of the colleges and their faculties to create and quality assure all areas of the activities of their fellows and members, and it was clear that Pain Medicine needed this focus. The College of Anaesthetists gained her Royal Charter in 1992, and this allowed for increasing freedoms in its management of areas of practice. In the mid-1990s, the Royal College of Anaesthetists set up the Pain Management Committee,⁴ under the Chair of Dr Doug Justins, to look into the training, recognition and accreditation of Anaesthetists, who have substantial commitments to Pain medicine. In 1999, the college published a document for units wishing to provide Pain training, and the number of Consultant Anaesthetic jobs requested some interest in Pain, was around 12% by 2000, reflecting growing recognition and support for this area of practice. The reform of curricula required by the regulating bodies in 2000 provided a serendipital moment to create specialist areas within the anaesthetic curriculum.

In 2003, the college created the posts of Regional Advisors in Pain Medicine as a means of advancing pain medicine, both as a core anaesthetic skill, and to guide local implementation of the curriculum for those with a specialist interest and to the hospitals providing training at various levels. With local networks of local pain educators (now the Local Pain Medicine Education Supervisors (LPMESs)) developed to reflect the College Tutor network. The

college also moved to new larger premises in Churchill house in 2000. By 2004/2005, consideration was being given to the creation of a faculty,⁵ and in 2006, a founding board had been created, with the faculty becoming a reality in April 2007.

Which bring us back to the 'What does it do?' question.

The faculty is the semi-autonomous arm of the Royal College which deals with education and training – through its Training & Assessment Committee (TAC) – and guidance on professional standards – through its Professional Standards Committee (PSC).

These are the broadest of broad strokes – and there are important implications to the work of the committees.

As examples, TAC is tasked with the 'Advanced' curriculum in Pain Medicine. All trainee anaesthetists must complete advanced training in some subjects and an individual needs a certain amount of training, experience and evidence of success in these to complete their anaesthetics training. This is a GMC requirement. If they choose this in Pain Medicine, although not named on the specialist register, this information is crucial to securing a consultant post with a Pain Medicine component. In theory, after completion of training any anaesthetist could change their job plan to do Pain work, but the existence of the curriculum effectively means that if they wish to do so, they would be expected to gain and prove similar experience, and there would be medico-legal implications if they did not.

The PSC produces material on how work is conducted, both at a

departmental level and with patients. But it is viewed by other bodies, including the various regulators. The work the committee has done on Core Standards is being used by the CQC as their template for reviewing pain services and is an important document in dealing with CCGs.

The faculty and the BPS collaborate on projects. Currently, we have a joint working group on the use of outcome measures in pain services, and are working, with others, arranging a meeting with parliamentarians to highlight the issues of Pain Medicine, in terms of education, resources and suffering.

The future

Pain Medicine is a multidisciplinary subject, and it is important that we recognise that this is not just at a local service level but also at an organisational one. The faculty, the BPS and others work closely together. We have representation on each other's boards, with formal and informal links: to support each other, to avoid duplication and to work together on projects which clearly fall into both our remits.

We are all stronger together.

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Pain management in a teenager with Morquio syndrome – case report

Mahesh Kodivalasa *University Hospitals of Leicester NHS Trust*

Thanthullu Vasu *University Hospitals of Leicester NHS Trust*



Credit: Janulla

Morquio syndrome is an autosomal recessive mucopolysaccharidosis¹ (mucopolysaccharidosis IV (MPS IV), Morquio–Brailsford Syndrome). Clinical features of this rare syndrome could include cervical subluxation, paralysis, kyphoscoliosis, joint hypermobility, genu valgum, pectus carinatum, respiratory failure, cardiac failure, visual defects and deafness. Pain is an under-reported symptom of Morquio syndrome.^{2,3} Pathology involves defect in metabolism of mucopolysaccharides leading to accumulation of keratin sulphate.⁴ Reports have clearly shown that these patients have significant functional limitations and reduced quality of life.⁵ We wish to report a rare case of a patient with Morquio syndrome who presented to our chronic pain out-patients clinic.

An 18-year-old patient was referred by the paediatric team to our pain clinic for the management of chronic widespread pain. Her pain was worse in the lower back and both hips. She mentioned that even light touch caused significant pain. Her pain was constantly affecting her and was varying in nature. She had been wheelchair bound since the age of

10 years. Her pain affected her quality of life significantly. She suffered with low mood and disturbed sleep also. On detailed questioning, her pain affected her university progression, as she was not able to concentrate on her lectures and study. She had tried amitriptyline in the past but could not tolerate the side effects and was commenced on gabapentin before she presented to our clinic.

She had a short stature and weighed 22 kg only. She had radiological features of C3/4 compression with diaphragmatic palsy; she used non-invasive positive pressure ventilation at night. She was under the care of multiple clinical specialists for the management of complications of Morquio syndrome and associated symptoms – this included paediatrics, transitional metabolic medicine, cardiology, respiratory medicine, psychiatry, spine surgery, ophthalmology, ENT and dermatology.

This patient with Morquio syndrome with multi-system dysfunction, depression and limited mobility posed a challenge for the chronic pain management. A patient-centred holistic approach was the goal of our management strategy. Her realistic expectations were explored in great detail. She was directed to educational tools to understand chronic pain and coping strategies. In our practice, significant efforts were taken to educate her about the pathophysiology of chronic pain; metaphors were used to educate her about the need to look at self-management strategies and the need for the biopsychosocial model.

She was offered various multimodal treatments including the following: a trial of a TENS (transcutaneous electrical nerve stimulation) machine through our specialist nurse, physiotherapy and psychological support through individual appointments in our pain service. She was advised to continue gabapentin and educated about how this neuropathic medication helps and in the pharmacokinetics of the medicine. She was offered topical 5% Lidocaine plasters along with her routine medication. Although we explored the interventional routes including a trial of acupuncture and trigger point injections, she wanted to try other options to start with. All the other specialists involved in the management of her complex rare medical syndrome were informed of the management plan to ensure continuity of care and co-ordination of overall management.

The management strategy for chronic pain patient with complex medical problems should involve understanding of basic underlying disease and tailored pain management strategy, which addresses patient's realistic expectations. It has been reported that better pain management in this rare syndrome can improve quality of life of these patients.⁶ Our patient was keen to try only simple treatments including TENS, psychology and physiotherapy; she continues to keep active and is an active part of her community. Our pain team was successful in inculcating the self-management strategies to help her chronic pain despite this rare metabolic disorder.

Pain management in a teenager with Morquio syndrome – case report

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Audit of non-theatre interventions in the Pain Service

Bhavesht Raithatha *University Hospitals of Leicester NHS Trust*

Thanthullu Vasu *University Hospitals of Leicester NHS Trust*

Kandasamy Bharathi *Wrexham Maelor Hospital*

Introduction

Out-patient injection procedures are an important part of the multimodal strategy to manage persistent pain in a biopsychosocial model. Non X-ray interventional procedures can be performed in a dedicated clean room to improve the efficiency of patient turnover. This designated area allows the admission and discharge of the patient with minimal disruption to the demands on hospital beds. It has to be assessed whether performing an increased number of cases as compared to a theatre setting also ensures whether high standards are met.^{1,2} We audited these clean-room injections in September–October 2014. Informed consent, patient review and patient outcome are the key areas that were assessed in this audit.

Aims

To audit the clean-room interventions in the chronic pain service at the University Hospitals of Leicester NHS Trust with the following standards:

- All procedures should have informed consent;^{1,2}
- All procedures should be reviewed by telephone follow-up (target = 90%);^{2,3}
- Efficacy of more than 30% pain relief (target = 60%).

Methods

A total of 40 patients were retrospectively audited from September 2014 to

October 2014. All these patients had clean-room injection procedures done under aseptic precautions. All patients had telephone reviews as per our standard protocol at 6 weeks after the injection; these clinical records were retrieved from the ICE computerised system. The data were input and analysed using Microsoft Excel.

Results

The data demonstrated a range of procedures performed in the clean room. Trapezius trigger injections were the most common procedure performed. Other injections included the following: occipital nerve blocks, trigger injections in abdomen, botulinum toxin injections,

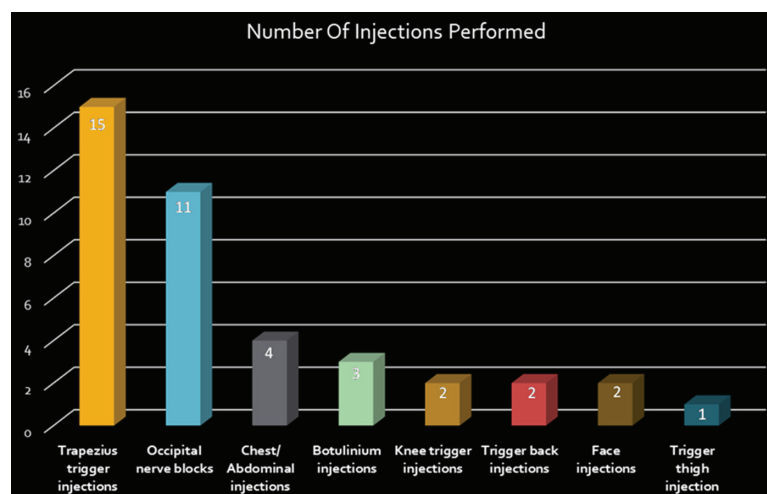
knee trigger injections, lumbar trigger injections, facial injections and other simple injections (Figure 1).



Credit: CSA-Printstock

100% of patients had informed consent, and all of them were reviewed by telephone consultation following the procedure. The mean time following the procedure for a telephone consultation was 10 weeks. 69.23% of patients had

Figure 1. Number of injections performed



Audit of non-theatre interventions in the Pain Service

successful pain relief with pain relief lasting for greater than 6 weeks. In this audit, steroid use had no difference in the success of pain management following an injection; however, our numbers were very small in this audit.

Conclusion

Clean-room injections have very good efficacy and are an important part of the multimodal chronic pain management.

Our audit demonstrated that all procedures received informed consent and had follow-up telephone consultations. 69.23% of patients had successful pain relief proving the effectiveness of our clean-room interventions. The audit also demonstrates that our structure and process adhere to the Royal College standards.

Acknowledgements

This audit was presented as a poster in the 50th Annual Scientific Meeting of the

British Pain Society, Birmingham, May 2017.

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The European Civic Prize on Chronic Pain: Patients as Teachers in Health Professional Education by Pelvic Pain Support Network

Bron Canwell *Pelvic Pain Support Network*

Members of the Pelvic Pain Support Network (PPSN) were excited and delighted to be invited to Malta to receive a prize for our work with trainee nurses and doctors.

In 2014, during the Italian Presidency of the Council of the European Union, there was particular focus on pain therapies, chronic pain and palliative care. The European Active Citizen Network has since investigated ways of promoting and supporting citizens' rights against pain. In 2015, they launched a research project: 'The European Civic Prize on Chronic Pain – Collecting Good Practices'. The aims of this are to raise awareness, encourage exchanges between professionals and patient associations, to gather evidence to support the care and treatment of patients with chronic pain and to raise awareness of technological advances.

We won a prize, in this first year of the award in the category – 'Professional Education'. It was awarded during the '7th Symposium on the Societal Impact of Pain' (SIP 2017) which was held in Valletta, Malta, and was supported by the Maltese Government. There were about 400 people at the symposium including medics, politicians, academics, pharmaceutical companies and representatives of patient groups. It was a great opportunity to meet a range of people, from all European Countries, who share the goal of improving the lives of people who suffer chronic pain, and to

do this effectively by collaboration. That we were staying in sunshine, in a beautiful hotel, by the Harbour in Valletta added to the experience!

The prize was presented by the President of Malta, H.E. Marie-Louise Coleiro Preca, at an evening banquet. She made an inspiring speech, showing insights and understanding

People living with chronic pain are not only dealing with the pain itself, but with uncertainty, discomfort, and confusion. Often, sufferers report feeling overwhelmed when they are dealing with their situation. These factors can all contribute to a disabling effect on the individual, who is, regardless, expected to continue to function in their places of work, their communities, and their societies...

This reality is often invisible to those who do not have disabilities, or disabling conditions, or to those who are not yet sensitive to these issues.

The President went on to look forward to new collaborations, good practices and policy recommendations. She was well informed having worked with various patient support groups in Malta.

The whole experience was memorable, encouraging and very exciting. As a sufferer from chronic pain, it made me feel validated and valued. I have suffered from chronic pelvic pain for

11 years, and despite support from family and friends and the PPSN, I have found life extremely difficult. Chronic pain can be an isolating, depressing, frightening experience, with no prospect of improvement. To know that there are so many people working towards improved outcomes gives me hope.

The award was given for our work: 'Patients as Teachers in Health Professionals Education'. Our objective is to give trainee health professionals, both nurses and doctors, the opportunity to hear first-hand, as part of the taught curriculum about the personal experience of people with long-term pain, and about their encounters with health professionals. Chronic pain has generally been neglected in medical education.

We have delivered these sessions to nurses since 2009, and to doctors since 2016, in Leeds and in Southampton. The sessions are lively and often humorous, despite the content. Students have the opportunity to ask questions, to delve deeper and to clarify the whole picture from the patient perspective. Our approach is one of openness and honesty. One husband of a pain sufferer joins the sessions to give a familial angle on the impact of pain on personal relationships. Evaluation questionnaires show that the students value our sessions highly. They say that there is no other 'Patient Pain Experience' in their curriculum, and they report that the impact it makes will benefit them in their



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The European Civic Prize on Chronic Pain: Patients as Teachers in Health Professional Education by Pelvic Pain Support Network

subsequent roles as practitioners. It was apparent from talking to attendees at the symposium, from other European countries, that our sessions are very innovative. They also raise students' awareness of chronic pelvic pain. Pelvic pain conditions are poorly diagnosed and treated, and although the recommendation has long been that of a multi-disciplinary medical approach, there are few examples of this in the

United Kingdom. Diagnosis can take a minimum of a year, and many sufferers fail to receive any help at all, and live restricted, painful lives.

We have been very lucky to have collaborated with lecturers/academic staff who are committed to the value of patient input and are willing to engage with patients who may have had difficult and negative experiences of services. This prompts students to consider their future

relationships with patients in clinical practice, and also gives them insights into the many approaches used by patients to self- manage their pain. The Nursing and Midwifery Council (UK) identifies the importance of Service Users and Carers involvement in curriculum planning. We look forward to developing this relationship.

I have returned from Malta feeling positive that there will be progress, and committed to helping that to happen.

➤ Keep us informed

How to amend your membership details

To check or amend your details, you need to sign-in to your **Online Account**.

Once signed in, click on **My BPS** and then **My Account**. Here you will see *Update Details*, *Change Password* and *Change Email Preferences*.

When you have made your updates, please click **Submit**.

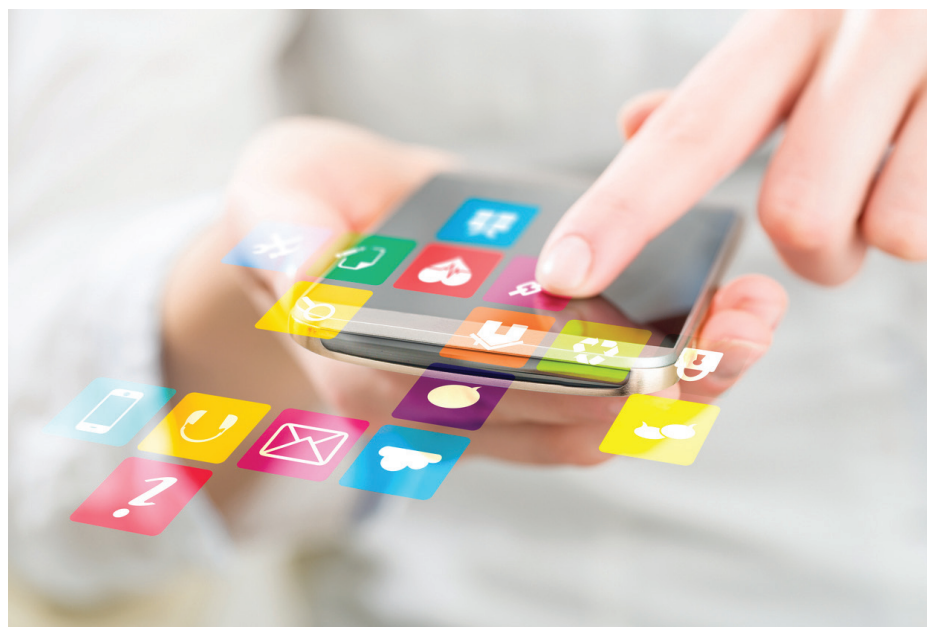
The screenshot shows a web browser displaying the 'My BPS' website. The navigation bar at the top includes links for 'BOM MEMBERS', 'BECOME A MEMBER', 'EVENTS', 'MEDIA', 'PEOPLE WITH PAIN', and 'ABOUT'. On the left sidebar, under 'MY BPS', there are links for 'TIMELINE', 'MY ACCOUNT' (which is highlighted), 'UPDATE SETTINGS', and 'MEETING BOOKINGS'. Below these links is a blue button that says 'DONATE TO THE SOCIETY'. The main content area is titled 'MY ACCOUNT' and 'Update Details'. It contains a form with the following fields: 'Email Address *', 'Given name *', 'Surname *', 'Address 1 *', 'Address 2', 'Town *', 'County', 'Country *' (a dropdown menu), 'Postcode *', and 'Phone Number *'. At the bottom of the form are two buttons: 'Submit' and 'BACK TO YOUR ACCOUNT'.

Pain Diary Apps – are they useful?

Rebecca Brierley *Lay Member of Patient Liaison Committee*

Being asked to keep a pain diary is something people living with chronic pain are often asked to do: by physiotherapists, pain psychologists or the various doctors they encounter. When my own pain became chronic, I was asked to do this by a number of clinicians either through informal jottings or the completion of charts. I did so by using pen and paper or through the use of the Notes App on my phone. Either way, I found the task dull and labourious – it was yet another job to do in my daily schedule which seemed to include ever-expanding pain-related activities (physiotherapy exercises, ensuring I changed position every 30 minutes, being mindful of my posture, being mindful generally, getting enough sleep, visualisations, reading information given to me, attending weekly appointments, etc.) and ever-decreasing free time – time that my mind wasn't in some way focused on my pain. Moreover, it was often a job that I forgot to do or was unable to carry out at the point of something notable: a possible trigger, a change in the pain or a change in my mood. I found that by the time I did manage to make an entry – usually in the evening or the following day – I'd have often forgotten key information.

This issue of pain diaries has come up a number of times at our Patient Liaison Committee meetings over the last year. At one point, we were considering developing a pain diary app. More recently, our discussions have revolved around whether pain diaries themselves are useful and whether there are apps already available that do what we were considering developing.



Credit: scyther5

Type 'pain' into the search bar of the App Store and a long list appears. Other than the Pain Toolkit by PainSense, which is more of an aid for self-management (diary keeping being just one part of this), and some apps aimed at helping people with pain to relax (hypnosis and meditation apps), the vast majority of pain apps are pain diaries or trackers. These range from general pain diaries to ones aimed at people with specific conditions resulting in chronic or frequent pain, such as migraines, fibromyalgia, irritable bowel syndrome (IBS) and rheumatoid arthritis.

One benefit of using a pain diary app is the speed at which an entry can be made. Apps enable users to record the locality, intensity, duration and type of

pain by the simple tap of a symbol, ticking a box or by doing a quick drawing. Pain diary apps therefore make it quicker and easier to make an entry on the go, especially as some of the apps do not require the user to be online to do so. Using a pain diary app would potentially have helped me to keep my pain diaries more up-to-date and accurate.

Another benefit of using an app compared to pen and paper is that an app takes the user through making an entry step by step, providing prompts of what to diarise. In my earlier days of living with chronic pain, some of these prompts would have been useful, for example, considering and recording my mood, stress or fatigue levels. Instead, I tended

Pain Diary Apps – are they useful?

to simply focus on the activity I was doing when my pain worsened, thus attributing this to be the trigger. Keeping a pain diary therefore made me make associations between certain activities in isolation and an increase in pain. For instance, the pain may have worsened during an afternoon walk, so I recorded this as an important event, believing it to be solely the walking that was responsible for an increase in pain. However, what was probably a more accurate account of what was at play was the walk was a little too long after a bad night's sleep and a stressful morning. It was therefore not the walk itself but the accumulation of events causing an increase in pain. Using an app that takes the user through a range of things to diarise could help build up a broader picture of potential triggers, either for self-management or to discuss with a clinician.

A quick scroll through the pain diary apps available in the App Store revealed the majority of are paid for apps, with the free options usually an introductory or taster version of a paid for version. For example, Chronic Pain Diary Lite and Chronic Pain Diary Pro. Alternatively, some of the 'free' apps provide limited functionality, such as a smaller number of diary entries or recording options, and offer top ups for a cost to expand the app's function, for example, Catch My Pain. However, a number of free versions potentially offer enough functionality to be helpful to people needing to keep a diary of their pain.

Catch My Pain

This app is easy to set up on first use, taking a new user through adding an entry step by step. It is also straightforward, quick and visual to add a new entry: the user chooses a colour for pain intensity, then with a pen tool draws a simple figure to show the localisation of pain (front, back and sides). Particularly useful is that the colour of the pen can be changed to show different intensities of pain in

different localisations. The time frame of the pain is then selected, with some short-cut options, for example, 'from last entry' or 'full day', but it is also possible to specify a specific time and duration. Next, the user is taken to a sliding scale of overall intensity of pain from 'no pain' to 'worst pain imaginable', and finally, a list of 30 options to describe the type of pain. These are helpfully listed in alphabetical order. However, although the user can tick multiple options to describe differing types of pain, it's not possible to match these to different areas of the body. In order to record this information on the app, the user would have to make a note of this at the end of the entry where there is a space for written comments. To add further details, such as happiness, stress and fatigue levels, the user would have to pay to add this option. Basic weather at time of pain can be recorded for free if the app is granted permission to access the phone's location. But any more detailed weather recordings, such as humidity, cloud coverage and wind speed, are also a paid add-on.

Other useful free features of this app include the following: notifications to remind the user to record an entry; an option to add medications, which are then saved for review; and a pain chart that begins to be graphed after three entries. The diary can also be emailed via a link, which expires after the time the user specifies (anywhere between 1 and 30 days) so could be shared with a clinician in advance of an appointment, and entries can be made without an Internet connection after the initial set up. In addition, the app also has a community forum for those who want to connect with others in pain – the posts I read were positive and supportive, with some users posting creative and uplifting exchanges, and not all pain-related.

Nanolume

Creating a diary entry for the first time was a little harder than in Catch My Pain

because there were more instructions in one go. Initially, the user is asked to choose a type of pain, and it is only possible to select one type from the list. The intensity of this pain is then described by using a sliding scale from 1–10. Therefore, on first glance, the app seems quite limited. However, after this, the user is again taken to a simple figure to draw the localisation of pain, and it is here that different types of pain can be added, each one with its own level of intensity. The user is then able to view the drawing with just one or all 'layers' of pain. This feature is a very quick and visual way of recording different types and intensities of pain in different locations of the body – something that is not possible to do in Catch My Pain. However, only front and back views of the body are available in Nanolume. From this information, the app charts pain intensity and coverage area. But given how it is very difficult to record the area of the body in pain with any level of accuracy, the usefulness of this feature – that then plots the pain intensity as a weighted mean and the coverage as a percentage – is questionable. Certainly, the option to view charts and entries as an interactive summary through an animation (in order to 'watch how each distinct pain type you are tracking changes with time or treatments') for £3.99 does not seem worthwhile. Moreover, the app has a limit of 10 entries that can be made for free – this is unclear at set up, and I was only alerted to this being the case because at the bottom of the screen, there is an upgrade option for 'unlimited pain entries' for £2.99. Nanolume is also more limited in use compared to Catch My Pain because once added, the entries simply appear as a list or chart to be viewed. Unlike Catch My Pain, there is no option for writing any other notes, emailing the diary or recording weather, mood or list of medications. However, if a user needed to record different types of pain that he or she was experiencing in

different areas of the body for a limited time, then this app would be a very quick and easy way of doing this.

Chronic Pain Tracker Lite

The initial look of this app isn't as friendly as Catch My Pain or Nanolume, and it took me a moment to understand how to get started despite the on-screen instructions. The first page suggests that you can have multiple diaries on the go, each with their own name. However, this is actually only

available when you purchase the function as an add-on. The idea is that these diaries can then be collated, data collected and patient reports generated and emailed. On the one new diary I was able to generate, the app suggested I could then select from a long list of 'Trackers', that is, things to diarise. There was a list of 19 Trackers, including ones common to the other two apps (pain triggers, pain intensity level, pain location mapping, etc.). But there were also Trackers that the other apps did not share: pain onset speed,

bowel movements, body weight, blood pressure, activity level, sleep history and milestones (lifestyle changes, medical procedures). Working out how to select these Trackers took a bit of trial and error, and even then I couldn't work out how to use the app effectively or efficiently, nor could I find any instructions. That said, once this has been worked out, the app certainly appears to provide the most options to diarise. The limitation of this free version, compared to the Pro version, is that the user can only record 20 entries.

Austin Leach *Professional member of the Patient Liaison Committee; retired pain consultant and anaesthetist*

From my (clinical) perspective, the value of these apps is to help engage the person in pain with the process of improving. Anybody who has attended a pain clinic as a patient will be familiar with the concept of the patient 'owning', or at least engaging with, their pain.

Many patients are initially taken aback by this notion – they have visited the doctor in good faith, and may be expecting the doctor to 'fire a silver bullet' and cure them. There is ample evidence that when successfully managing long-term symptoms, it is vital to have a deep understanding of how the pain can vary from one day to another, varying its impact on you, and thus how the pain can impede progress in a variable way.

The value of a pain app is to enable the patient to understand the subtleties of their pain more deeply, and using the recorded evidence of past episodes and how they were handled (what was done well, what was done badly, how would this better be managed in the future?) learn to deal more successfully with individual bouts.

Which app is best for you depends on what you want to record and how you want to use this record to help you develop more useful patterns of behaviour and effective strategies for dealing with awkward situations when they arise.

We are all familiar with the concept of goal-setting and pacing oneself, and the evidence is quite clear that this approach is often successful. The difficulty comes

with actually doing it, and becoming increasingly skilled at applying pain management techniques to allow a more fulfilling day-to-day life. If a pain app allows patients to do this, it is worthwhile.

Remember, the app is yours, not the doctor's. A doctor probably won't be interested in examining a long list of the whys and wherefores that made you miserable. She or he will be much more interested in an account of a painful episode that you attempted to deal with, particularly if you were able to complete a task. Adjusting your response to a given situation, with guidance from an expert, is more likely to improve your ability to handle episodes of pain in an increasingly effective manner.

Acute post-surgical pain in the United Kingdom – Post-Operative Pain Study: time for a national consensus on acute pain outcomes

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Background

About 266.2 to 359.5 million surgeries are undertaken every year globally,¹ and World Bank and Lancet Global surgery data report that 15,280 surgical procedures per 100,000 population² are performed in the United Kingdom. Despite the availability of clinical research and high-quality guidelines, acute post-operative pain management in the United Kingdom remains suboptimal. Pain after surgery remains a significant problem³ despite a rapid expansion of Acute Pain Services in the United Kingdom.⁴ Very recently, the SNAP1 National Audit surveyed patients in 257 hospitals in the United Kingdom (15,040 patients) and reported that anxiety and pain were the top two worst things about their operation.⁵ In addition, we now have the phenomenon of developing chronic pain after surgery.^{6–8} Tawfic⁹ report that unrelieved acute pain is recognised as a risk factor for developing this condition.

Hence, treatment of acute post-surgical pain is far from adequate. The disappointing acute pain outcomes internationally were highlighted once again in the scientometric analysis conducted by Correll, Kissin and Vlassakov.¹⁰ The authors concluded that despite introduction of new drugs and techniques in the last 20 years, there has been no improvement in national outcomes for acute pain relief.

What has been done so far? United Kingdom

Powell et al.¹¹ in their qualitative study concluded that national policy recommendations for acute pain services were severely undermined by a range of organisational factors that undermined each other. Duncan et al.¹² set out to describe current pain service provision and set up a registry to study efficacy and side effects of analgesia technique. They reported that there was a wide variation in staff provision. 12% of hospitals did not routinely collect data. 56% of patients reported moderate to severe post-operative pain overall. Thus, there was minimal change in acute pain outcomes from 1990 when the Royal College of Surgery (RCS)¹³ report was published. However, the uptake of this registry has been limited so far.

International initiatives on acute pain databases

'Pain Out' is a German registry for acute pain outcomes (Zaslansky, 2014)¹⁴ on day 1 post-surgery. One of the important messages emanating out of 'Pain Out' is that pain-related interference rather than raw pain scores is much more useful in assessing pain outcomes. A few UK sites have participated in this study.

'CHOIR' – chronic health outcomes registry is based at Stanford.¹⁵ This was established initially as a chronic pain

registry and patients enter the data for this registry. They have published 12 papers in the last couple of years, and the authors plan an acute pain outcomes registry next. This registry closes the gap between randomised clinical trials (not applicable globally) to obtaining real-time local data to fuel clinical effectiveness.

What do we need to do?

There is no doubt that we have to improve post-surgical pain outcomes. It is not acceptable that one out of two patients after surgery in the United Kingdom suffer moderate to severe pain. The obvious solution would be to measure pain outcomes and then allow benchmarking against the best performing hospitals. However, pain is a complex and subjective experience and measurement poses many challenges. A statistical change in pain outcome may not necessarily denote a clinically significant effect, that is, a meaningful change has occurred for the patient (Todd, 1996).¹⁶ For acute pain, a variety of instruments are used as research tools and in clinical practice (Breivik et al., 2008).¹⁷ While research continues, a multitude of accepted tools continue to be used for tracking pain-related outcomes (Younger et al., 2010).¹⁸ However, like anaesthesia outcome measures, there seems to be lack of consensus on which among the current

Acute post-surgical pain in the United Kingdom – Post-Operative Pain Study: time for a national consensus on acute pain outcomes

acute pain outcome measures should be used as a dashboard measure to assess acute pain treatment outcomes and hence allow for national benchmarking.

Thus, it's clear that we need to focus on two things. We need to gain a national consensus on acute pain outcomes for quality improvement and also focus on improving organisational factors to improve acute pain services across the United Kingdom.

The Post-Operative Pain Study (POPS) leading to a National Acute Pain database: a multiparty coalition

The POPS study aims to develop a consensus on post-surgical outcome measures and eventually allow for national quality benchmarking. The multiparty collaborators include the British Pain Society (Acute Pain Special Interest Group (APSIG) and Education SIG), Faculty of Pain Medicine, academics from Imperial College, Universities of Birmingham, Warwick and Plymouth. The POPS project has been submitted to HSRC/NIAA (Health Services Research Centre/National Institute of Academic Anaesthesia) board for consideration as a collaborator. In phase 1, the study team aims to produce a systematic review of all acute post-surgical pain indicators. In phase 2, using the Delphi process and

stakeholder/expert involvement, a consensus will be sought to whittle down the indicators to an acceptable minimum core outcome measure for post-surgical acute pain. In phase 3, a national database will be instituted on the basis of these outcomes, and intermittent data collection (say once in a few months to prevent data input fatigue) is planned to drive performance/quality improvement and power acute pain outcome research.

We are acutely aware that collaboration and inclusiveness are key to the project. We would welcome your comments, suggestions and advice.

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What's being talked about in the world of Acute Pain?

Ruth Day *Chair of the Acute Pain Special Interest Group*

Acute Pain Special Interest Group (SIG) set up the Acute Pain Hub UK (hosted on the Knowledge Hub UK platform) about a year ago. With over 100 members, there is the opportunity to discuss any number of topics. It has to be said, as with many social media sites, that the statistics show we have many more browsers than active participants. My rather infrequent use of Facebook (mainly to see what my kids and grandkids are doing) means I try not to worry about the apparent lack of interaction. We are all busy and a quick look is sometimes all we can put in.

But for those who do post something – thank you. Recently, there has been discussion around using fentanyl mixed with ketamine in PCAs. In this thread, there is discussion about ketamine increasing the safety of PCAs, of experience with other opiates in combination and the thorny question of opioid-induced hyperalgesia. One member also shared his department's criteria for adding ketamine to IVPCAs.

It's not just about personal experience; evidence is also shared.

One of the advantages of the platform is that related links are highlighted. So, from the recent discussion above, you can easily link through, with just one click, to the discussion last year on opioid-induced hyperalgesia. Again, here, you will find links through to relevant publications, posted by the contributors, which help us all to broaden our understanding and keep up to date.

Using the message, board members have been able to share information about audits and education, enabling different Trusts to work together. Can't be bad!

There is a 'library' function in the Hub, and there are a few useful uploads here. This is an area we could expand to enable further sharing, but things uploaded really do have to have their provenance clearly marked. Another function you might like to use is the ability to put up events. So, you may be running a study day which has wider appeal than just your locality – tell everyone about it. It costs nothing but 5 minutes of your time!

Your activity on the Hub can count as evidence for your personal development too – just take a screenshot of your posting, etc. to show involvement in current debates in your area of work.

So ... let's keep talking in Acute Pain.



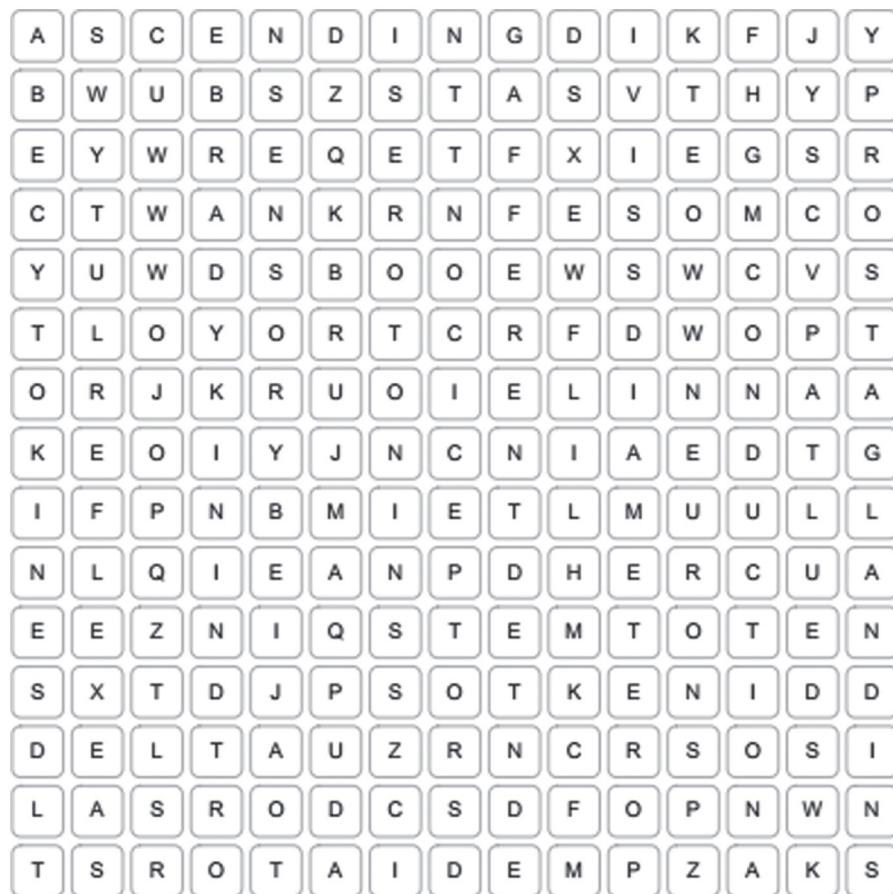
Acute Pain Hub UK 105 members

Started: May 2016

Lead organisation: Acute Pain Special Interest Group of the British Pain Society

Facilitators: Sailesh Mishra , Ruth Day , Harriet Barker

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nociceptors
delta
bradykinin
cytokines
reflex

afferent
neurons
serotonin
conduction
dorsal

sensory
mediators
prostaglandins
diameter
ascending

End stuff

New members



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Name	Current post	Place of work
Dr Luke Arthur	Honorary Research Associate	UCL Institute of Child Health
Dr Russell Goodall	ST6 Anaesthesia & ICM (Dual)	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Ms Alison Hewitt	Self-employed Physiotherapist	amhRehab
Dr Lesley Haines	Independent Psychiatrist	Shrinkwork
Ms Emma Bartlett	Clinical Specialist Physiotherapist, Pain Management	Solent NHS Trust



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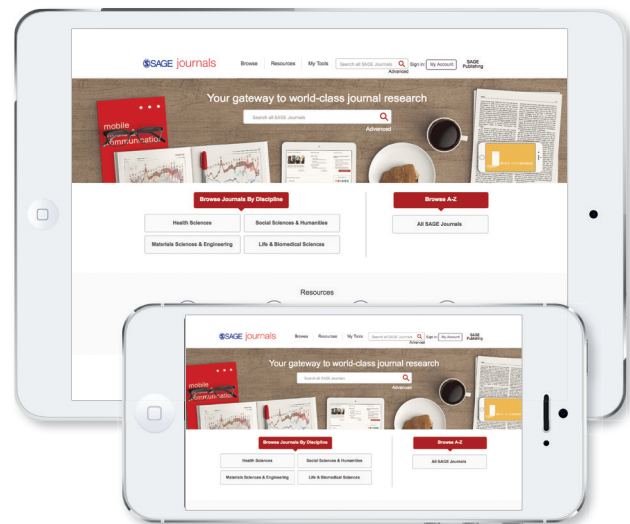
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