SEPTEMBER 2016 VOLUME 14 ISSUE 3

PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY

A different perspective on pain

Are men difficult to engage in pain self management?

Oxycodone in children

Training on pain management for neonates, children & young people

ISSN 2050–4497

The British Pain Society

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

Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Tel: +44 (0)20 7269 7840
Fax: +44 (0)20 7831 0859
Email info@britishpainsociety.org
www.britishpainsociety.org

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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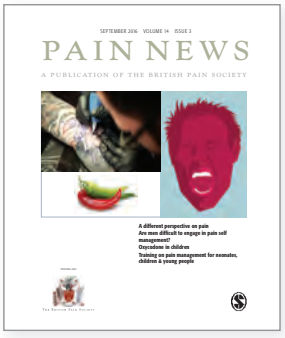
PAIN NEWS is published quarterly. Circulation 1300. For information on advertising please contact
Neil Chesher, SAGE Publications,
1 Oliver's Yard, 55 City Road,
London EC1Y 1SP, UK.
Tel: +44 (0)20 7324 8601;
Email: advertising@sagepub.co.uk



The Editor welcomes contributions including letters, short clinical reports and news of interest to members, including notice of meetings.
Next submission deadline : 30th September

Material should be sent to:

Dr Arasu Rayen
PAIN NEWS Editor
The British Pain Society
Third Floor Churchill House
35 Red Lion Square
London WC1R 4SG United Kingdom
Email pns.rayen@gmail.com

ISSN 2050-4497 (Print)
ISSN 2050-4500 (Online)
Printed by Page Bros., Norwich, UK

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

Regulars

News

Professional perspectives - Margaret Dunham, Associate Editor

Informing practice - Christina Liossi, Associate Editor

End stuff

British Pain Society Calendar of Events

To attend any of the below events, simply book online at:
www.britishpainsociety.org/mediacentre/events/

2016

Patient Liaison Committee Annual Seminar
3rd November 2016
Churchill House, London

Headache SIG Annual Meeting
16th November 2016
Churchill House, London

2017

50th Anniversary Annual Scientific Meeting
Wednesday 3rd – Friday 5th May 2017
Birmingham

Put the dates in your diary now for this flagship event – the 50th Anniversary Annual Scientific Meeting of the BPS. We are putting together an exciting and stimulating programme and will be announcing plenary speakers and parallel session topics in the near future. The ASM is a great opportunity to:

- Network with colleagues
- Keep up to date with the latest cutting edge research and developments relevant to pain
- Raise questions, partake in debates and discuss outcome
- Meet with poster exhibitors and discuss their research

For regular updates please visit: https://www.britishpainsociety.org/2017-asm-birmingham/

Philosophy & Ethics SIG Annual Meeting
26th to 29th June 2017
Rydall Hall, Cumbria

This meeting promises to be a most stimulating conference considering the power of the human mind in pain. It will be held at Rydal Hall near Ambleside in the Lake District and during the conference there will be time to explore the gardens and grounds of the hall as well as the beautiful surrounding lakes and hills.

Further details for all our meetings can be found on our events listing page:
www.britishpainsociety.org/mediacentre/events/

Editorial

THE BRITISH PAIN SOCIETY

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2016, Vol 14(3) 93

SAGE

Dr Arasu Rayen *Editor*

pns.rayen@gmail.com

I hope you have had wonderful summer. it has been an eventful one in this ever changing dynamic world. One week it was sweltering heat up to 36°. The very next day the temperature plummeted to 14°. We had the European Union (EU) membership referendum which led to a change in Prime Minister. Hillary Clinton and Donald Trump were nominated as candidates for Presidential election in the United States. We had our own event as well - the 2016 Annual Scientific Meeting (ASM) in Harrogate, which was a great success. There are written and photographic evidence in this issue of *Pain News*. Both the academic and social programmes were wonderful. Brock Bastian, one of the plenary speakers, has kindly written on 'different perspectives on pain'. This was the topic of his talk. As specialist in pain management, we rarely think about the 'different aspects of pain'. Brock talks about positive effect of pain, about people who seek out pain for reward. He asks us to think about people who get pleasure from pain – people who have tatoos and body piercing. He has written this article on the same topic. Please read it; you won't be disappointed.

We all have the experiences of dealing with different patients – demanding, unreasonable, with unrealistic expectations, angry and frustrated. In this issue, Sandeep Kapur has written an article titled 'Game Theory in Pain Clinic'. It examines the science of conflict or cooperation between rational individuals. He explains the theory and helps us to understand how it applies to us in pain clinic. It is thought-provoking.

Next year, 2017, is the 50th year of Annual Scientific Meeting. To mark the anniversary, *Pain News* is planning make the March 2017 issue a special edition focusing on the ASM. Leading up to this, from next issue onwards, we are planning to publish more articles and photographs on yesteryears of BPS and ASM. May I request all of you to send me any information or photographs of previous years' ASMs. The 2017 ASM is going to be a huge success in Birmingham. Please book your study leave for this meeting.

From the President

Dr Andrew Baranowski

The British Pain Society

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In my last newsletter commentary, I emphasised the importance of the multidisciplinary membership of the British Pain Society (BPS) and the symbiotic relationship that should exist between the membership and the Society. I would like to examine that a bit more in my contribution to this newsletter.

Multidisciplinary membership

The importance of meeting the needs of the membership by the Society has been reaffirmed by the members and subsequently Council when we changed the MoA that resulted in the appointment of two Vice Presidents to the Society; Dr Paul Wilkinson whose remit is to lead on the National Awareness Campaign, and Dr Martin Johnson, whose remit is to review the membership, their needs and the benefits the Society offers; he will be working closely with our Honorary Secretary, Prof. Roger Knaggs. Key to this piece of work has been the employment of Sue Froggatt, a consultant in membership and recruitment for Societies. The bottom line is that Council are reviewing the costs and the key benefits of being a member of the British Pain Society.

So what are the current key benefits of being a member of the British Pain Society? These include but are not limited to:

Our publications

The British Journal of Pain and *Pain News*. We were pleased at the editorial board meeting of the *British Journal of Pain* to hear that the journal now has Medline recognition. This is reflective of the huge amount of work and true dedication of Felicia Cox. It always amazes me how she is able to balance professionalism with a great sense of humour which brings the best out of those she works with. It is great to see contributions by a range of specialities and disciplines within the journal, and this recent recognition is a major accolade for nursing which is Felicia's background. It has been important that the journal has been freely available electronically to enable us to get to this position. However, soon we will see the journal begin to produce an income for the Society. This is important as it is a very expensive benefit of being a member of the BPS. Unfortunately for Felicia she has been unwell recently and we all missed her at the ASM. The Council and Execs are very grateful to Roger Knaggs, Deputy Editor, for his time and expertise being devoted to keeping the BJP a leading pain journal.

At the end of the day the BPS is only as good as the articles and papers you submit, please support the BPS by supporting the BJP!

Pain News, edited by Arasu Rayen, is the BPS' main platform that enables members to contribute and inform each other of exciting activities that they're involved with. We would like you to consider news articles for *Pain News*, as this is your Society and your news and views.

Push emails

Other ways of keeping our members informed include push emails, our website with a members-only section and of course our Annual Scientific Meeting (ASM). We are trying to keep push emails to a minimum though it needs to be recognised that this is a rapid means of accessing your opinion particularly when combined to electronic surveys. We hope that you'll find the current push emails to be informative and thought-provoking. The content for these emails is currently edited by Margaret Dunham.

Social Media

The BPS website needs to be alive and responsive and for that 'We Need You' to contribute. The SIGs all have their own areas and if you are a member of a SIG please work with your committee to populate those areas. Some of the SIGs are working towards discussion forums for members; Council and the Execs are interested to see how these progress so that we can bring them together on a platform of the website. It is my vision that all the discussion forums should be available to all members and the logical platform for that is the members only section of the website. Getting this to work and how it works is not clear but something that were looking into. As well as the above it would be useful to have a repository of information including links to other societies and agencies that provide useful information, this is also being thought about by our Webmasters Ann Taylor and Sam Ahmedzai supported by Arun Bhaskar.

The BPS website is being updated in response to members views to make it more responsive to those viewing it and more user friendly. Over the past few months the opportunity of combining our website with the resources of the Pain Community Centre has become possible. This is an exciting venture and hopefully we can take that forward over the next year.

The BPS Facebook page has been launched. The aim is to promote discussion and debate around pain. We are always looking for articles and papers to present. If you get an award, are proud

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of a paper published or have read something interesting, let us know and will consider publishing it on our facebook page. Not everything we publish will be top science. That's not the point. The aim is to generate discussion. PLEASE.

Similarly, we are trying to be active with Twitter and the more we have to tweet, the better.

Membership of EFIC is another key benefit of being a member of the BPS

Many of you may not be aware that membership of the BPS includes access to all the benefits of being a member of EFIC (European Federation of IASP chapters). EFIC's constituent chapters represent Pain Societies from 37 European countries and close to 20,000 physicians, basic researchers, nurses, physiotherapists, psychologists and other healthcare professionals across Europe, who are involved in pain management and pain research. Brexit does not effect this.

By being a member of the BPS you do not have to pay the €100 membership for EFIC. The EFIC website indicates you all gain:

The European Journal of Pain (EJP) and *EFIC Newsletters* (online);
EFIC member reductions in congress fees for EFIC-organised events;
Being able to apply for new EFIC-recognised pain schools;
Being able to apply for EFIC grants such as Greppi and IBSA;
Request meeting endorsement subject to approval;
Support from the EFIC office and secretariat;
In future, access to website with members-only portion.

And after 1 year's membership:

Application for examination;
Application for fellowships and pain schools;
Requests for meeting support subject to approval.

Many BPS members are active within EFIC and are very appreciative of this free BPS benefit.

The Annual Scientific Meeting was held in April 2016 at Harrogate

From the perspective of the elected Council, this was hugely successful and we were impressed with the high standards of the presentations. This was also reflected by the feedback from those who attended.

Pat Wall Lecture, Preaching to the unconverted: new treatments for chronic pain were given by Professor Stephen Hunt (London). The talk was eloquent and informative. It was a pleasure to hear the stories of Pat Wall, as well as to explore the future. Genetic research and manipulation of compounds in pain medicine is certainly taking off in exciting ways. More within this issue of *Pain News*.

The BPS Lecture, Care for people with painful joints: what works and by whose standards? Was given by Dr Rachael Gooberman-Hill (Bristol). With 2016 being the global year against pain in the joints, Dr Gooberman-Hill presented a provocative talk around how decisions are made by guidelines committees and the issues around ethics and implementation. Again, more within this issue of *Pain News*.

It would be impossible to recognise all the speakers in a meaningful way. However, I am sure all will agree that those presenting the prize papers deserve a special mention. Finally, it would not have happened without Professor Kate Seers and the Scientific Progamme Committee, as well as the Secretariat Jenny, Dina, Rikke and Ken.

There are two others of the ASM I wish to acknowledge on our behalf. The patients and the organisations who attended; especially the Patient Liaison Committee that collected the member's views for the National Awareness Campaign – great team effort. And trade for supporting us when trade support is rapidly shrinking.

The financial issues predicted 5 years ago are progressively biting.

The annual party!

Well that was an event ... dancing till 2.30 a.m., well past my bed time. The concept of re-instigating the party was one of those 'over a drink discussions' with Felicia (Flick) Cox and Julia Cambitzi putting me in a corner when I was Honorary Treasurer; not surprisingly, both nurses. We missed Flick as mentioned above but hopefully she did not miss us due to the filming efforts of Emma Briggs. The film has hopefully now been locked away – for many years.

IASP

Congratulations Chris Main, Chris Wells and Stephen Morley on receiving IASP (International Association for the Study of Pain) Honorary Membership – well deserved.

Westminster politics

The Pain Consortium was set up several years ago and has morphed into being a body that looks to co-ordinating the activities of the BPS, the Faculty of Pain Medicine of the Royal College of Anaesthetists and the Chronic Pain Policy Coalition (CPPC). Each member has a slightly different role. The BPS represents the MDT. The CPPC is now led by Neil Betteridge and Dr Martin Johnson with Baroness Rennie Fritchie as President.

The CPPC's Mission Statement states: (first part only reproduced ...)

The CPPC promotes policy solutions that contribute towards the improvement of the quality of life of those affected by chronic pain.

The Coalition works to achieve this by linking representatives of people living with pain, policy-makers, parliamentarians and professionals, creating an expert forum to increase awareness and understanding of the issues surrounding

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pain and to influence and facilitate positive action that will reduce the impact of pain in individuals and society.

As a consequence, the CPPC acts as the link between the Consortium members and Westminster with an emphasis on promoting policy production. There are currently a number of initiatives underway and hopefully more to report in the future.

The Faculty of Pain Medicine, Royal College of Anaesthetists

We are pleased to see that Dr Barry Miller has been appointed Dean of the Faculty and that Dr John Hughes has been appointed as Dean Elect. I would like to take this opportunity to thank Kate Grady who steps down as Dean for all her work undertaken in supporting the BPS and in particular for ensuring that the clear differences between the Faculty and the BPS have been maintained so the BPS remains the principal official body for the multidisciplinary team (MDT). The BPS looks forward to working with Barry and John over the next few years and I am convinced that close collaboration between the Faculty and the BPS is vital for the long-term survival of pain medicine as a speciality, a cornerstone service.

Honorary Membership of the BPS

This year's Honorary Membership of the BPS places the 'patient' centre stage by acknowledging all the effort that Pete Moore has spent around supporting fellow 'patients' and self-management. The Pain Toolkit is a vital survival kit for many people living with pain. Dr Martin Johnson provided the citation at the AGM.

Dr John Goddard's name keeps cropping up as he has been involved in so much with diligence unsurpassable. He was also appointed an Honorary Member with the citation provided by Dr William Campbell.

The National Awareness Campaign

These reports are written 2 to 3 months prior to landing on your door step. By the time you receive this, Bill Wallsgrove (our marketing and branding consultant) will have been working with Paul Wilkinson for 3 months. The importance of this project was recognised by the elected council when they elected Paul as the second Vice President of the BPS.

Welcome to Council and goodbyes

Thank you to Neil Berry and John Goddard whose term on Council came to an end. We also thank Prof. Maria Fitzgerald, a co-opted Member of the Council for Science who stands down after several years in this role.

We are delighted to welcome Zoey Malpus and Glyn Williams as newly elected Council Members, and Dr Tim Johnson continues for a second term of office, along with Amanda C de C Williams and Elaine Boland as new co-opted Council members.

So, this message from the President has looked at some of the many things that are great about the BPS, its members and its working relations. I am writing it at a time that we are consolidating much change that has been introduced over the past year or so but I am aware there is still a lot to do, particularly around developing our relations with the MDT membership and other agencies. Key to everything is around raising awareness of how many people live with chronic pain, the implications of that on their lives and the importance of self-management when able and MDT support and intervention when required. These two projects on members and awareness will be centre stage for the next two years or so.

Executive Summary of work that we are doing to modernise the BPS:

National Awareness Campaign

- BPS brand: Modernise our appearance ensuring we have a brand that is consistent throughout our activities.
- Prospectus: Having a well-defined sales pitch, supporting our mission, vision, values and aims.
- Fundraising: This follows on the branding and prospectus.
- Social media plan: Improving our social media profile.
- ASM marketing: Improving raising awareness of what the ASM has to offer
- Website homepage: making the website more interactive.

Membership Recruitment & Retention Strategy

- Focus Group: Working to look at the needs and benefits of the BPS membership to members.
- Quantitative Survey. Gathering more data to support change.

Website merger (BPS/Pain Community Centre)

- Review of content and agreement as to what to keep and how: The BPS website is merging with Pain Community Centre website to provide a great pain medicine resource for members.
- Quotes for work to be undertaken: maximizing the cost benefit of working with the Pain Community Centre.

Reformatting ASM for 2017

- Themed parallel sessions: Ensuring the ASM is meeting the needs of all members.
- Joint pain focus for IASP Year: Building on our links with IASP.
- Shorter plenary sessions to allow for Q&A: Responding to our members.

Committee Outputs for 2016: meeting our Values

- Membership discussion forum (Education)
- Acute Pain publication (PLC)
- Engagement with national funders such as NIHR (Science & Research)
- ASM (see project above) (Scientific Programme Committee)
- National Awareness Campaign (see project above) (Communications)

From the Honorary Secretary

Professor Roger Knaggs

THE BRITISH PAIN SOCIETY

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Although it will be some time before you read this edition of *Pain News*, I am writing this column just after the Brexit decision to leave the European Union in the referendum. The country remains in states of financial and political uncertainty, and there will be many difficult and challenging decisions on the future of our country and economy to be made over the coming months and years. Health only featured in a small way in the campaign by both sides. However, in the short-to-medium term, no doubt it will be 'business as usual' for us all, including the British Pain Society.

Membership

As all members will be aware, over recent years, there has been a continued slow decline in membership. Last year we undertook a member survey, and a summary of the major findings was reported in a previous edition of *Pain News*. We also took the time to listen to former members about why they chose not to renew their membership. We intend to use the information collected to inform the development of a membership and retention strategy and define clearly member benefits. This work is now being progressed further over the summer, and no doubt I will be writing more on this topic in future editions.

Social media

Many readers will have seen that following the publication of the paper in *BMJ Open* on pain epidemiology in June. As part of the work increases the visibility of the British Pain Society on social media and now has a Facebook page, we would like to invite all members to like and share this page with your friends – https://www.facebook.com/thebritishpainsociety/

This is not our official website, but a social site where we share current articles, papers and blogs about pain awareness, pain treatments and pain management. By sharing these posts, we are not endorsing their content, indeed some may very well be controversial, but would like to invite everyone to join the conversation because we believe it is NOT a pain to talk about pain.

Annual Scientific Meeting

I am sure that there will be many more reviews and comments about the Annual Scientific Meeting (ASM) in Harrogate. I heard many comments about the high quality of both the plenary presentations and workshops. Next year marks the 50th anniversary of the first ASM of the Intractable Society, a predecessor of the British Pain Society. The ASM next year will be held in Birmingham between 3rd and 5th May. Keep the dates in your diary as it promises to be a meeting to remember.

Deadline for Council Reports

If you have any items you wish to bring for the attention of Council please submit them by the deadlines given below to: info@britishpainsociety.org

Deadline for Report	Meeting date
2nd November 2016	30th November 2016
13th January 2017	8th February 2017
19th May 2017	16th June 2017

Spotlight – Leila Heelas

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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 Leila Heelas

Leila Heelas
Nuffield Orthopaedic Centre, Oxford University Hospitals NHS FT

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

I saw the BPS ASM advertised online and decided that I would like to join the society, particularly due to its multidisciplinary nature.

2. *What is your role in the BPS? What excites you about this role?*

Currently I have no formal role although I was a member of the PMP SIG committee a few years ago. I enjoyed the multidisciplinary nature of the committee, contributing to the BPS, as well as talking to people from different trusts and understanding a little about their services. I met people whom I respect hugely and still enjoy catching up with them at BPS conferences. I was also fortunate enough to be selected to present a poster orally at this year's ASM.

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

I would arrange a Dragon's Den–type event with representatives from the different fields of pain management and research, and then ask them to pitch what they believe are the priorities for the BPS. Second, I would arrange a workshop titled 'Influencing Commissioners for Dummies', so that I could attend it!

4. *What are you known for professionally?*

Without wishing to sound too complacent, our team is known for providing high-quality rehabilitation for patients with persisting pain. Nationally, we are known as the centre that provided rehabilitation for the MRC spinal stabilisation trial, and we are lucky enough to work collaboratively with the Oxford Rehabilitation Research Unit. On a personal level, I also have a special interest in treating CRPS and working with colleagues across the trust to improve the care of these patients.

5. *What are you most passionate about professionally?*

Working as part of a multidisciplinary team who are committed to improving the lives of people with pain and maximising on their physical potential. Also, educating undergraduate physiotherapists so that they can provide empathic, effective treatment and not feel overwhelmed by patients with pain-related disability.

6. *What do you have a knack for?*

Allowing people with pain to feel heard and valued.

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

I enjoy being outdoors but preferably beside the sea, which is rather ironic since I live in Oxfordshire. My favourite weekend activity would be going on a country walk or visiting an art gallery.

8. *Any other volunteer activities apart from the BPS that you're passionate about?*

I am only a volunteer for fundraising events at my children's schools.

9. *Any favourite non-profit organisations that you support and why?*

'Save the Children' because they have an international presence that can

provide aid during a crisis, they lobby government and support children and mothers.

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

Coffee

11. *How do you want to be remembered?*

Hopefully as enthusiastic, empathic, interested and committed.

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

Working in Oxford among the great and the good means that my academic achievements feel rather small; however, I am proud of undertaking an MSc in Pain Management while working and raising two very young children. I'm also proud to work with dedicated colleagues who have helped to improve the quality of our service over the last few years.

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

I think that's plenty for now.

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 joins 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!

Follow the Society on twitter

Please follow the Society on twitter **@BritishPainSoc**

We will be sharing relevant information and updates from the Society.

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Feedback from the Annual Scientific Meeting 2016

Kate Seers *Chair of the Scientific Programme Committee*

First of all, before I go on to the actual feedback from 2016 Annual Scientific Meeting (ASM), I would like to inform you that the Scientific Programme Committee (SPC) is starting to work on the ASM programme for 2017, *our 50th ASM*, so really something to celebrate together.

We will welcome your poster abstracts for that meeting. We really want to accept as many as we can, so please follow the poster abstract submission guidance to give you the best chance of being accepted (https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/.) The online submission will open in September and close on Monday 12th December 2016.

2016 ASM at Harrogate was a resounding success. I'd like to summarise the very helpful feedback that was provided on the ASM 2016. Thank you to the over 350 people who submitted feedback; we had 71 pages of feedback, all of which I have read with care.

First, I would like to thank all our plenary speakers, those who ran and spoke at workshops and those who presented their posters for their contributions. Most comments about the meeting were very positive.

Plenary sessions: It was encouraging that on a 1–5 scale from poor to excellent, all of the plenaries were rated on average around 4 or above. However, it is also interesting to note the spread of responses, with most plenaries attracting the full range of scores from 1–5.

I am really pleased to report just some of the positive comments made about the whole range of plenary speakers: *well set out and contemporary; fantastic overview; really helpful for my clinical practice; relevant and informative; visionary and thought provoking; extremely relevant; fascinating insights; stunning delivery and content; this was a wonderful session; appealed to a variety of levels, excellent; engaging speakers and interesting topic; clear and concise, a good demonstration of how to give a lecture; made a complex subject easy to understand; fabulous broad ranging insights*.

If you didn't make it last year, then I hope this feedback on the ASM will encourage you to come in 2017!

As in previous years, the student/trainee oral presentations were very well received: *really good quality of presentations and good to hear from emerging experts; the quality of the talks was phenomenal; excellent session an absolute must keep*.

Parallel sessions were mostly well rated averaging around 4, but again often a diverse range of views from 1–5 (poor to excellent): *a good sleeves rolled up practical session; made me want to rush back to work and start something; this actually felt like CPD and I'd love more of this at the ASM*.

There was feedback around wanting more interactive parallel sessions where there was plenty of time for discussion, and we will be emphasising this even more strongly to our parallel session presenters again for next year's ASM. There were also requests for more clinical sessions, which we will take into account as we plan for 2017.

A new initiative in 2016

We started oral presentation of the top-rated poster abstracts from those who are not trainees or students in response to your feedback for the first time. These were very well received with 95% who attended these sessions wanting this to continue.

General feedback

In all, 40% felt there were enough clinical sessions and 47% would like more. Most (85%) felt the poster viewing time is about right.

At times feedback was conflicting: *too much science; not enough science; make it more multidisciplinary – heavily focused on medics this year; needs of physicians are being submerged in an attempt to satisfy the non-medical group; talks better for a multidisciplinary audience this year*.

It was fed back that some speakers forgot the audience was largely not research based. We will re-emphasise to all speakers that the clinical implications are crucial to consider in all presentations.

Encouragingly, 86% felt something they'd learnt at the ASM would change their practice and many people talked about how they valued the networking opportunities.

People were very complimentary about the organisation of the meeting. Thank you to all in the Secretariat for all your hard work to make the meeting run smoothly.

Views on food this year ranged from good food to dreadful food, but most

people thought the food was better this year.

There was a strong theme of wanting a less expensive meeting, and a small proportion of people would prefer a 2-day meeting or end at lunchtime on the last day. Most people valued the social gathering, but felt it had been somewhat crowded on this occasion.

Having presentations online was requested, and a feedback survey that could be saved as you went along was requested. Overall, 97% would recommend the ASM to a colleague, which was very encouraging.

There were many good suggestions for the 50th ASM 2017, and the SPC will be working hard to consider these suggestions.

Thank you to the 2016 SPC for all your hard work on behalf of the British Pain Society, and I look forward to developing the 50th Anniversary ASM with our Committee for 2017.

Congratulations to all the prize winners at the 2016 ASM

Student/trainee prize paper presentations

These were the highest scored abstracts from all those submitted by students/trainees:

1st Prize – Rhiannon Edwards
2nd Prize – Katelynn E. Boerner
3rd Prize – Muna Adan
Runners up – Kristy Themelis and Hannah Durand

Thanks to the judging panel for these prizes who were Professor Nick Allcock (chair), Dr Heather Cameron, Dr Gillian Chumbley and Professor David Walsh.

The People's Choice award went to Fiona Owen (poster 98).

Non-student/trainee prize paper presentations

These were the top-rated poster abstracts submitted by those who are not students/trainees, and the prizes were awarded (in no particular order) to Janet Bultitude, Richard Harrison, Alison Llewellyn and Candy McCabe. Thanks to the judging panel for these prizes who were Dr Lesley Colvin, Dr Gillian Chumbley, Professor Kate Seers (chair) and Professor David Walsh.

I look forward to seeing you at the 50th ASM in Birmingham in 2017.

Have your say and contribute to *Pain News* today

Pain News is the Members newsletter and as such we encourage and welcome 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 2016	30 September 2016
March 2017	2nd January 2017
June 2017	31st March 2017
September 2017	30th June 2017

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Annual Scientific Meeting 2016 in Harrogate – Event Review

Szilvia Vas

This was my first attendance to a British Pain Society (BPS) conference, and I attended as a Trainee Health Psychologist from Milton Keynes University Hospital NHS Foundation Trust. I had heard great reviews of the Annual Scientific Meeting (ASM) from others and therefore felt privileged to be accepted and present my poster during the scientific exhibition. I was very ardent to attend a variety of plenary talks and parallel sessions delivered by renowned scientists and experienced health professionals.

The plenary sessions highlighted the research milestones of the past decades and the challenges of treating pain in general and in specific populations (e.g. CRPS and dementia). I was stunned by the plethora of offered sessions to attend.

As I aspired to expand my knowledge of evidence-based approaches towards understanding and supporting pain patients with psychological co-morbidities in the achievement of better quality of life and health outcomes, the choice was made to join the parallel sessions that focused primarily on the psychosocial aspects of pain.

Interestingly, among the different sessions I attended, there was an overarching theme, that is, to recognise the many possibilities of the brain's neuroplasticity and how this can be utilised within pain management. For instance, conceptualising recovery through education and enhancing self-management strategies, managing treatment outcome expectations and increase psychological flexibility to move the patient towards acceptance.

Through an experienced practitioners-led workshop that was moderated by Dr Andrew Baranowski and conducted on developing abdomino-pelvic pain services, I was able to gain a greater awareness, sensitivity and understanding. I learned a great deal from Dr Anna Mandeville's 're-connect' three-step model (i.e. cognitive, sensory-affective and behavioural-action experimentation) and obtained practical information on how to facilitate intimacy and sexual relationship in persistent pelvic pain.

The poster exhibition area also offered plentiful opportunities to view other colleagues' and students' recent work. It also provided a fantastic occasion to discuss research curiosities and network with others. Meanwhile, the technical exhibitors presented one-to-one opportunities to learn more about new advances in pharmaceuticals and fascinating medical technologies.

The ASM was superbly organised, with Stewards on-hand for assistance at all times (handy for a conference first-timer).

Upon my return, I decided to update our local pain management programme and put some of the new learning into practice, which has already benefitted our patients.

I look forward to the next ASM in Birmingham in 2017. Thanks to the BPS for their bursary support! Attending the conference was a rewarding experience for which I am very thankful.

News

Annual Scientific Meeting 2016 in Harrogate – Reflective Precis

Justin Daniel Graham

The British Pain Society

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What I felt to be of use and value at the meeting

This was my first Annual Scientific Meeting since joining the British Pain Society, and I am grateful for receiving a bursary which enabled my attendance. Harrogate was an extremely pleasant choice of location and the International Conference Centre an ideal venue with good facilities that allowed the meeting to function smoothly. There was a good variety of plenary sessions and a good choice of parallel sessions, as well as useful satellite symposia.

Plenary sessions of particular interest to me were those covering complex regional pain syndrome (CRPS), neuroimaging of placebo analgesia and the role of the central nervous system in chronic musculoskeletal pain. I found speakers engaging and felt they projected enthusiasm and clarity when sharing their work.

Listening to authorities on CRPS, chronic musculoskeletal pain was stimulating. Hearing about central and peripheral pain mechanisms, the role of inflammation and the immune system as well as recommended treatment approaches has re-stimulated my interest in these areas.

The plenary lecture on placebo analgesia also stood out for me and was clinically useful. I was reminded to capitalise on the placebo effect to boost therapeutic analgesia while being mindful of certain caveats. This is an area I wish to pursue further and hearing a stimulating lecture about findings from a respected research group was valuable.

The parallel session jointly provided by the Pain Education and Pain Management Programmes Special Interest Groups was particularly interesting. It was valuable to learn about the early research and development of a potentially and clinically useful tool to help the assessment and management planning of complex patients. Comparing this tool with a model, I presently use clinically and learning about other models the group had come across when developing their initial tool was useful. This has stimulated my interest in continuing to develop my own clinical work in this area.

As a newcomer to submitting my work for publication in peer-reviewed journals, with my poster abstract being the first, I found the parallel session on the pitfalls and pinnacles of publishing extremely valuable for future submissions.

Gaining insight into the new NICE guidelines on low back pain and sciatica was illuminating. It was also useful to gain an understanding about the perspectives of some guideline committee members and about the NICE guideline development process.

Finally, opportunities for networking at the event were extremely valuable. This is likely to be of increased importance at future meetings I attend.

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Annual Scientific Meeting 2016 in Harrogate – Feedback Summary

Leila Heelas

I have a special interest in complex regional pain syndrome (CRPS), and I am a recruiter for the CRPS UK registry. The sessions on CRPS were most illuminating and gave inspiration for clinical practice. Frank Birklein's plenary talk focused on mechanisms for CRPS based on research extrapolated from animal models suggesting that adaptive immune responses mediate inflammatory mechanisms associated with CRPS. He proposed that there may be slightly differing CRPS phenotypes depending on which cascades are activated, that is, substance P may result in oedema and calcitonin gene-related peptide (CGRP) may result in plasma protein extravasation leading to inflammation and sweating. This is interesting as clinically there are variations in presentation and this may be a model that could be used to explain this to patients.

He also explained that inflammatory mechanisms are important in the first 3 to 6 months and then the classic diagnostic signs may fade, but CRPS is still evident. This was useful to reflect on as in the chronic pain service, the patients with CRPS whom we see have often lost the 'cardinal' signs of the condition. He also stated that thermoregulatory disturbances may disturb body perceptions. Candy McCabe later highlighted that patients may develop an avoidance or deselection bias of the painful region which may manifest as hypoalgesia. A method of restoring more normal sensory perception involved visualisation of the non-painful region, specific concentration in the CRPS region and retraining of tactile discrimination while visualising pleasant sensations, first on the non-painful side of the body. This resonated with my practice as I have begun to incorporate pleasant sensory techniques and mindfulness while practicing tactile discrimination and desensitisation. I shall now progress this further based on the techniques described in Candy McCabe's talk.

Later in the day, Frank Birklein went on to describe a study where innate immune activation had been inhibited which reduced inflammation but did not alter pain behaviour, pin prick hyperalgesia or weight-bearing difficulties. He proposed that this was like acute versus chronic CRPS when the swelling, thermoregulatory changes and so on have abated but altered sensory perception and pain persists. This issue was mentioned again in relation to clinical practice during the poster presentations when the problem of what to call CRPS in the later stages was raised, when only pain and altered perception remain. This creates problems for patients in terms of how they describe their condition to employers, family, general practitioners (GPs), benefits agencies and so on. This is something I will discuss in more detail with my consultant colleague with a special interest in this area. It also has implications for how we recruit patients to the registry, which I was able to discuss with Janet Bultitude.

Other fantastic talks were from Eva Kosek and Tim Solomons, and I shall look at the papers that they referenced. The update on the STAR trial was also an excellent session providing thought-provoking ideas on how to improve current clinical practice. Finally, the posters about primary care service design were useful and will inform future discussion with the Clinical Commissioning Group (CCG). Information about resources for patients from the BPS Patient Liaison Committee stand, Breathworks and Pain Sense were also very helpful.

THE BRITISH PAIN SOCIETY

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Citation for Honorary Membership of the British Pain Society for John Goddard

By Dr William Campbell

It is with great pleasure that I provide this citation to support the award of Honorary Membership of the British Pain Society (BPS) for Dr John Goddard.

Following his graduation in medicine from St Bartholomew's Hospital in 1977, John moved to Bromley Hospital in Kent where he started his training in anaesthesia. Within 2 years, he attained Membership of the Royal College of Physicians and after 2 years, his Fellowship of the Faculty of Anaesthetics, Royal College of Surgeons, England, no mean task.

Immediately after this, John moved to Alder Hey and the Royal Liverpool Children's Hospital, where he commenced training in paediatric anaesthesia. During this 2-year attachment, he attained a 6-month Fellowship as Clinical Fellow in Paediatric Anaesthesia at Izaac Walton Killam Children's Hospital, Halifax, Canada, and completed his anaesthetic training in 1989, within the Sheffield and North Trent region. At this point, he accepted a Consultant post in Paediatric Anaesthesia and Pain Management, at the Sheffield Children's Hospital, where he continues to work.

John has been a lead in paediatric pain services at Sheffield for many years. He developed a strong and cohesive multidisciplinary paediatric pain team for acute, procedural and chronic pain: currently, a team of 20 members. His determination in having paediatric pain recognised nationally as a specialised service paid off – there now being five such centres in England, Sheffield being one of them.

Having been elected to Council of the BSP in 2007, John went from strength to strength, establishing strong liaisons with NICE and completing a huge number of feedback reports on behalf of the BPS, for their proposed clinical guidelines. John was our Honorary Treasurer from 2010 until 2013, keeping our finances in order over an unsettling period. He didn't say more than what was essential at Council meetings, but what he did say was very thoughtful, concise and valuable. As Vice President of the Society from 2013 until 2015, John did what he kept telling others to do – 'stop talking, just do it!' He carried out the key and final work in the establishment of our new BPS interactive website.

John probably thought he had completed enough work for BPS Council however at the 2015 Annual General Meeting (AGM) with our need for an Interim Honorary Treasurer, he took on a ninth consecutive year on Council, his seventh on the Executive Team. He did all of this in addition to being an active Board member of the Faculty of Pain Medicine, Royal College of Anaesthetists.

His long suffering wife Sue must hardly ever see him, between his Territorial Army activities over the past 28 years and his work for the BPS. Now it is time to relax John, more racketball an occasional wee drink and lots more time with Sue.

Considering his major contribution to best management of adult and paediatric pain, in addition to his major contribution to this Society, John Goddard is richly deserving of Honorary Membership of the BPS.

The British Pain Society

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Citation for Honorary Membership of the British Pain Society for Pete Moore

By Dr Martin Johnson

Members of the British Pain Society (BPS), it is my pleasure and honour to deliver this citation for Honorary Membership of the BPS to Pete Moore.

I am indebted to the numerous people who have sent me contributions for this citation, but in particular, I would like to thank Frances Cole and Meherzin Daz. One colleague I spoke to said that Pete's award was not only well-deserved but truly outstanding.

Several Annual Scientific Meetings (ASMs) ago, I spotted this chap in an Arsenal cap holding an audience captivated with his common sense messages about chronic pain – I had met Pete for the first time and I have admired his work ever since.

Despite his apparent confidence in front of huge audiences, Pete is a shy and humble man. Originating from Woolwich, the original home of Arsenal, he learnt some of his communication skills by selling on a local market – an upbringing, that he once told me, that has disturbed his sleep pattern forever – it is quite common to get emails from Pete at 4 a.m.

With a long history of back pain, including an exacerbation while up a ladder painting and decorating outside Windsor Castle as the Queen was doing a walk past at the time of her jubilee in 1992, Pete made the common journey of trying to search for the elusive cure to his problem. July 1996 was his turning point – he attended an INPUT Pain Management Programme, which gave him the skills to turn his disability and desperation into confidence, resilience and increasing activities. In the early part of the millennium, Pete worked for Back Care – where he ran a self management programme, which he had previously developed, called the 'Think-Back' programme. The embryonic Pain Toolkit had been conceived.

Pete's talents were spotted by the Expert Patient Programme in 2002, where he became a Senior Health Trainer and subsequently Business Development Manager. He remained with the EPP until 2011. During his time at the EPP, he started to write, in his own time, more self management programmes, eventually developing into a dedicated 6-week course for people with persistent pain. These early versions of the Pain Toolkit were developed further with additional co-authorship with Frances Cole and support from the 'Living with Pain' team at Bradford. Support and encouragement from Angela Hawley, Department of Health (DOH) Long-Term Health Condition Lead, led to the distribution of 250,000 copies nationally. In 2011, with a desire to reach and help as many people as possible, the Pain Toolkit website was created – a few years later, the app was also created.

Today Pain Toolkits are in 21 languages, including Arabic. Over half a million copies have been printed, with reach into multiple countries. Looking at the Pain Toolkit website today showed that there had been over 700,000 visitors since December 2014. The toolkit has been adapted for secure units and also for teenagers and young people. Pete's unique ability to create memorable and most importantly, understandable, messages can be used not only for pain education but also in other long-term conditions – so, for example, we now have 'My Asthma Toolkit'.

On an international scale, Pete has pioneered the crucial role for the self care of pain in several other countries and he works with IASP (International Association for the Study of Pain), EFIC (European Federation of IASP Chapters) and Societal Impact of Pain.

Pete has multiple different skills, including being a driving instructor, painter/decorator, EPP senior trainer, website and app developer and arguably the biggest 'tweeter' of pain issues on the planet!

There is only one time I have seen Pete completely lost for words; at the 2014 ASM, Meherzin managed to arrange to surprise Pete with a personal written citation from the manager of his beloved Arsenal. All who witnessed the surprise presentation shed a few tears.

At the end of 2013, Pete was nominated by Pain UK, CPPC (Chronic Pain Policy Coalition) and BPS as the Patient Pain Champion for 2014 for his outstanding contributions to the field of pain. In his usual unassuming way, he accepted the award, not just for himself, but for all who work in pain management, and the many who do un-paid hours to support patients and colleagues.

In his response to the award, he mentioned that he was reflecting on an email that he had received from a patient who felt imprisoned with their pain. Pete said it reminded him of a line from a book that he had read many years ago which said '*when you look out of the window, do you see the bars or the stars*'. He stated that he wished to dedicate the remainder of his working life to help others to look at the stars. Pete, there is no doubt that thanks to you, many people can now see the whole Galaxy.

Ladies and Gentlemen, may I commend Pete Moore, communicator extraordinaire, to you for the extremely well-deserved award of Honorary Membership of the BPS.

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/

The British Pain Society

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Poster abstract submission – 2017 Annual Scientific Meeting

Dear Colleagues,

You are invited to submit poster abstracts for exhibition at the 50th Anniversary Annual Scientific Meeting (ASM), 3–5 May 2017 in Birmingham.

We really want to accept your abstract! We would like to accept as many high-quality posters as we can for the ASM. Many delegates really value the discussions that take place and new contacts they make when viewing the posters. Make sure your poster is one of the ones on display. All types of high-quality research relevant to pain are welcome. To view the simple tips for writing a good abstract, please visit the following link: https://www.britishpainsociety.org/static/uploads/resources/files/Tips_for_writing_a_good_poster_submission_for_the_ASM_Kate_Seers_PN.pdf

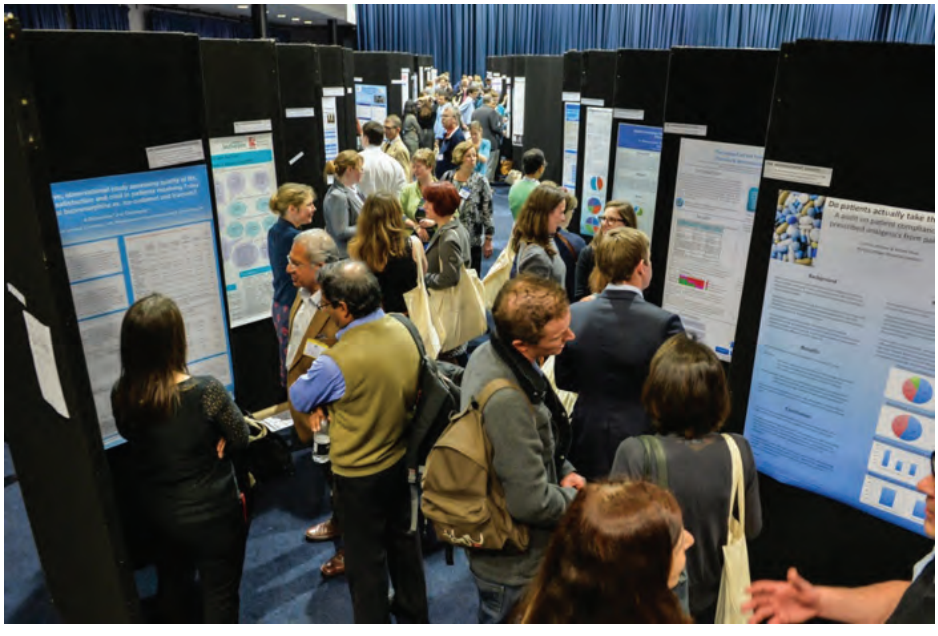
All abstracts will be reviewed by the Scientific Programme Committee subject to review; those accepted will be invited to exhibit throughout the meeting and will be published as a supplement to the *British Journal of Pain*, which will be available as a hard copy in the conference pack and electronically for members to download from the website at the conclusion of the ASM.

The most highly rated poster abstracts will be invited to present their work orally at the ASM.

The deadline for submission is Monday 12th December 2016 at midday (12:00).

To submit an abstract and to view the poster submission guidelines, please go to our website: https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/

Again, this year, we will have prizes for best poster prize presentations by trainees/students, People's choice award and the best oral poster presentations. For further information, please visit the following link: https://www.britishpainsociety.org/2017-asm-birmingham/poster-exhibition/



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Are men more difficult to engage in Pain Self-Management? A two-part study looking into the gender split among people attending the Pain Self-Management Service in Gloucestershire and Herefordshire

Emelie Hasselgren *Psychology Placement Student, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust; BSc Psychology Student, Aston University*

Katie Parker *Psychology Placement Student, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust; BSc Psychology Student, Cardiff University*

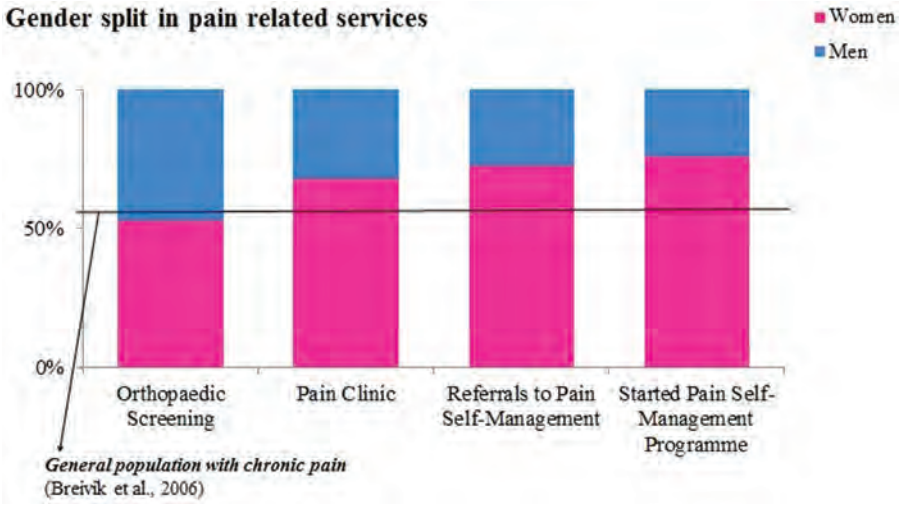
Polly Ashworth *Consultant Clinical Psychologist, Gloucestershire and Herefordshire Pain Management Service, Gloucestershire Hospitals NHS Trust*

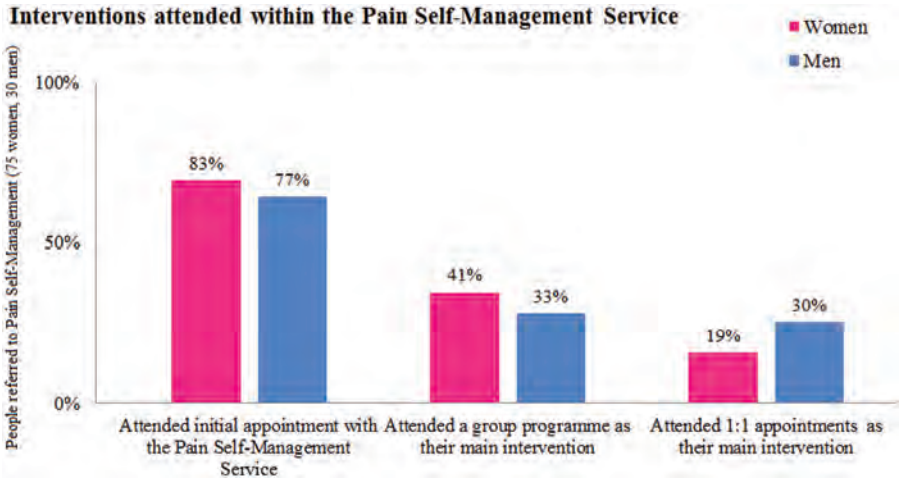
The prevalence of chronic pain in the general population is estimated as 44% men and 56% women.[1] At the Gloucestershire and Herefordshire Pain Self-Management Service, we noted that people attending our group programmes were predominantly women and we had no information about the gender split among people who chose to attend on a 1:1 basis. Pain self-management improves quality of life for people with chronic pain,[2] and it is important that men and women are equally able to access the service, even though men have been described as 'hard to reach' when it comes to engaging them in self-management support.[3] Masculine ideals and socio-cultural expectations may influence men's health behaviours.[4] We were concerned that we were being less successful in engaging men in our service. We conducted a two-part study trying to investigate why we did not see as many men as women in our Pain Self-Management Programmes.

Method

In order to get an overview of the gender split in a number of pain services, we first used a cross-sectional study to look at activity at Orthopaedic screening (n = 1,109), activity at Pain Clinic (n = 2,057), referrals to the Gloucestershire and Herefordshire Pain Self-Management Service (n = 1,016) and people starting Pain Self-Management Programmes in Gloucestershire and Herefordshire (n = 266), during the financial year 2014–2015.

Second, a cohort study followed every third patient referred to the Gloucestershire and Herefordshire Pain Self-Management Service between August and October 2014. We mapped the treatment pathways of a total of 105 people (75 women and 30 men). The





treatment pathways consisted of initial referral, interventions attended, completion of main treatment intervention and discharge from service. This enabled us to compare the uptake of different interventions available in the service between men and women.

Results

We found a fairly equal gender split in patients attending Orthopaedic Screening (47% men and 53% women), and this was near to the general population estimate. However, a larger gender split was found among people attending Pain Clinic (32% men and 68% women), referrals to Pain Management (27% men and 73% women) and attendance at our Pain Self-Management group programmes (23% men and 77% women). Thus, the gender split seen in Orthopaedic Screening and the general population estimate is not reflected in the gender split in people attending Pain Self-Management group programmes.

Looking at our cohort of 105 people, referred between August and October 2014, a similar gender split of the referrals to Pain Self-Management was confirmed, that is, 29% men and 71% women. This means that our Pain Self-Management Service receives over twice as many referrals for women than men. The level of service uptake was equivalent between men and women, indicating that once referred, men and women are equally likely to engage in an intervention (77% men and 83% women attend their initial appointment with the service, that is, introduction session or assessment appointment). When looking at the different treatment interventions, 33% of men and 41% of women referred to our service decided to start a group programme. Also, 30% of men and 19% of women attended 1:1 appointments as their main course of intervention. Even though the proportion of men and women are similar, we can see that women are slightly more inclined to attend a programme, whereas men are more likely to attend 1:1 appointments. This, alongside with the big gender split in referrals may explain why we see fewer men on our programmes.

Conclusion

Our investigation shows that fewer men are attending our Pain Self-Management Programmes mainly because of the high gender split in referrals to the service (29% men and 71% women). Although fewer men attend programmes than expected from general population estimates, we found that once people are referred to our Pain Self-Management Service, men and women are equally likely to attend an intervention, which is reassuring given that it is recognised that men can be more difficult to engage.[3] Analysis of the treatment pathways through the service revealed a slightly higher percentage of women attend a programme as their main course of intervention, and a slightly higher percentage of men attend 1:1 appointments. No particular approach of self-management support has been identified as most effective for engaging men.[4] It would be useful to have a better understanding of the factors underlying

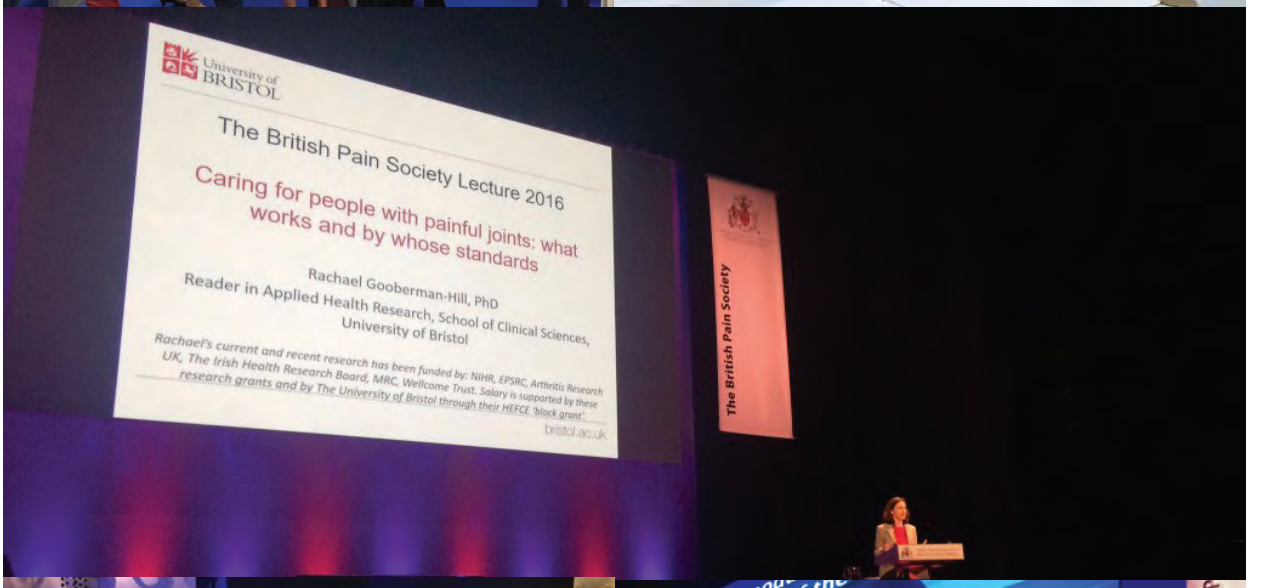
these preferences to why women and men prefer different types of interventions.

The gender split in Pain Self-Management referrals reflects the population attending Pain Clinic, but interestingly not for the orthopaedic screening service which, for some, is earlier in the treatment pathway. The next step would be to investigate the influences on referral patterns which result in fewer men attending the Pain Clinic which is a key source of referrals to the Pain Self-Management Service. This would identify ways in which we could ensure that Pain Self-Management is equally accessible to both men and women.

References

1. Breivik H, Collett B, Ventafridda V, et al. Survey of chronic pain in Europe: Prevalence, impact on daily life, and treatment. *European Journal of Pain* 2006; 10: 287–333.
2. Williams ACD, Eccleston C, and Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews* 2012; 11: 111.
3. Galdas P, and Pollard J. *How to Engage Men in Self-Management Support*. London: Men's Health Forum/Haynes.
4. Galdas P, and Baker P. Engaging men with long-term conditions in self-management support. *Trends in Urology & Men's Health* 2015; 6: 16–20.

ASM Harrogate 2016



ASM Harrogate 2016

Pain and education

Amanda Howarth *Senior Lecturer in Nursing (Pain), Sheffield Hallam University*

The British Pain Society

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As a nurse specialist, and more recently as a senior lecturer at Sheffield Hallam University, the issue of pain and its teaching has always been high on my agenda. From health care assistants, to RGN's across the professions to physios, psychologists, medical students and qualified medics, pain needs to be an integral part of their curriculum and/or ongoing training packages. The question arises as to whether pain should be taught as an independent subject or as an integral part of modules throughout undergraduate and postgraduate modules. The implementation of the IASP (International Association for the Study of Pain) guidelines in medical students' curriculum is not apparent, and without a dedicated and enthusiastic educationalist within an organisation, the issue of pain management could (and does) easily get diluted down or missed all together.

The IASP Core Curriculum for Professional Education in Pain[1] covers key aspects that should be included in a curriculum, yet having recently discussed such issues at the British Pain Society meeting in Harrogate, differences across professions and institutions are apparent. A discussion was held about the benefits of using online-based training packages, the possibilities of social media platforms as a way of encouraging a healthy discussion between professionals and the implementation of pain education being incorporated within mandatory training. The latter is already happening in some areas but seems to be focused around PCAS (patient-controlled analgesia systems) and epidural training for acute pain management. But, what about our aging population experiencing chronic pain, and the ever increasing population of people with dementia? The

Office for National Statistics[2] estimates that the number of people 60 and above will exceed 20 million by 2030, by 2040. One in four of the population will be 65 or over, and the population of over 75 year olds is projected to double in the next 30 years. And by 2025, it is anticipated that over 1 million people in the United Kingdom will have dementia.[3] The assessment and management of the pain among this group of patients is going to become an increasing problem as our population gets older with more people experiencing damage to the central nervous system along with age-associated pain. The assessment of pain in older people is widely documented,[4] yet its implementation in clinical practice is variable. Even if medical and nursing students are taught the theory in their education institutions, if it is not followed through to their clinical practice then the theory will soon be lost, widening the theory – practice gap, leaving a large population of vulnerable patients in pain.

References

1. Charlton JE. *Core Curriculum for Professional Education in Pain*, 3rd edn. Seattle, WA: IASP Press, 2005.
2. Office for National Statistics (ONS). *National Population Projections for the UK, 2014-based*. Newport: ONS.
3. Alzheimer's Society. *Dementia 2014 Report Statistics*. London: Alzheimer's Society, 2014.
4. Schofield P, Sofaer-Bennett B, Hadjistavropoulos T, et al. A collaborative expert literature review of pain education, assessment and management. *Aging Health* 2012; 8(1): 43–54.

Applying Game Theory in the pain clinic

The British Pain Society

Pain News
2016, Vol 14(3) 115–116

SAGE

Sandeep Kapuur *Consultant in Pain Management, Queen Elizabeth Hospital, Birmingham*

Game Theory is a term used to study the science of conflict or cooperation between rational individuals. A classic Game Theory scenario, the prisoners' dilemma, plays out as follows:

The police arrest two men (A and B) on suspicion of armed robbery, though they lack enough evidence to convict them in court. The men are taken to separate cells for questioning and have no means to contact each other. The police then individually offer prisoner A and prisoner B the following deal:

- The prisoner who turns informer and cooperates with the police walks free, while the one who stays silent and refuses to cooperate gets 10 years in prison.
- Both prisoners confess to their crime and get 5 years each in jail.
- Both men stay silent and get 1 year imprisonment apiece on a less serious charge.

On the face of it, the prisoners' choice appears straightforward enough: they both keep their lips sealed and walk free after 1 year in prison. However, lack of mutual trust invokes the 'prisoners' dilemma': unable to communicate with one another, each prisoner fears that if he keeps quiet and the other confesses, then he will spend 10 years in prison and the other will walk free. This then pushes them to separately choose the 'least bad' option: both confess to their crimes and get handed 5 year sentences. The prisoners' dilemma therefore represents an aspect of Game Theory in which the 'players' fail to cooperate with each other (non-cooperative gameplay) and end up getting a relatively worse deal than if they had cooperated to achieve a better outcome for both parties.

While Game Theory has wide-ranging applications in mathematics, economics, computers and many other fields, it has increasingly been recognised as having value in understanding the complex dynamics underpinning doctor–patient interactions as well:

> *I know I'm addicted to (opioids), and it's the doctors' fault because they prescribed them.*
>
> *But I'll sue them if they leave me in pain.*[1]

The current healthcare zeitgeist of 'all pain is treatable' pushes the patient to seek and the clinician to prescribe opioids. The fear of being at the receiving end of a patient's complaint reduces the clinician's motivation to confront the patient's opioid-seeking behaviour; the patient in turn uses this fear to his or her advantage to achieve his or her goal. Moreover, prescribing is quicker and relatively easier than a prolonged, difficult consultation focused on patient education and counselling. A lack of trust in each other means that both patient and doctor end up as losers in this zero-sum game.[1]

In their recent paper 'Modern Health Care as a Game Theory Problem', Djulbegovic et al. describe how the conflicting demands of healthcare provision (limited resources and time) and patient needs (rising healthcare costs and expectations) collide to create the 'perfect storm'. They state, '*In times of financial and overall societal uncertainty, all stakeholders are struggling to exploit healthcare systems to serve their own interests best*'.[2] In other words, both play the strategy most suited to their interest and chose the 'least bad' option, much like the prisoners' dilemma scenario described above. This outcome is termed the

'Nash equilibrium', named after the Nobel laureate John Nash, played by Russell Crowe in the Oscar-winning film 'A Beautiful Mind'.

So, how then do we escape the prisoners' dilemma in doctor–patient relationships? The answer lies in building trust between patients and doctors: trust leads to collaboration and better outcomes for both parties, resulting in greater satisfaction for both the patient and the doctor. As Tarrant et al.[3] state in their paper 'Models of the Medical Consultation: Opportunities and Limitations of a Game Theory Perspective',

> *In the context of the consultation, mutual cooperation becomes a more attractive prospect if future interactions are anticipated. There are incentives for the doctor to spend time finding an appropriate management approach: consultations with the same patient in the future are likely to take up less time and the doctor will have the satisfaction of carrying a management plan through to completion. The patient is likely to follow through with the treatment if there is an expectation that the doctor will monitor his progress in the future. Both the doctor and the patient can anticipate future payoffs from this mutual cooperation, and this model implies that higher quality of care can be achieved when the patient sees the same GP repeatedly.*

All this makes eminent sense of course, but runs contrary to the NHS-wide push to reduce follow-ups. 'See, treat and discharge' within 18 weeks is the new mantra. In my view, the 18-week 'referral-to-treatment' model is therefore uniquely unsuited to the complex circumstances of the pain clinic; while this strategy may help reduce waiting times, it does not allow time to build trust between the patient and the clinician, which is vital to working collaboratively and escaping the prisoners' dilemma.

References

1. Lembke A. Why doctors prescribe opioids to known opioid abusers. *New England Journal of Medicine* 2012; 367: 1580–1.
2. Djulbegovic B, Hozo I, and Ioannidis JPA. Modern health care as a game theory problem. *European Journal of Clinical Investigation* 2015; 45(1): 1–12.
3. Tarrant C, Stokes T, and Colman AM. Models of the medical consultation: Opportunities and limitations of a game theory perspective. *BMJ Quality and Safety Care* 2004; 13: 461–6.

Oxycodone in children

THE BRITISH PAIN SOCIETY

Pain News
2016, Vol 14(3) 117–119

SAGE

Anna-Karenia Anderson *Consultant in Paediatric Palliative Medicine, Royal Marsden Hospital and Shooting Star Chase Hospice*

In 2015, clinicians working with children with severe pain across the Atlantic welcomed the US Food and Drug Administration (FDA) decision to license long-acting oxycodone[1] for older children and adolescents. This move provided prescribing guidance for the first time for children as young as 11 years of age using long-acting oxycodone. However, there was condemnation in many quarters, with shouts and consternation about legalising opiates and giving 'Hillbilly Heroin' to children. In the United Kingdom, and other countries, oxycodone liquid and long-acting formulations continue to remain unlicensed for children.

Oxycodone in children

Globally, children's pain is under-recognised and undertreated.[2] The World Health Organization (WHO) guidance,[2] published in 2012, looked to improve the recognition, assessment and pharmacological management of children with a medical illness who were experiencing persisting pain. This included changes to the stepwise treatment approach from three to two steps and promoting and encouraging the appropriate use of strong opiates for moderate to severe pain.

With the WHO guidance only recommending morphine as a first line strong opiate, oxycodone seems an

obvious second-line contender. As in most areas of paediatric pain management robust research is lacking. However, there is some safety data available, albeit in limited numbers, across the age range: 62 post-spinal surgery patients aged 10–19 years,[3] 22 patients requiring wound care procedures aged 5–14 years[4] and various pharmacokinetic studies in infants and young children.[5–7]

Oral oxycodone has a higher bioavailability and a slightly longer half-life compared to morphine. It is hepatically metabolised by cytochrome P450 in contrast to morphine which undergoes glucuronidation.[8] Pharmacokinetic studies in infants and young children (6–93 months) using variable administration routes (IV, IM, enteral and buccal) have shown intravenous oxycodone as fairly similar to those reported in adults. Intramuscular administration provides relatively constant drug absorption, but the administration itself causes pain and is generally avoided where possible in children. However, buccal and enteral administrations have a large inter-individual variation in the rate and extent of absorption.[6] In the less than 6 months age group, a small study of 22 infants noted marked inter-individual variation in clearance and half-life. The author suggested the dosing of oxycodone must be 'titrated individually'.[5]

Route of administration is often a key issue in paediatric prescribing; oxycodone has tablet, liquid and parenteral formulations. There is some research available on oxycodone's potential sublingual and buccal absorption properties in infants and young children[6,7] making it a viable alternative to morphine, especially in the palliative care setting for rapid severe onset pain. In younger children, oxycodone is prescribed according to weight due to the significant influence on both clearance and volume of distribution.[9]

Oxycodone is extensively metabolised in the adult liver, but the maturation of metabolism is not well understood. However, data suggest that there are no children-specific oxycodone metabolites. Moreover, CYP3A activity seems to be the major determinant in metabolic clearance of oxycodone regardless of age group or individual variability in hepatocytes.[10]

Indications for use

As a strong opiate, oxycodone is 'rarely indicated in the long-term treatment of chronic non-malignant pain in children, although it may be beneficial in certain painful conditions with clearly defined aetiologies (e.g. sickle cell disease, incurable degenerative joint and neurodegenerative diseases)'.[11] Potent opioid analgesics, such as oxycodone, may also be 'indicated in osteogenesis imperfecta, epidermolysis bullosa and neuromuscular disease'.[12] Unfortunately, a study in a North American adolescent non-cancer pain population found the

most common conditions where strong opiates were prescribed were back pain, followed by headache, neck pain and arthritis.[13] These findings are indicative of a need for clearer prescribing guidance.

In paediatrics, oxycodone is often seen as an alternative or switch from morphine. However, its properties suggest a slightly different use in some areas. Bone cancer pain is chronic and often difficult to control with opioids. Oxycodone has a distinct analgesic profile[14] with laboratory research suggesting a specific benefit in bone pain compared to morphine and fentanyl.[15] Anecdotally, oxycodone may, in practice, be offered as first-line strong opiate for severe pain secondary to bone metastases, bone cancers and avascular necrosis; a common sequelae of cancer-directed therapy in children. However, there are no robust studies in children to support this practice.

Frequency of use in children

A recently published North American study of 34,218 paediatric outpatient controlled-drug prescriptions in the 0–21 year age group demonstrated that regardless of age, the most commonly prescribed opioid was oxycodone (73%).[16] In contrast, codeine was prescribed to 7% of patients. In an under 12 years of age paediatric inpatient Australian population, 300 patients were prescribed a total of 887 medicines.[17] Of these, 31.8% were off-label with 57.3% of children having received an off-label medication. The drugs most commonly used off-label were oxycodone, salbutamol and paracetamol.

Opioid prescribing in children and addiction

There is a long held fear and concern regarding opioid addiction by prescribers and those administering opiates to children. It has often been seen as one of the primary barriers to appropriate prescribing of strong opiates in children with moderate to severe pain.

In the United Kingdom with the safety warning on codeine[18] prohibiting the prescribing in children under 12 years and limiting its use in the 12–18 year age group, other weak and strong opiates are gaining popularity.[19] With further endorsement of strong opiate use by WHO for those children with moderate and severe persisting pain, the prescribing of strong opiates in children may rise. However, currently, opioid prescriptions for children and adolescents have remained low and stable. In 1996, 2.66% of children received an opioid prescription with only a small increase to 2.91% by 2012. The most common opioid prescriptions for children and adolescents in 2012 were codeine, hydrocodone and oxycodone. In contrast, opioid prescriptions to adult family members have significantly increased during the same period.

It is estimated that more than 6% of 12–17 year olds have engaged in recreational opioid use in the past year.[20] Recent studies have identified a strong link between increased opioid prescriptions and increased rates of opioid misuse and abuse in adults. Future studies should assess the association between adult opioid prescriptions and child or adolescent opioid misuse.[21] Oxycodone addiction in the adult population is an increasing concern in the United States[22] and United Kingdom[23] with access to oxycodone through personal or family member prescriptions or wider society. In a North American adolescent population, an estimated 1 in 25 senior high-school students misuse oxycodone. Oxycodone has started to appear in the UK adolescent population with a cheaper street value than heroin, hence its nickname ‘Hillbilly Heroin’, leading recently to the reported death of one teenager in the United Kingdom.[24]

The FDA and oxycodone in children

An open-label study[25] of 6–16 year olds evaluated the use of oxycodone modified release (MR) in 155 patients. They were recruited after having been established on oxycodone immediate release (IR) for five consecutive days. The most common adverse reactions (>5% incidence) were constipation, nausea, somnolence, dizziness, vomiting, pruritus, headache, dry mouth, asthenia and sweating. There were insufficient participants in the under 11 year age group to establish safety. Therefore, the FDA approved oxycodone MR for 11–16 year olds only due to the age group appropriate safety data[25] along with ‘adequate and well-controlled trials in adults’.[1]

The prescribing guidance for oxycodone MR (oxycontin) in children between 11 and 16 years old is for those with ‘pain severe enough to require daily, around the clock long-term opioid treatment for which alternative treatment options are inadequate’.[1] Oxycontin can be prescribed if the child, 11 years and older, is receiving and tolerating opioids for at least 5 consecutive days with a minimum of 20 mg of oxycodone or equivalent for at least 2 days immediately preceding the dosing with oxycontin.[1]

To be or not to be licensed

Oxycodone is one of the most common off-label/off-license prescription medications used in paediatric inpatient[17] and paediatric accident and emergency department settings.[26]

The approach by the FDA to license oxycodone is a pragmatic one, supporting the WHO guidance on ensuring children with severe persisting pain receive appropriate strong opiates including oxycodone. Moreover, it gives guidance on the prescribing of oxycodone to clinicians. Bringing oxycodone on-license, thus providing an indication of use and dosing, may start to address poor prescribing practices. Also it ‘... may curb the current practice of off-label prescriptions to children and provide prescription guidelines informed by clinical trials specially designed for children’.[27] This may eventually reduce

the need for 'extrapolating data from adult trials without evidence of efficacy in children'.[11]

Critics of oxycodone being placed on-label/license cite limited evidence for the conclusions reached by the FDA, from both the paediatric trial (open-label and its relatively low recruitment numbers) and extrapolation from adult oxycodone research. Others have criticised it from the other side stating it is 'unnecessarily limited and restrictive – leaving some to suffer'.[22]

Conclusion

With constant calls for 'high-quality paediatric randomised, double-blinded, placebo-controlled trials to demonstrate efficacy and safety of analgesics for various pain conditions in children',[28] prescribers may struggle in a climate of increasing evidence (from the United States) of addiction to prescription medication to prescribe opioid analgesia. For clinicians, managing a child's pain is paramount, including, when indicated, prescribing opioids for severe pain. The lack of robust high-quality research is a universal challenge in paediatric pain management, with much prescribing practice being extrapolated from adult practice.[11] The FDA approach of combining paediatric safety data alongside adult research enabling licensing of a commonly used opiate like oxycodone is welcomed. This does not negate the urgent need for high-quality research in children. But for today, it supports the prescriber and more importantly, the child in pain. The licensing of oxycodone MR for children beautifully highlights the conflict between the individual's need (to manage pain) and society's need (to minimise prescription medication addiction). For professionals currently prescribing for children in pain, clear indications for use, safety and dosing instructions in children 'outweigh the concerns of potential risk of increased opioid addiction and abuse in the youth population'.[1] I look forward to the follow-up study requested by the FDA due out April 2019.

References

1. US food and Drug Administration (FDA). CDER conversations: Pediatric pain management options, http://www.fda.gov/drugs/newsevents/ucm456973.htm (2015, accessed 4 July 2016).
2. World Health Organization. WHO guidelines on the pharmacological treatment of persisting pain in children with medical illnesses. *Guidance*, 2012, http://apps.who.int/iris/bitstream/10665/44540/1/9789241548120_Guidelines.pdf
3. Czarnecki ML, Jandrisevits MD, Theiler SC, et al. Controlled-release oxycodone for the management of pediatric postoperative pain. *Journal of Pain and Symptom Management* 2004; 27(4): 379–86.
4. Sharar SR, Carrougher GJ, Selzer K, et al. A comparison of oral transmucosal fentanyl citrate and oral oxycodone for pediatric outpatient wound care. *Journal of Burn Care & Research* 2002; 23(1): 27–31.
5. Pokela ML, Anttila E, Seppälä T, et al. Marked variation in oxycodone pharmacokinetics in infants. *Pediatric Anesthesia* 2005; 15(7): 560–5.
6. Kokki H, Rasanen I, Reinikainen M, et al. Pharmacokinetics of oxycodone after intravenous, buccal, intramuscular and gastric administration in children. *Clinical Pharmacokinetics* 2004; 43(9): 613–22.
7. Kokki H, Rasanen I, Lasalmi M, et al. Comparison of oxycodone pharmacokinetics after buccal and sublingual administration in children. *Clinical Pharmacokinetics* 2006; 45(7): 745–54.
8. Lugo RA1, and Kern SE. The pharmacokinetics of oxycodone. *Journal of Pain & Palliative Care Pharmacotherapy* 2004; 18(4): 17–30.
9. El-Tahtawy A, Kokki H, and Reidenberg BE. Population pharmacokinetics of oxycodone in children 6 months to 7 years old. *Journal of Clinical Pharmacology* 2006; 46(4): 433–42.
10. Korjamo T, Tolonen A, Ranta VP, et al. Metabolism of oxycodone in human hepatocytes from different age groups and prediction of hepatic plasma clearance. *Frontiers in Pharmacology* 2012; 2: 87.
11. American Pain Society. Assessment and management of children with chronic pain: a position statement from the American Pain Society, http://americanpainsociety.org/uploads/about/position-statements/Pediatric%20Pain%20Policy.pdf (2012, accessed 4 July 2016).
12. Schechter N, and Walco G. The potential impact on Children of the CDC Guideline for prescribing opioids for chronic pain: above all, do no harm. *JAMA* 2016; 170(5): 425–6.
13. Richardson LP, Fan MY, and McCarty CA. Trends in the prescription of opioids for adolescents with non-cancer pain. *General Hospital Psychiatry* 2011; 33(5): 423–8.
14. Kato A, Minami K, Ito H, et al. Oxycodone-induced analgesic effects in a bone cancer pain model in mice. *Oncology* 2008; 74(Suppl. 1): 55–60.
15. Nakamura A, Hasegawa M, Minami K, et al. Differential activation of the μ-opioid receptor by oxycodone and morphine in pain-related brain regions in a bone cancer pain model. *British Journal of Pharmacology* 2013; 168(2): 375–88.
16. George JA, Park PS, Hunsberger J, et al. An analysis of 34,218 pediatric outpatient controlled substance prescriptions. *Anesthesia and Analgesia* 2016; 122(3): 807–13.
17. Ballard CD, Peterson GM, Thompson AJ, et al. Off-label use of medicines in paediatric inpatients at an Australian teaching hospital. *Paediatrics and Child Health* 2013; 49(1): 38–42.
18. MHRA. Codeine for analgesia: restricted use in children because of morphine toxicity. Report, 10 July 2013. Available online at https://www.gov.uk/drug-safety-update/codeine-for-analgesia-restricted-use-in-children-because-of-reports-of-morphine-toxicity
19. Ali S, Drendel AL, Kircher J, et al. Pain management of musculoskeletal injuries in children: current state and future directions. *Pediatric Emergency Care* 2010; 26(7): 518–24.
20. *The NSDUH Report: State Estimates of Nonmedical Use of Prescription Pain Relievers*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relie. (2013, accessed 4 July 2016).
21. Groenewald CB, Rabbitts JA, Gebert JT, et al. Trends in opioid prescriptions among children and adolescents in the United States: a nationally representative study from 1996 to 2012. *Pain* 2016; 157(5): 1021–7.
22. CNN. Unintended consequences: why painkiller addicts turn to heroin. Available online at http://edition.cnn.com/2014/08/29/health/gupta-unintended-consequences (2016. accessed 4 July 2016).
23. Mail online. Sharp rise in 'hillbilly heroin' painkiller prescriptions could lead to explosion in middle-class drug use in the UK, warns health experts. Available online at http://www.dailymail.co.uk/news/article-2895254/Sharp-rise-hillbilly-heroin-painkiller-prescriptions-lead-explosion-middle-class-drug-use-UK-warns-health-experts.html (2015, accessed 4 July 2016).
24. Mail online. Hillbilly heroin epidemic warning. Available online at http://www.dailymail.co.uk/health/article-106569/Hillbilly-heroin-epidemic-warning.html (2016, accessed 4 July 2016).
25. US National Institutes of Health. Safety of twice daily oxycodone hydrochloride controlled-release tablets in children with moderate to severe malignant and/or nonmalignant pain requiring opioids, https://clinicaltrials.gov/show/NCT01192295 (2015, accessed 4 July 2016).
26. McD Taylor D, Joffe P, Taylor SE, et al. Off-label and unlicenced medicine administration to paediatric emergency department patients. *Emergency Medicine Australasia* 2015; 27(5): 440–6.
27. Yang YT, Chen B, and Bennett CL. FDA approval for extended-release oxycodone for children with severe pain. *Pediatrics* 2016; 137(5): E20160205.
28. Saps M, Youssef N, Miranda A, et al. Multicenter, randomized, placebo-controlled trial of amitriptyline in children with functional gastrointestinal disorders. *Gastroenterology* 2009; 137(4): 1261–9.

Informing practice

The British Pain Society

Pain News
2016, Vol 14(3) 120–124

SAGE

Training on pain management for neonates, children and young people: a joint Royal College of Paediatrics and Child Health and Faculty of Pain Medicine e-learning resource

Dilini Rajapakse *Consultant in Paediatric Palliative Care, Great Ormond Street Hospital NHS Foundation Trust*

Richard F Howard *Consultant in Anaesthesia and Pain Medicine, Great Ormond Street Hospital NHS Foundation Trust*

E-learning, that is, the use of Internet technologies to enhance knowledge and performance has emerged as a viable mode of accessible medical education.[1] It is increasingly challenging to apply a traditional teacher-delivered lecture-based format for continuing medical education (CME) due to the increasing demands of patient care on physician's time and the need for up-to-date research-underpinned, direct 'bedside' delivery of care by the first-line practitioner.

E-learning offers the learner flexibility in time management, content delivery and media, and it allows for self-assessment and the ability to tailor the learning needs to individuals' personal learning plans. The teacher's or specialist's role is then less about delivery of learning materials but more about facilitating learning.[2]

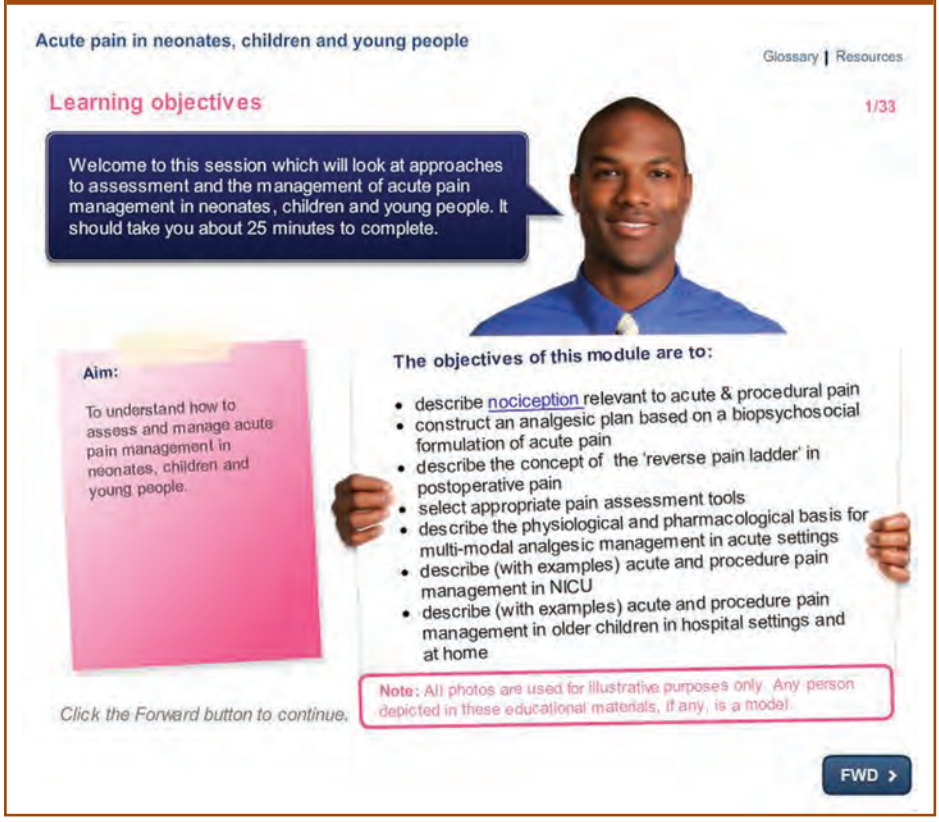
Pain management is known to be an aspect of healthcare which has been largely overlooked in health professionals' education and training programmes, although in recent years some effort has been made to redress this problem.[2,3] That children are not 'little adults' and that paediatric pain management therefore differs from adult pain management in many important aspects is widely accepted. Nevertheless, education and training in the management of pain in children continues to lag behind even that available in adult practice and so more and better learning resources have been long overdue.

Initiatives such as the International Association for the Study of Pain (IASP) *Core Curriculum for Professional Education in Pain 2012*[4] provide useful guidance to draw on for the development of medical undergraduate curricula: focussing on four care areas (multidimensional nature of pain, pain assessment and measurement, management of pain and pain in specific clinical conditions) with the salient issues around pain in children and infants being highlighted in all these areas. However, surveys have reported poor uptake of IASP guidelines into undergraduate medical school curricula in both the United Kingdom[3] and North America.[2]

In the United Kingdom, the advent of the Faculty of Pain Medicine of the Royal College of Anaesthetists has led to the publication of a curriculum as part of a comprehensive postgraduate training programme incorporating clinical and competence-based assessment processes and the development of an exit examination for anaesthetists who wish to sub-specialise in pain medicine. As a part of this training programme, there are competence-based guidelines which are endorsed by the Association of Paediatric Anaesthetists in Great Britain and Ireland (2010) for the training of anaesthetists who wish to sub-specialise in paediatric pain medicine.[5] However, local training programmes have sometimes struggled to provide sufficient education in paediatric pain to support this training.

There are also very few educational resources for postgraduate training in paediatric pain medicine aimed at

Figure 1.



paediatricians, primary care physicians, other medical and surgical practitioners and allied healthcare professionals. Nevertheless, the recognition that there is significant financial and biopsychosocial societal burden attributed to paediatric pain-related functional compromise has driven the impetus for provision of more appropriate, accessible and user-friendly training resources in the field.

The example of *chronic pain* in children highlights the importance of providing access to the right type of education to the most appropriate professionals, and how this directly impacts on patients' illness and clinical management experience. Although there is a paucity of epidemiological data for the occurrence of chronic pain in childhood and adolescence as compared to adults, the prevalence is thought to range from 6% to 25% in the United Kingdom, with up to 40% incidence worldwide reported in some studies.[6] Many children and young people with chronic pain successfully self-manage their pain and never present to healthcare services but there is emerging evidence that a significant proportion develop treatable functional impairment and disability as a consequence. A recent review of children and adolescents with musculoskeletal (MSK) pain highlighted data from the World Health Organization (WHO) Global Burden of Disease study which reported that low back pain (LBP) was responsible for the second most lived with disability for 15–19 year olds, ahead of asthma and road traffic accident injuries.[8,9] The prevalence of LBP escalates from childhood to adolescence and approaches that reported in adults[9] with associated functional impact on the daily lives of many of these young people. These aspects of living included school absence and reduced physical activity, which have an impact on the individual during adolescence but also have far-reaching consequences into adulthood.[8] In addition, there may be some evidence that adolescents with chronic MSK pain are at increased risk for chronic pain in adulthood.[10]

Poorly trained but well-meaning healthcare professionals apply a traditional biomedical model of illness to pain management; focussing on attempts to identify a cause and neglecting the impact of pain on the individual can perpetuate the frustrating experience expressed by many of these patients and families of feeling hopeless, helpless and disbelieved. Awareness of the impact of developmental issues during childhood and adolescence on the biopsychosocial model of pain, recognition of red flags for further assessment, indications for referral to tertiary pain management services and commencing interdisciplinary management including involvement of education and social care services is vital from the outset but not always sufficiently prioritised.

E-learning is a potentially powerful vehicle which can help to address this educational gap, and two recent initiatives have now become available. E-pain, a joint British Pain Society and Faculty of Pain Medicine–authored e-learning programme, is accessible on e-learning for healthcare platform (http://www.e-lfh.org.uk/home/), available free for all UK National Health Service care professionals; it includes five modules delivering *basic* or *introductory level* pain management education in children and young people. In September 2015, together with the Royal College of Paediatrics and Child Health (RCPCH), the Faculty of Pain Medicine launched an *intermediate level* series of six modules of e-learning in paediatric pain

Figure 2.

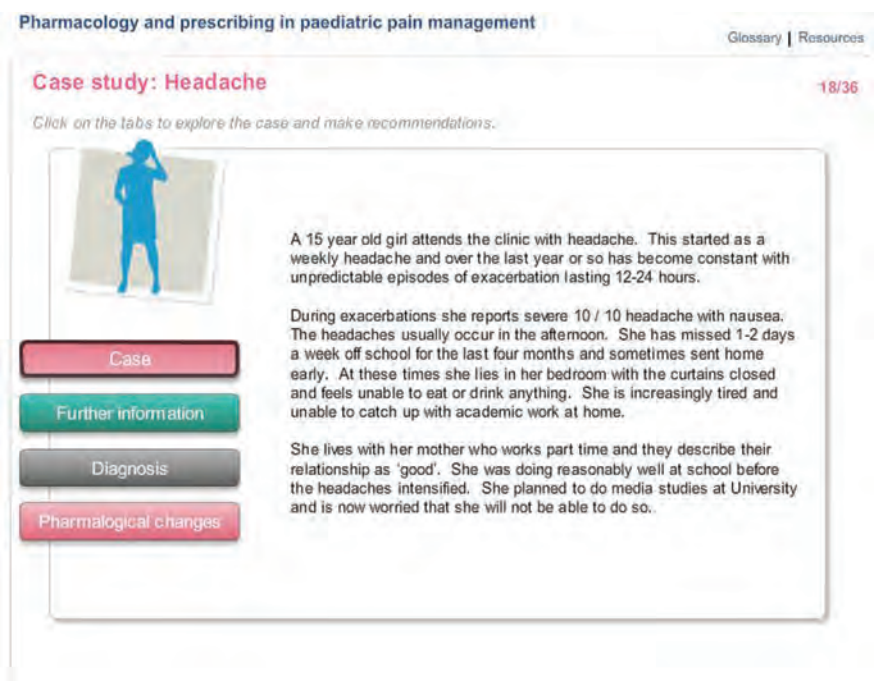
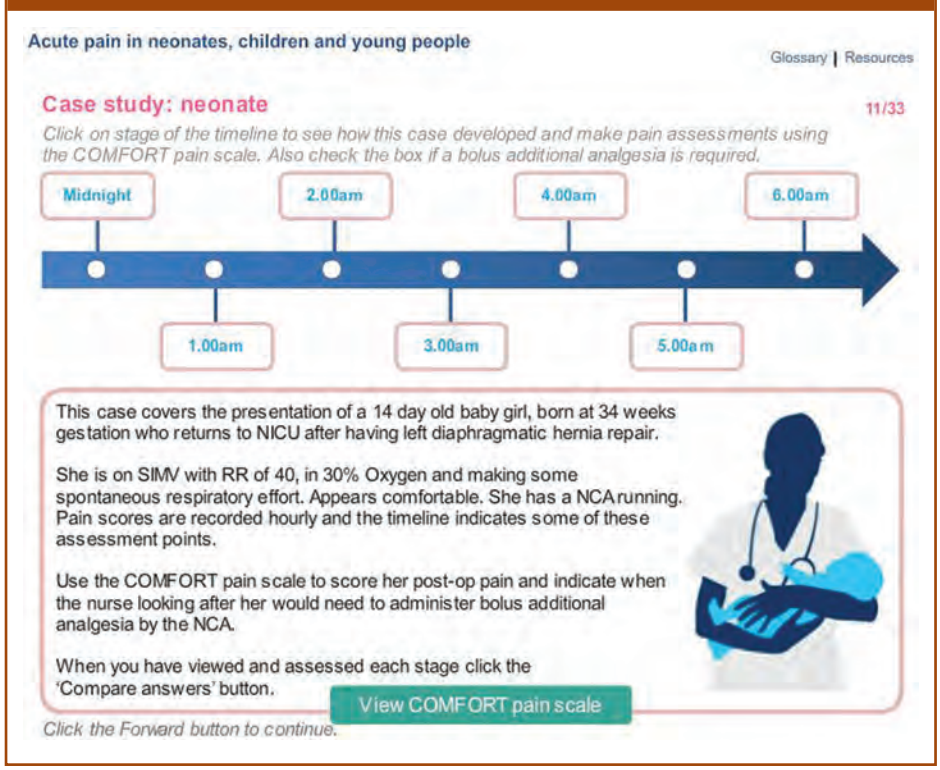


Figure 3.



management hosted by the COMPASS e-learning platform of the RCPCH website; it is free to access for both members and non-members. It builds on the knowledge and skills acquired in the basic modules and incorporates key learning needs identified by clinicians (paediatricians and pain management trainees) surveyed by the RCPCH education and training department in 2013.[11] This survey found that paediatricians, in training and non-training grade posts, felt that suitable education resources in this field of paediatrics were lacking. Their preference for training in this area was that it should be 'case-based' and 'clinical scenario' driven with underpinning explanatory basic science and so it was with this in mind that the modules were written.

The entire programme takes about 2.5 h to complete, and the topics covered are as follows:

- Acute pain in neonates, children and young people;
- The biopsychosocial assessment of chronic pain;
- Neuropathic pain conditions;
- Psychological and physical therapies in pain management;
- Pharmacology and prescribing in paediatric pain management;
- Case studies.

The modules apply multimedia learning format, and there are several examples of use of adult learning theory (relating new learning to past experiences). Each topic sets out key learning objectives and incorporates case studies throughout the module with self-assessment questions at the end. There is an opportunity to evaluate the format and content of the package by the user which will aid ongoing update and improvement of presented learning materials.

The learning objectives assume knowledge of the basic level e-pain resource but also provides some

Figure 4.

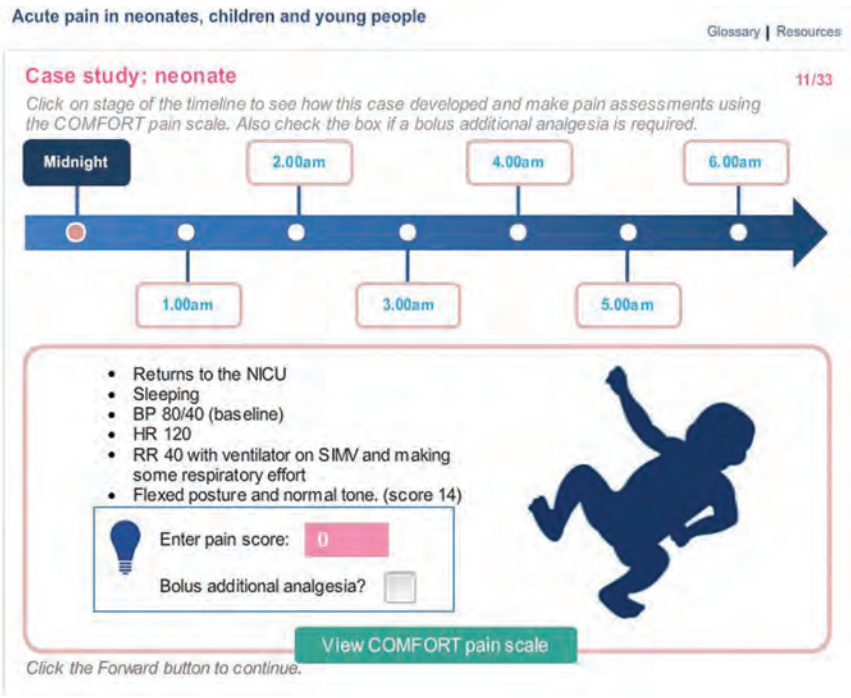
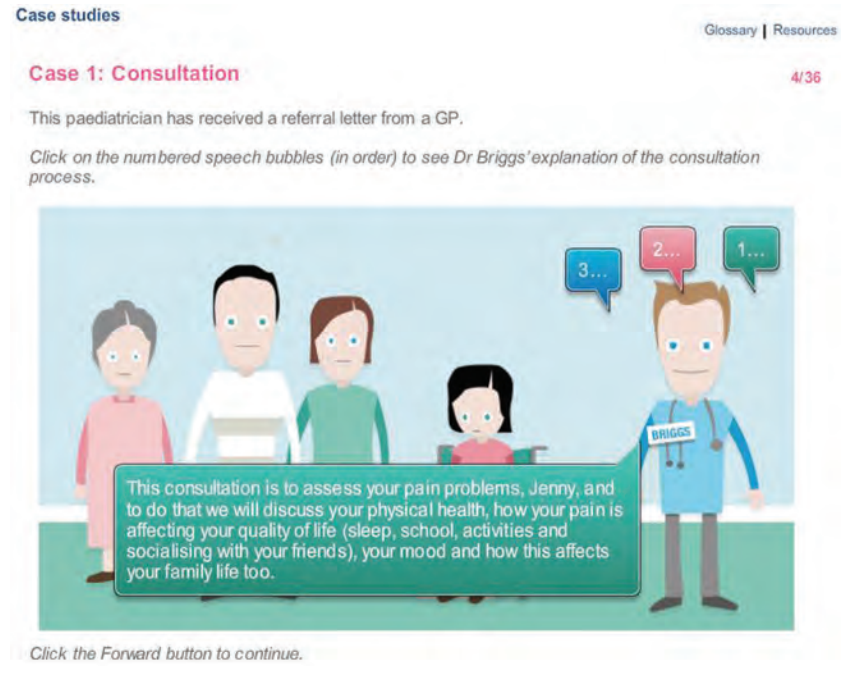


Figure 5.



opportunity to revise and consolidate this material. This focusses and links learning to specific needs (Figure 1).

There are a variety of formats used (tutorial, case-based discussions, simulation and game-based) which appeals to different individual learning styles (Figures 2–4). There are case-based examples for assessment and knowledge consolidation throughout and self-assessment questions at the end of each topic and module 6 – case studies; Figure 5 illustrates a worked example of a typical presentation of a child with chronic pain and demonstrates application of a proposed pain management pathway highlighting the use of biopsychosocial model for assessment, formulation and management. At the end of each module, there is an opportunity to evaluate the format, content and style of the module.

This resource helps to enhance understanding of a practical approach to managing children's pain, incorporates basic science into clinical examples and puts pain management into the context of general paediatric care for children of different ages and developmental levels. The format of e-learning enables widespread dissemination of essential knowledge and skills and practice change in this area of paediatrics which we hope will enhance practitioners' education and thereby patient care in the future.

References

1. Ruiz JG, Mintzer MJ, and Leipzig RM. The impact of e-learning in medical education. *Academic Medicine* 2006; 81(3): 207–12.
2. Mezei L, and Murinson BB. Pain education in North American medical schools. *Journal of Pain* 2011; 12(12): 1199–208.
3. Briggs EV, Carr ECJ, and Whittaker MS. Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom. *European Journal of Pain* 2011; 15(8): 789–95.
4. IASP. IASP curriculum updated May 2012, www.iasp-pain.org/Education/CurriculumDetail.aspx?ItemNumber=729
5. Royal College of Anaesthetists, Faculty of Pain. Curriculum in pain medicine, 2010, www.rcoa.ac.uk/faculty-of-pain-medicine/how-do-you-train-in-pain-medicine

6. Manual for prescribed specialised services for 2013/14 – Prepared by NHS England, www.england.nhs.uk/wp-content/uploads/2014/01/pss-manual.pdf
7. Howard RF. Chronic pain problems in children and young people. Continuing education in anaesthesia. *Critical Care & Pain* 2011; 11(6): 219–23. Available online at http://ceaccp.oxfordjournals.org/content/11/6/219.extract
8. Kamper SJ, Henschke N, Hestbaek L, et al. Musculoskeletal pain in children and adolescents. *Brazilian Journal of Physical Therapy*, 2016. Available online at http://www.scielo.br/pdf/rbfis/2016nahead/1413-3555-rbfis-bjpt-rbf20140149.pdf
9. Hoy D, Bain C, Williams G, et al. A systematic review of the global prevalence of low back pain. *Arthritis & Rheumatology* 2012; 64(6): 2028–37.
10. Brattberg G. Do pain problems in young school children persist into early adulthood? A 13-year follow-up. *European Journal of Pain* 2004; 8(3): 187–99.
11. Brokenbrow L. RCPCH stakeholder consultation: Managing children pain – E-survey for health professionals. Report, September 2013, Royal College of Paediatrics and Child Health.
12. E-learning for health modules of paediatric pain management, Compass E-learning platform hosted on RCPCH website: http://rcpch.learningpool.com/

A different perspective on pain

THE BRITISH PAIN SOCIETY

Pain News
2016, Vol 14(3) 125–128

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Brock Bastian *Social Psychologist, Melbourne School of Psychological Sciences, University of Melbourne, Australia*

Siri Leknes, a co-author on the paper, has written extensively on the underlying neuro-biological commonality between pain and pleasure.[1] Both pain and pleasure activate the release of a range of common neurotransmitters, including opioids. Opioids are good for not only reducing pain but also enhancing pleasure. In fact, recent research has shown that the so-called 'runners high' – the experience of euphoria experienced by runners after an intense run – is linked to opioid release.[2] By pushing ourselves against the pain barrier, we are able to increase our experience of pleasure.

There is one thing that is sure – pain hurts! Whether it is a stubbed toe, a shin splint or chronic back ache, the pain associated with these experiences is at best described as 'unpleasant' and at worst as 'suffering'. None of us wants to have unpleasant experiences or to suffer, right?

Well, this is true if we limit our view of pain to instances of illness, injury and harm. None of us want to be sick or injured. But one thing we often forget is that pain is not limited to these experiences; pain occurs in a wide array of experiences, many of which people commonly seek out.

Just think of the many sporting and physical exercise activities that people engage in – running, gym workouts, boot camps, swimming, rugby and the list goes on. But surely, I hear you say, people are not doing these things because they hurt? Surely, if we could engage in these activities without pain we would be better off? Maybe, but take a moment to imagine running a marathon. You train for the marathon beforehand pushing yourself further and further until you feel sure that you can make it. Perhaps, you are running to raise money for a charity, so you ask people to sponsor you to run the marathon. After you complete the marathon, people praise your efforts, pat you on the back and view you in a new light – as someone who finishes marathons. Now imagine if the marathon was completely pain free! It would be no more difficult than sitting at home on your couch! Would you even bother? You certainly would not need to train, you probably would not raise any money and it is unlikely that you would get much respect from your family and friends. When we stop to consider what is rewarding about many of these physically challenging events, it is the experience of pain. Indeed, they would not even be physically challenging in the first place if it were not for pain.

People also seek out pain in many other contexts. People enjoy the taste of hot chili on their food. They get pleasure from the sensation of capsaicin irritating the pain receptions on their tongues. Many people also enjoy deep tissue massage which invariably involves pain. What about those who get tattoos, body piercings or engage in even more bizarre subcultures such as the practice of suspension; this is where people suspend themselves from hooks through their flesh. Of course, these 'subcultures'

have been around for a very long time. Suspension has been practiced for as long as 5,000 years, perhaps the earliest examples were in India and these practices were often linked to religious rituals. Even today one can go to Mauritius during the traditional Hindu festival Thaipusam where people practice the kavadi which involves piercing the flesh with hooks and skewers.[3] Many of us view people who seek out extreme forms of pain as moral suspect in our own cultures, yet in traditional cultures extreme and painful rituals have been around for a very long time.

Another common form of pain seeking is winter swimming in the ocean. In Melbourne, we have the Brighton Icebergs swimming club who pride themselves on swimming all year round, including in winter when the temperature outside is in single digits and so is the water. In the northern hemisphere, people commonly jump in the ice-cold ocean on New Year's Day, and ice-swimming events take place across Europe in the midst of winter. A PhD student of mine, Laura Ferris, recently surveyed swimmers in Tasmania both before and after they jumped in the ice-cold waters of the Pacific Ocean as part of a winter solstice festival. What was

fascinating was that they reported not only more pain after being in the ice-water but also more pleasure – they enjoyed the experience!

These examples challenge our common conceptions of pain as something that is simply bad. If pain were only bad, then how can we ever hope to explain these various and exceedingly common examples of pain-seeking behaviour? It was this question that got me and my colleagues interested in the benefits of pain. We wondered what people could possibly be getting from these experiences that cause them to go back for more? So, we wrote a paper titled '*The positive consequences of pain: A biopsychosocial approach*'[4] which happily also won the Dan Wegner Award for the most theoretically innovative paper in social psychology in the year it was published.

So what did we discover? Well, it appears that pain has many benefits. We came up with nine different examples, but this was only a start and I am convinced there are more. Let me run you through a few of these here.

Myself and my colleagues also ran some behavioural studies looking at the relationship between pain and pleasure. In one study, we found that people were more likely to indulge themselves in 'guilty pleasures' such as chocolate after they had put their hand into a bucket of ice-water.[5] In fact, we observed that this was explained by a sense of justice. After enduring the 'punishment' of pain, people felt more entitled to a little reward. This explains why a beer or a piece of chocolate is so enjoyable after a trip to the gym. It is completely counter-productive but who cares – we deserve it!

We also examined whether pain might make people more sensitive to their other sensory experiences. One of the functions of pain is that it captures our attention and makes us more aware of what is happening right here and now.[6] When we are in pain, our attention is focused on pain, but what about when that pain stops? Where is our attention then? We reasoned that it might still be more engaged with our sensory experiences. Support for this possibility came from our finding that people are better at discriminating between different flavours after pain.[7] They also happen to rate a range of tastes as more intense, and it is perhaps for these same reasons that they reported enjoying a Tim Tam (you know those delicious chocolate biscuits that we have in Australia) more after a brief tussle with the ice-bucket.

So, pain can increase our experience of pleasure in life, what else can it do? Well, we also found that pain is a good way to restore your own self-image when you are feeling guilty.[8] We asked some of our volunteers to write about a time when they had done something immoral – a guilty act so to speak – while the other half wrote about something common that happened yesterday (a control condition). We then gave some of our volunteers the opportunity to put their hand into a bucket of ice-water, while some of them put their hand into a bucket of room-temperature water. Now, it is important to note that we made them believe that the essay task was about 'memory recall' and the ice-bucket task was about 'physical acuity'. I am still not entirely sure what 'physical acuity' means, but importantly, neither did our participants and as such they were distracted from any obvious link between the two tasks. We also asked them to complete the PANAS (a 20-item measure of affective states) which included the key word 'guilty' mixed in with all the other emotion words. They completed this measure just after writing the essay and just before putting their hand in the ice-bucket and then again after they took their hand out of the ice-bucket.

So what did we find? Well, first when people had written an essay about something that made them feel guilty, they held their hand in the ice-bucket longer than those who had written about an everyday common experience – the guilty participants were motivated to experience more pain. Second, we also found a reason for why they might want to do this. We found that the guilty participants who experienced pain rated their levels of guilt as significantly lower than those who had experienced the room-temperature water. The painful task reduced feelings of guilt more so than did the non-painful task.

This finding was interesting for a number of reasons. It was published around the same time as the Christian observance of Lent. The idea that people could relieve their feelings of guilt by enduring pain jelled with this practice where people forgo certain comforts to atone for their sins. It was also interesting because it provided a novel insight into a possible motivation for self-harm. While self-harm is multiply determined, it could also be that people engage in this practice to relieve their feelings of guilt. Furthermore, our findings suggested that this might not only work because pain distracts people from their other thoughts and feelings but also that the pain of self-harm could restore some sense of internal justice. Critically, if true, then our study also indicated that one need not self-harm to get this effect, and even positive experiences of pain (perhaps associated with running or going to the gym) might also have this same effect.

Another positive effect of pain is that it can bond people together – we referred to this as the 'pain as social glue' effect. There are good examples of this in contexts that involve not only physical pain but also negative and threatening experiences more broadly. Research indicates that after the terror attacks of September 11 in New York, volunteering rates spiked right across America, and not only in relation to the crisis itself but also for a range of activities that had nothing to do with 911. The experience of threat from this experience triggered a

deep social drive within people to bond together and to help each other. I was living in Brisbane, Australia, during the 2011 floods. People lost their homes, their businesses and many their entire belongings. What was truly inspirational was watching the 55,000 people turn up to help with the clean-up that weekend. This was interesting because the state of Queensland (where Brisbane is located) had been winning the state of origin rugby matches against New South Wales for the past 5 years. This is a game that piques a great deal of state-based competition and pride – yet even with all of this success, nothing that even approached the sense of community engagement arising from the floods was evident. It took a tragedy to bring people together.

I was at the University of Queensland, and my colleagues and I wondered if we could recreate this kind of effect with small amounts of physical pain.[9] To do this, we had groups of students come into our laboratory and they played a cooperation game. In this game, you can choose numbers between 1 and 7. If you choose a 7, you get the biggest payout ($7.80), but only if everyone else chooses a 7, if anyone in your group were to choose a 1, they would guarantee themselves a moderate payout ($4.20), but everyone who had chosen a 7 would now only get a very small amount ($0.60). So choosing lower numbers was about protecting your own self-interest from possible defectors, but choosing higher numbers was about trusting others in the game and working together to achieve a better outcome for all. Now, before the groups of students played this game, we had them share two different kinds of experiences. Again using the cover of calling it a 'physical acuity' task, we had half of the groups put their hand in an ice-bucket and then we asked them to hold a leg squat for as long as they could. So, in effect, we exposed them to two different sources of pain – the ice-water and the burn of holding a leg squat. In the control condition, we had them put their hands in room-temperature water and balance on one foot, both for 90 s.

What did we find? Well, the groups who endured the physically painful activities chose higher numbers in the game – they cooperated more. This was exactly as we had predicted. But we still wanted to make this more 'mundane', more like the kinds of everyday experiences we might choose to engage in.

So, we ran the study again, but this time instead of the physical acuity task, we had the students participate in what we called a 'consumer survey'. This time half of the groups consumed a butter scotch sweet together before playing the game, while the other half consumed a birds eye chili pepper – these are very hot chili peppers and their task was to eat them raw and whole (we gave them some yoghurt afterwards to ease the burn!). Again we found the same effect. Those who shared the experience of eating hot chili chose higher numbers in the game. In fact, in both studies, we had people play six rounds of the same game and across all six rounds in both of our studies, the level of cooperation (i.e. the tendency to choose higher numbers) was maintained for the groups who shared pain more so compared to the groups who shared a non-painful or pleasurable experience.

So, pain can increase pleasure, it can restore justice or justify our guilty pleasures in life, it can even make us more aware of our other sensory experiences, including the pleasant ones, and it can also bond us together fostering cooperative and prosocial behaviour between individuals. There are other examples and other possibilities, but hopefully, it is clear that pain is more than just 'bad', it has a number of positive consequences, and this can help us understand why people commonly seek out pain.

Yet, I think that this different perspective on pain can also do more than that. I think it can also point us to some new and potentially different approaches to managing those pains that we don't want and that we don't seek out. There is now a number of studies showing that if we change the meaning of pain, it can literally make it hurt less.[10] Surely, if this is true, assigning only a big black 'bad' label to pain is not especially helpful. Sure it is bad, but there are other angles too; it also had other 'not-so-bad' qualities. Perhaps, keeping these other effects of pain apparent in the minds of those who suffer from chronic pain can provide different perspectives from which to understand and manage pain.

I was incredibly honoured to present a plenary lecture at the British Pain Society's Annual Scientific Meeting in Harrogate this year. This experience also increased my own exposure to a range of new ideas on pain. For instance, Professor Candy McCabe spoke about the close connection between the experience of pain and our expectations for sensory events, and Dr Katja Wiech spoke about placebo analgesia, an effect that appears to be linked to our expectations of medication.[11] This made me think that changing people's expectations of the experience of, and the outcomes of, pain would not only be possible but also may even present another avenue through which people can manage their pain. Of course, I am a social psychologist not a clinician or someone who knows much about the treatment of pain, so I will leave the final word on this implication to others.

In short, I think there is room to take a different perspective on pain. Exploring these others sides to pain may not only provide a range of social insights into the reasons why people do the things they do but also it also might provide some novel clinical insights into how to manage the pains that people don't seek out and would prefer they did not have.

References

1. Leknes S, and Tracey I. A common neurobiology for pain and pleasure. *Nature Reviews Neuroscience* 2008; 9(4): 314–20.
2. Boecker H, Sprenger T, Spilker ME, et al. The runner's high: opioidergic mechanisms in the human brain. *Cerebral Cortex* 2008; 18(11): 2523–31.
3. Xygalatas D, Mitkidis P, Fischer R, et al. Extreme rituals promote prosociality. *Psychological Science* 2013; 24(8): 1602–5.
4. Bastian B, Jetten J, Hornsey MJ, et al. The positive consequences of pain: a biopsychosocial approach. *Personality and Social Psychology Review* 2014; 18(3): 256–79.
5. Bastian B, Jetten J, and Stewart E. Physical pain and guilty pleasures. *Social Psychological and Personality Science* 2013; 4(2): 215–9.
6. Eccleston C, and Crombez G. Pain demands attention: A cognitive-affective model of the interruptive function of pain. *Psychological Bulletin* 1999; 125(3): 356–66.
7. Bastian B, Jetten J, and Hornsey MJ. Gustatory pleasure and pain. The offset of acute physical pain enhances responsiveness to taste. *Appetite* 2014; 72: 150–5.
8. Bastian B, Jetten J, and Fasoli F. Cleansing the soul by hurting the flesh: the guilt-reducing effect of pain. *Psychological Science* 2011; 22(3): 334–5.
9. Bastian B, Jetten J, and Ferris LJ. Pain as social glue: shared pain increases cooperation. *Psychological Science* 2014; 25(11): 2079–85.
10. Benedetti F, Thoen W, Blanchard C, et al. Pain as a reward: Changing the meaning of pain from negative to positive co-activates opioid and cannabinoid systems. *Pain* 2013; 154(3): 361–7.
11. Bingel U, Wanigasekera V, Wiech K, et al. The effect of treatment expectation on drug efficacy: imaging the analgesic benefit of the opioid remifentanil. *Science Translational Medicine* 2011; 3(70): 70.ra14.

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SAGE

Survey of Pain Association Scotland self-management groups

Sonia Cottom, *B.A. (Hons), MIoD, IASP, MBPS*

Background

The network of staff-led, community-based self-management groups throughout Scotland and Northumbria has enabled chronic pain sufferers to make positive practical changes leading to improved levels of coping, well-being and quality of life, not only for the sufferers but also their carers, family and colleagues.

We understand the pressures this creates within the chronic pain service of increasing demand coupled with reduced resources. The local monthly self-management groups provide a cost-effective benefit to the local pain service, health benefits to patients, a potential reduction in service usage and an increase in patient engagement.

Methods

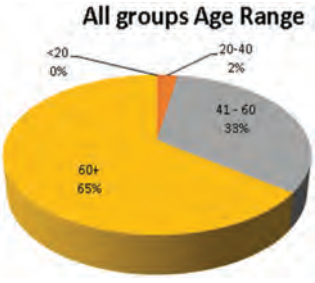
Service users were asked to participate in an anonymous survey to help the Association evaluate the effectiveness of the provision of their monthly self-management group meetings. The survey included questions about their experience and interaction with our training officers, the relevance of the various topics and any recorded differences or improvements in coping strategies

The Survey

Items on the survey were worded as positive statements or direct questions and included the following topics:

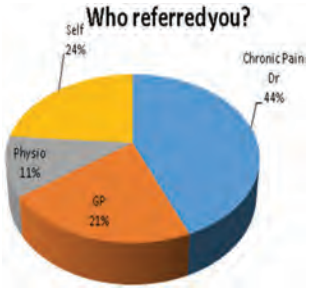
- Overall communication response time;
- The customer-service representative's level of knowledge;
- Professional characteristics of the customer-service representative;
- Whether the problem had been resolved.

Results



Age Range

These results clearly demonstrate the importance of self-management to support patients back into employment, keep those who are in work at work and also to be able to have the benefit of an improved quality of life in the long-term.



Referral Process

A total of 44% of respondents had been referred by a chronic pain clinician from secondary care. There is much focus around the importance of enabling patients to have access to self-management at a much earlier stage in their journey, from within primary care. It is envisaged that with all the work around the integration of health and social care that is going forward, the 21% of patients referred by general practitioners (GPs) will be improved upon as patients are empowered and directed to supported self-management at a much earlier stage in their pathway of care.

Survey Question	Response Scale and Count									
	1	2	3	4	5	6	7	8	9	10
Relevance of the group to my situation	1	0	1	3	3	4	7	17	27	53
Experience of being in a group	1	1	0	2	4	1	10	25	27	45
How well the training officer explained the topic	1	0	0	0	0	2	2	9	19	83
Relevance of pacing	1	1	0	2	4	4	8	16	28	50
Relevance of stress management	0	0	0	3	6	6	9	18	23	47
Relevance of dealing with difficult thoughts/ feelings	0	3	1	5	2	4	16	22	18	44
Relevance of relaxation	1	2	2	2	3	4	9	21	22	50
Benefit of meeting others	1	1	0	2	2	0	6	14	21	67

Since these topics are inter-related, the experienced staff member leading the group can guide the pace and individual needs of participants attending each session.

It can be clearly seen that the service users are benefiting from the various topics the Association delivers and demonstrates how the relevance of these is seen as applicable to their respective coping issues.

The group meeting content underpinning these figures includes the following:

- The relationship between stress and health (bio-psy-cho-social) ;
- Understanding chronic conditions;
- Relaxation;
- Breathing and distraction techniques ;
- Combined breathing and gentle stress-reducing movement;
- Communication and understanding
- pacing and goal setting;
- Dealing with unhelpful thoughts and feelings .

The overall benefit to patient's health and well-being in terms of improved coping, fewer GP visits and fewer flare-ups cannot be underestimated. The fact that 93% of our service users have experienced an increase in their overall coping of chronic, painful condition as well as 61% also seeing a reduction in flare-ups clearly demonstrates the effectiveness of the topics and how they are delivered in their group.

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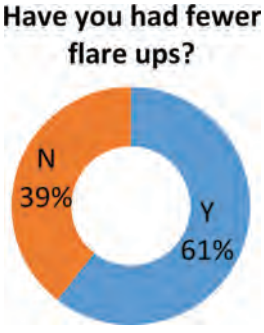

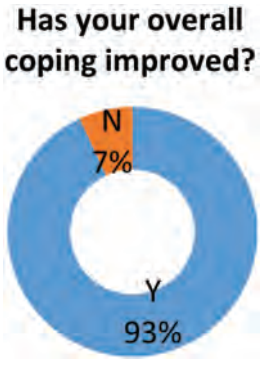

Pain Levels

The majority (58%) of service users have been living with their pain for over 10 years, recognising that chronic pain is a long-term condition which has a significant impact on a persons' quality of life and also recognising the fact that people also need to consider the economic impact of managing this long-term condition particularly if they are in employment or even unable to work because of their chronic pain.

Conclusion

Sufferers of chronic pain have been poorly supported in the past, and many sufferers report that their pain is not believed or that there is apathy to the condition. This discussion has shown that through a network of staff-led, community-based self-management groups and training programmes, service provision can be developed to help with this situation. Utilised in this way, the correct service structure empowers chronic pain sufferers, their carers, family and colleagues to make positive practical changes leading to improved levels of coping, well-being and quality of life, without impacting the already under-resourced NHS services. Clearly, focused, managed and monitored resource can help sufferers understand and manage their chronic pain condition and unwanted change in health outlook by seeking positive adaptive and coping mechanisms which can ultimately lead to a better quality of life

Book reviews

THE BRITISH PAIN SOCIETY

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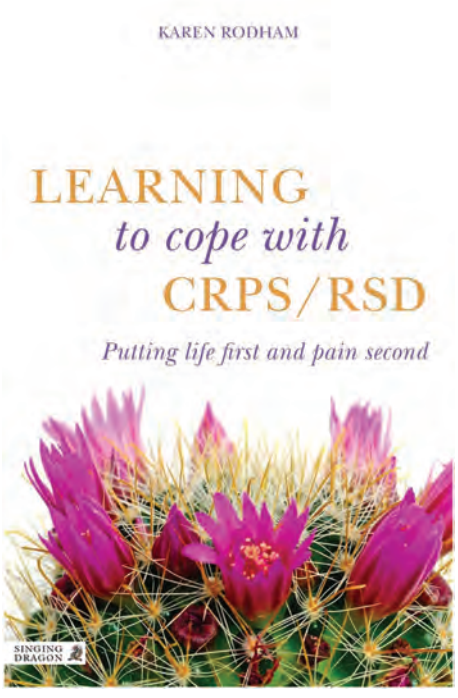


Karen Rodham. Learning to Cope with CRPS/RSD, Singing Dragon, London; ISBN 978-1-84819-240-9

Reviewed by Dr Daniel E. Schoth, *Lecturer in Health Psychology, Pain Research Laboratory, Academic Unit of Psychology, University of Southampton, Southampton, UK*

Complex Regional Pain Syndrome (CRPS; commonly referred to as Reflex Sympathetic Dystrophy in America) is, as the name suggests, a complex medical condition typically developed following some form of trauma. Further to persistent pain, a range of signs and symptoms is associated with CRPS including allodynia and hyperalgesia, swelling, abnormalities in sweating and changes in mood. CRPS is a debilitating condition which can negatively impact quality of life, and which to date has no known cure. Following years of clinical experience with patients with chronic CRPS, Professor Karen Rodham has written *Learning to Cope with CRPS/RSD*, a book aimed primarily at patients and their families.

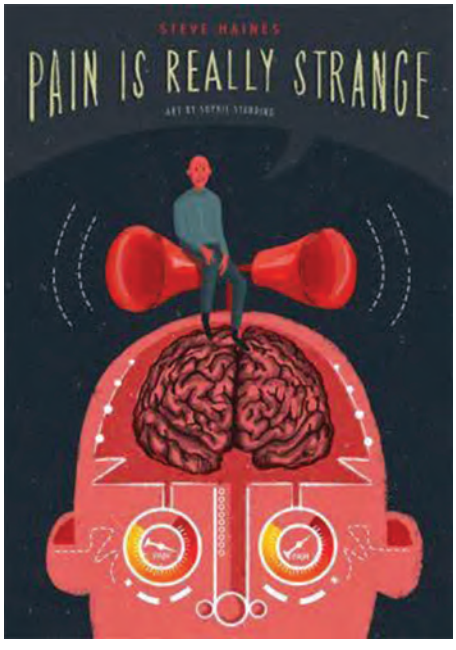
This book appropriately begins with a chapter outlining the current understanding of CRPS, including details on diagnosis and available treatments. While brief, this chapter nevertheless provides informative details, along with references to peer-reviewed research which the author states is likely to be of interest to patients and not just academics. Many of the difficulties experienced by patients with CRPS are also highlighted. A more detailed discussion of living with CRPS is saved for the second chapter, however, which presents the stories of 10 patients interviewed as part of Professor Rodham's research. These 10 stories come from a range of individuals, with different backgrounds and circumstances surrounding the development of CRPS. Particular difficulties expressed include side effects of medications, changes in identity, lack of understanding by family and friends, the experience of anger and depression, difficulties obtaining accurate information on the Internet and changes in daily activities and lifestyle. While the negative effects of CRPS are clearly highlighted, patients also speak of learning to live with CRPS and engaging with life despite their pain. Common themes include acceptance of their medical condition and the importance of pacing as an adaptive coping strategy.

The third chapter in this book discusses coping in more depth and begins with less-effective coping strategies commonly observed, including denial, suffering in silence and removal of self from social life. The majority of attention is appropriately devoted to adaptive coping strategies, however, which are split into subsections focusing on strategies for body reactions, feelings, thoughts and behaviours. Although the interconnectedness of these domains is acknowledged, this structure provides a straightforward introduction to a range of techniques including visualisation, breathing exercises and pacing. It is also acknowledged that the suggestions provided will not necessarily resonate with every reader, and the importance of individual choice is therefore emphasised. The penultimate chapter focuses on the perceptions of the informal caregiver, summarising the main points from one of the author's investigations which involved interviewing 10 carers. Family members can act as a key source of support for patients with chronic medical conditions, and yet misunderstandings on their behalf can result in relationship strains. Involving one's partner in the rehabilitation programme is recommended, as is acknowledging the impact CRPS can also have on their quality of life. Towards the end of the book, and following a one-

page chapter of brief conclusions, a list of useful Internet resources is provided. This will likely be of benefit to patients and carers, especially considering the difficulties some express in obtaining reliable information online.

Succulently and clearly written, *Learning to Cope with CRPS/RSD* is an informative read for patients with CRPS and their families. This book will also likely be of interest to those who know somebody less well with this complex medical condition, such as a work colleague, and who for one reason or another may find it difficult to discuss CRPS with them. By providing patients themselves a voice via the 10 case studies, this book offers readers a poignant glimpse into their lives and their methods of coping.

End stuff



Steve Haines. Pain Is Really Strange, Singing Dragon, London
ISBN-13: 978-1848192645

Reviewed by Antony Chuter, *Lay Chair of the Patient Liaison Committee, the British Pain Society*

'Pain Is Really Strange' by Steve Haines is quite helpful and descriptive, but I did think that it is slanted towards neuropathic pain; it does cover some other types of pain.

'Pain Is Really Strange' uses quite technical language – the sort that a clinician or an academic would use, but it does then go on to explain to the reader what the terms mean. I do wonder if many ordinary people who have not been medically trained will get much from the longer terms. In some ways, it could be off putting and in others, it is very informative. There is also some text in red at the bottom of each page that goes into some more detail about what is on each page. Overall, I think that once people get used to reading the format, that they will enjoy reading this booklet.

Towards the end, there is some information on self-management, which is helpful but could be longer. I think this booklet could be helpful for someone who has already attended a Pain Management Programme but needs a reminder now and then. It is something that would be easy to come back to again and again, to refresh and remind you about all the different aspects of pain.

The illustrations are great! The artist (Sophie Standing) has spent a lot of time and effort converting images from clinical text books and in some cases, creating whole cartoons of ideas. It reminds me of a cartoon in 'The Beano' called 'The Numbskulls', who were a band of little people who lived in and controlled the person whose head they were in. It sounds like a nightmare, but it was really fun.

This is a very nicely produced booklet about pain with cartoons; it feels very 'High Quality' for the £6.85 price tag on Amazon.

Word Search

The British Pain Society

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Pain Descriptors

K O A L Q G Z K F D W Z U L W	POUNDING
G N I W A N G R K Y J B M U M	QUIVERING
T L J N W G T Q L F F T G F U	SHOOTING
E A T F N H A E Q T X I N D V	BORING
G G G N I N E K C I S C I A J	GNAWING
T J M J H O N Q S N Y Q R E A	SEARING
H G N I T A C O F F U S E R W	HEAVY
G N S F D Q A E K H N Y V D O	RASPING
N I H B Z M P N F J B A I J H	SICKENING
I Z O H P O U N D I N G U H E	SUFFOCATING
R E O S E Q V X X H X J Q W A	GRUELLING
A E T Y G N I L L E U R G C V	TEARING
E U I K G N I R O B P E Z P Y	SQUEEZING
T Q N C G N I R A E S R J Z D	DREADFUL
F S G R R G N I P S A R O B H	

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New members ratified since February 2016

Name	Current Post	Place of work
Mr Abdullah Abahussein	PhD Student	Leeds Beckett University
Dr Khalid Alaib	Pain Fellow	Ashford and St. Peter Hospital
Mrs Gillian Bartlam	Practice Counsellor/Hypnotherapist	Plowright Medical Centre
Dr Janet Bultitude	Lecturer	University of Bath
Miss Dearbhla Burke	Doctoral Researcher	University College Dublin
Dr Line Caes	Lecturer of Psychology	University of Stirling
Mrs Rebecca Cantrell	Specialist Nurse Acute Pain	Sheffield Teaching Hospital NHS Trust
Dr Simon Cohen	Consultant in Paediatric Pain Medicine	Monash Children's Hospital
Mrs Joanna Cooper	Pain Management Nurse	St Mary's Hospital
Mrs Janet Cowling	Staff Nurse	Calderdale and Huddersfield NHS Foundation Trust
Dr Hannah Dawe	ST6 Anaesthetics/ Higher Pain	Ashford and St Peter's NHS Trust
Dr Martin Dunbar	Consultant Clinical Psychologist	East CHCP, Glasgow
Mrs Elisabeth Farquhar	Advanced Clinical Pharmacist for Chronic Pain	Leeds Teaching Hospitals NHS Trust
Mrs Annegret Hagenberg	Research Physiotherapist/ Research and Knowledge Transfer Fellow	UHL NHS Trust/ University of Leicester
Dr Adrian Head-Rapson	Consultant	Ormskirk Hospital
Mrs Katie Jackson	Specialist Pain Physiotherapist	Haywood Hospital
Dr Pungavi Kailainathan	Advanced Pain Trainee	The Hillingdon Hospital
Miss Aalia Karamat	Research Student	Kings College Hospital
Dr Ranj Khaffaf	Advanced Pain Trainee	James Cook Hospital
Dr Frances Hoi Ling Leung	Pain Fellow	Chelsea and Westminster Hospital
Dr Alison Llewellyn	Research and Grant Development Facilitator	Royal United Hospitals Bath NHS Foundation Trust
Miss Jessica Makwana	Graduate Orthotist	Queen Mary's Hospital, London
Mrs Louise Mifsud	Physiotherapist	Hospital of St John and St Elizabeth
Dr Marcus Navin	Occupational Physician	Brisbane, Australia

Name	Current Post	Place of work
Mrs Caroline Neal	Advanced practitioner Occupational Therapist / Cognitive Behavioural Psychotherapist	Nottingham University Hospitals NHS Trust
Mrs Kathryn Nur	Clinical Nurse Specialist	Withybush General Hospital
Dr Mohamed Rabie	StR Anaesthetics	Royal Shrewsbury Hospital
Dr Prit Singh	Consultant in Pain Medicine and Anaesthesia	NHS Lothian
Miss Deborah Skeete	Specialist Occupational Therapist in Falls Prevention	Central London Community Trust
Mr Cas Van Oort	Anaesthesiologist and Pain Specialist	Ikazia Hospital, Netherlands
Miss Szilvia Vas	Volunteer Trainee Health Psychologist	Milton Keynes NHS Trust
Ms Margaret Wigram	ESP physiotherapist (Pain)	Nottingham University Hospitals
Miss Hannah Wilson	PhD Student	Leeds Beckett University
Mrs Christine Wilton	CNS Pain Management	Princess of Wales, Bridgend
Ms Priscilla Wittkopf	PhD Student	Leeds Beckett University
Miss Samantha Wratten	PhD Student	University of Bath

Faculty of Pain Medicine - Upcoming Events
at the Royal College of Anaesthetists, London

9th Annual Meeting: Core Topics in Pain Medicine

Friday 2nd December 2016 £195, £140 for trainees/nurses

https://www.rcoa.ac.uk/education-and-events/fpm-9th-annual-meeting-core-topics-pain-medicine

- Spinal injections for back pain: What is the evidence?
- Mental health problems in patients with persistent pain
- Patrick Wall Guest Lecture: Moving towards a better understanding of neuropathic pain
- Transforaminal injections – particulate or non-particulate steroids: Does it matter?
- Debate: Epidural analgesia for abdominal surgery - Friend or foe?
- Thoracic paravertebral blocks: role in acute and chronic pain management.
- Myofascial trigger points: Fact or myth?

Acute Pain: Challenges & Complexities

Monday 6th February 2017 £175, £140 for trainees/nurses

https://www.rcoa.ac.uk/education-and-events/fpm-study-day-acute-pain-challenges-and-complexities

- Frequent attenders: the psychiatry of acute pain (re) admissions
- Acute pain management in patients with chronic pain
- Managing pain: Striking the right balance following joint replacements
- Acute pain management in opioid dependent/abuse patients
- Debate: Intravenous lidocaine: the answer for effective post-operative pain management

The Science & Art of Pain Management

Tuesday 7th February 2017 £175, £140 for trainees/nurses

https://www.rcoa.ac.uk/education-and-events/fpm-study-day-the-science-and-art-of-pain-management

- Nocebo response: The art of communication
- Neuroimaging of placebo analgesia
- Relaxation and distraction in paediatric pain
- Litigations in pain management
- Prescribed medication, sleep and driving

Book both February study days for the reduced rate of £330, £255 for trainees/nurses

FACULTY OF PAIN MEDICINE of the Royal College of Anaesthetists