Unrelieved pain is a global problem
National In-Patient Pain Survey (NIPPS)
The standardisation of care?
The different angles of pain
Treating pain in body, mind and soul
Hope and hopelessness
Work-related learning for acute pain
Art and chronic pain
Versatis is a novel analgesic plaster which delivers 5% lidocaine topically. Versatis has demonstrated sustained efficacy and has a reassuring safety and tolerability profile. Adverse events should be reported. Reporting forms and information can be found at: www.yellowcard.gov.uk. Versatis is a novel analgesic plaster which delivers 5% lidocaine topically. Adverse events should be reported. Reporting forms and information can be found at: www.yellowcard.gov.uk. Adverse events should also be reported to Grünenthal Ltd (tel: 0870 351 8960).

**Versatis 5% medicated plaster.** Refer to the Summary of Product Characteristics (SPC) for full details on side effects, warnings, and contra-indications before prescribing. Presentation: Versatis is a medicated plaster (100 x 14 cm) containing 700 mg (5% w/w) of lidocaine in an aqueous adhesive base. Indication: Symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN). Dosage and method of administration: Adults and elderly patients: Use up to three plasters for up to 12 hours, followed by at least a 12-hour plaster-free interval. Cover painful area once daily. Apply the plaster to intact, dry, non-irritated skin (after healing of the shingles). Remove hairs in affected area with scissors (do not shave). Remove the plaster from sachet and its surface liner before applying immediately to the skin. Plasters may be cut to size. Re-evaluate treatment after 2 to 4 weeks. Patients under 18 years: Not recommended.

Contra-indications: Hypersensitivity to active substance, any excipients, or local anaesthetics of amide type (e.g. bupivacaine, etidocaine, mepivacaine and prilocaine). Do not apply to inflamed or injured skin (e.g. active herpes zoster lesions, atopic dermatitis or wounds). Warnings and precautions: Should not apply to mucous membranes or the eyes. Plasters contain propylene glycol which may cause skin irritation, methyl parahydroxybenzoate and propyl parahydroxybenzoate which may cause allergic reactions. Use with caution in patients with severe cardiac impairment, severe renal impairment or severe hepatic impairment. In animals, metabolites of lidocaine have been shown to be genotoxic, carcinogenic and mutagenic, with unknown clinical significance. Interactions: No clinically relevant interactions have been observed in clinical studies. Absorption of lidocaine from the skin is low. Use with caution in patients receiving Class antiarrhythmic drugs (e.g. tocainide, mexiletine) or other local anaesthetics. Pregnancy and lactation: Do not use during pregnancy or breast-feeding. Undesirable effects: Very common (>10%): Administration site reactions (e.g. erythema, rash, pruritus, burning). Uncommon (0.1%-<1%): skin injury, skin lesion. Very rare (<0.01%) but potentially serious: anaphylaxis, hypersensitivity.

Adverse reactions were predominantly of mild and moderate intensity. Systemic adverse reactions are unlikely. See SPC for full details. Overdose: Unlikely. If suspected, remove plasters; provide supportive treatment (see SPC). Legal classification: POM. Marketing Authorisation number, pack sizes and basic NHS cost: PL 21727/0016, 30 plasters (£72.40). Marketing Authorisation Holder: Grünenthal UK, Reyez Lakeside House, 7 Furzeground Way, Middlesex Park East, Uxbridge, Middlesex, UB11 1BD, UK. Date of text: August 2010. V10 0069.

References:
The opinions expressed in PAIN NEWS do not necessarily reflect those of the British Pain Society Council.

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The new editor welcomes contributions including letters, short clinical reports and news of interest to members including notice of meetings.
Next submission deadline: 15 July 2011
Material should be sent to:
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Fuller version of this content is available on the PAIN NEWS website, which can be accessed at www.painsociety.org/news
In breakthrough cancer pain

Abstral®

Because time is precious

I can be at home
I can spend more time with my wife
I can see more of my family
I can manage the pain

Abstral® 100 micrograms, 200 micrograms, 300 micrograms, 400 micrograms, 600 micrograms and 800 micrograms Sublingual Tablets (fentanyl)

Abbreviated Prescribing Information Please refer to Summary of Product Characteristics before prescribing. Presentation Sublingual tablets containing 100µg, 200µg, 300µg, 400µg, 600µg and 800µg of fentanyl. Indication Management of breakthrough pain in adult patients using opioid therapy for chronic cancer pain. Dosage and Administration Only for use in patients who are considered tolerant to their opioid therapy for persistent cancer pain (i.e. using 60 mg oral morphine per day or 25 micrograms transdermal fentanyl per hour or equivalent). Administer directly under the tongue and allow to dissolve without chewing, sucking or swallowing. Adults: Initially 100µg, titrating upwards as necessary. Patients must be monitored closely by a health professional during the titration process. Once an appropriate dose has been established patients should be maintained on this dose and should limit consumption to a maximum of four doses per day. Elderly and patients with renal and hepatic impairment: Special care needed in titrating elderly patients and patients with kidney or liver dysfunction; observe for signs of fentanyl toxicity. Children and adolescents: Must not be used in patients less than 18 years of age. Contra-indications Hypersensitivity to any of the ingredients; opioid-naïve patients; severe respiratory depression or severe obstructive lung conditions. Warnings and Precautions Instruct patients and carers to keep tablets out of the sight and reach of children. Ensure patients and carers follow instructions for use and know what action to take in case of overdose. Before starting Abstral, ensure long-acting opioid treatment for persistent pain is stable. Dependence may develop upon repeated administration of opioids. Risk of clinically significant respiratory depression. Particular caution needed during dose titration in patients with COPD or other conditions predisposing to respiratory depression. Administer with extreme caution in patients who may be particularly susceptible to the intracranial effects of hypercapnia. Opioids may mask the clinical course in patients with head injuries. Use with caution in patients with bradyarrhythmias, hypovolaemia, hypotension, mouth wounds or mucositis. Monitor carefully use in elderly, cachectic and debilitated patients. Possible symptoms of withdrawal on cessation are anxiety, tremor, sweating, paleness, nausea and vomiting. Interactions Fentanyl is metabolised by CYP3A4. Use with caution if given concomitantly with CYP3A4 inhibitors such as macrolide antibiotics, azole antifungal agents, protease inhibitors or grapefruit juice. Concomitant use of other CNS depressants, such as other morphine derivatives, general anaesthetics, skeletal muscle relaxants, sedative antidepressants, sedative H1 antihistamines, barbiturates, anxiolytics, hypnotics, antipsychotics, clonidine and related substances may produce increased CNS depressant effects. Respiratory depression, hypotension and sedation may occur. Concomitant use of alcohol or partial opioid agonists/antagonists (e.g. buprenorphine, pentazocine) is not recommended. Not recommended for use in patients who have received MAO inhibitors within 14 days. Pregnancy Safety in pregnancy not established. Use only when necessary. Long-term treatment may cause withdrawal symptoms in newborn infant. Do not use during labour and delivery since fentanyl crosses the placenta and may cause respiratory depression in foetus or infant. Lactation Fentanyl is excreted into breast milk and should only be used if the benefits clearly outweigh the potential risks for both mother and child. Driving, etc Fentanyl may impair mental or physical ability. Advise patients not to drive or operate machinery if they become dizzy, drowsy or experience blurred or double vision. Undesirable Effects Typical opioid side-effects are to be expected. The most serious adverse reactions are respiratory depression, hypotension and shock. The most commonly reported adverse reactions include nausea, vomiting, constipation, headache, somnolence/fatigue and dizziness. See SPC for details of these and other undesirable effects. Overdose: Immediate management includes removal of any remaining tablets from the mouth, physical and verbal stimulation and an assessment of the level of consciousness. A patent airway should be established and maintained, and assisted ventilation initiated if appropriate. Adequate body temperature and intravenous fluid intake should be maintained. Consider the use of opioid antagonists. Pack Size and UK Price: Abstral 100-400µg 10 tablets: £49.99 Abstral 100-800µg 30 tablets: £149.70. Marketing Authorisation Numbers: UK PL 16508/0030-35; ROI PA1049/6/2 7. Legal category: CD POM. Further information is available from the Marketing Authorisation Holder: ProStrakan Ltd, Galashiels, TD1 1QH, UK or in ROI from Fannin Ltd, South County Business Park, Leopardstown, Dublin 18. © Registered Trade Mark. Date of PI Preparation: Oct 2009.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk or www.imb.ie. Adverse events should also be reported to the following: UK ProStrakan Ltd. on +44 (0)1896 864000; Rep. of Ireland: Fannin Ltd on +353 (0) 1 2907000.

Date of preparation: February 2011
M017/0545
EDITORIAL

Plus ça change, plus c'est la même chose

“the more things change, the more they remain the same”

As ever the National Health Service is going through further revolutions, but one thing remains constant throughout - we continue to fight for the recognition of our pain management services! There is a strong evidence base for many features of the management of pain; yet in these difficult times (due to current financial worries and constraints) there are still many battles, old and new, that need to be won for our specialty and more importantly for our patients.

Friends, if you had asked me whether I would be writing to you in this capacity even a few months ago, I would have laughed! Sometimes, the tides of change can move us into unexpected and interesting waters.

On reflection, I did wonder whether I was the right person to edit the BPS newsletter. Could I remain neutral and maintain the confidence of our multidisciplinary members? Will members still provide interesting articles despite these difficult times and NHS pressures? Further, I neither have any literary acclaim nor much philosophical knowledge. If anything, I think the main strength of my editorial time will be to listen to you all. I can promise that I will maintain the multidisciplinary views of our newsletter and every SIG will be given opportunity to voice their thoughts. I will try my best to attract all members to Pain News, even those with opposing views. Sometimes, if something matters, it will produce controversy and only flawed ideas oppose illumination.

I am also grateful to the outgoing editor, not only for encouraging me to write for Pain News but also as a sounding board of support in this new post. Now, I realise the challenges of this job. The only resource available for this post is the help from the Secretariat and of course, this is invaluable! I strongly believe that Mike's dedicated interest, hard work and passion have brought Pain News to a totally different level. The best example would be the time during the NICE guideline controversies; his neutral position as the editor and the fantastic issue with different views gave members more confidence in the Pain News and more so with the Society. If you meet him at the ASM or anywhere else, please give your word of thanks.

I am being well supported by the Secretariat including Jenny, Rikke and Ken. Yves Lebrec, our illustrator is the main reason for our newsletter to be so attractive. I am thrilled by the enthusiasm shown by the members of the Society for contributing to our newsletter, keep writing for Pain News - your help is very much appreciated. I thank my friend Shyam Balasubramanian, Coventry for his guidance and my colleagues Rhian Lewis and Sonny Mano, Bangor for their support.

IASP has proclaimed this year as global year against acute pain. The Acute Pain SIG is working hard to raise the profile of acute pain and there are few articles in this issue from the SIG; the National day against acute pain is on Friday 16 September. Please help us to create awareness of this event.

This issue has interesting articles: I am delighted to have a guest editorial from Dr Ken Hardy, who is a pioneer in our field and one of our past presidents; Rayen's column will be very interesting and thought provoking; Drs Hacking and Wells debate whether pain as a specialty is disappearing; Mr Neil Berry has given an update on Improving Access to Psychological Therapies; Dr Stoiloa describes a clinician's perspective on diabetic neuropathy; Dr Oomman enlightens us about non cardiac implanted devices. I thank Peter Wemyss-Gorman, Philosophy and Ethics SIG for all his kind support and providing a variety of articles from the SIG's meetings.

The Annual Scientific Meeting is just round the corner; the Scientific Committee has done a wonderful job and the programme is inspiring. Our Canadian colleagues will share their experience with us. I look forward to see you all in Edinburgh!

I thank all the contributors for this issue and those who intend to do so in the future. Please email me any innovative ideas to raise the standard of our newsletter. Remember – without your contribution, Pain News can’t exist.

Thanthullu Vasu
Bangor, North Wales

The front cover of this issue has a photograph of an artwork done by SSC module student Dannielle Lam in Kings’ College Hospital, London. This illustrates the feelings of a patient suffering with persistent pain. We thank Joan Hester for providing these interesting photographs and the article. More details on page 38.
I could hardly refuse to write a few words at the request of your new editor as we are both denizens of that magical land of Wales on the shores of the Celtic Seas, the world of Llareggub and far away from London. A few-very few-remember that I was President and possibly the first President of the new Society in the late Eighties. It was a time when we all realised that as health care professionals we would make no progress in the improvements in care for our patients, with better facilities for ourselves, unless we acted together. So those of us in the Intractable Pain Society (I.P.S.), the Needle Doctors, the I.P.S. joined with all others with similar interests to form the British Pain Society with a decent degree of political clout.

The early days in the I.P.S. in the sixties were those of the interventionist; Maher in Rochdale with the use of intrathecal phenol, Sam Lipton in Liverpool with his percutaneous cordotomy, John Lloyd in Oxford with spinal barbotage and others with similar invasive techniques: they were hardly evidence based medicine and not common enough to subject to meta analysis but they seemed to change character of treatment that the cancer patient now receives. How often I wonder is a splanchnic block used for abdominal pain relief in hospice care? How often are we timid when we should be bold in the care of our patients? My initial interest in pain came from general practice and then as a Senior Registrar for Professor Mushin in Cardiff and Professor Roy Van Dam at Harvard and the Peter Bent Brigham Hospital in Boston; both men were enthusiasts, superb teachers and with the vision to see the elephant in the room.

We all know the early pioneers such as John Bonica in the field of relief of pain, but there are others who deserve notice such as James White, Professor of Surgery at Harvard from 1955 and his volume on a forty year experience of chronic pain as a neurosurgeon is worth studying. He was the first to point out how strange it was that we focussed our energies and intellectual endeavours on a symptom… perhaps one day we will have a British Itch Society!

The Society has been through turbulent times recently, possibly the old divisions were still at work, but a stronger Society has emerged and we have been lucky in our officers. Sir Michael Bond was our Churchill of 1940 and I hope that we acknowledge it enough to have his portrait hanging in our central office.

We should always look at the future through the eyes of our patients and I think that they will see that though hesitant at times, the Society is on the right track for their welfare. I wish you well for 2011 and beyond.

"Ring out the old, Ring in the new". From: 'Ring Out, Wild Bells'; by Alfred, Lord Tennyson, 1850 (the year he was appointed Poet Laureate)

Before you hurriedly check the issue date on the front cover, or my cognitive function, let me reassure you that the quote above relates not to a new year, Hogmanay, 'Auld Lang Syne …’ etc but to another famous Scottish institution, Dr Mike Basler, immediate past Editor of Pain News!

As we welcome and congratulate Thanthulu Vasu on his appointment and this, his first issue as Editor of Pain News, I know that he and all of you will join me in expressing the warmest thanks to Mike Basler for the hard work, energy, flair, determination and professionalism which he brought to the editorship. We are most grateful that in Mike we had such an excellent custodian of Pain News, which is our flagship publication and our most important vehicle for communication and dialogue in the British Pain Society.

As an aside, Tennyson’s poem goes on to say: “ring out the false, ring in the true”, quite a good motto, I thought, for an Editor!

Of course, Mike remains very active in the Society, with his recently convened Pain in Developing Countries Special Interest Group, and in parallel his fundraising for Hospice Africa, which promotes palliative care in sub-Saharan Africa, using oral morphine.

I’m really pleased to say that two thirds of pain centres (over three hundred and twenty healthcare professionals) have started the three-month data collection phase, with to date, 1700 'new patient' data sets entered by the time of this writing in the first week of May. Very many thanks for having made this additional effort. The pain...
community has been entrusted to deliver on this highly resourced project, and I have previously emphasised our collective responsibility. We have made an excellent start, and I hope that the remaining centres will also be contributing to this exercise by the time that this issue reaches you.

Finally, if you haven’t already done so, may I remind you to double-check that your pain service is correctly described on the website listing, and to confirm this or correct your clinic description by emailing painaudit@drfoster.co.uk.

**Vice President and Council Member appointments**

By now, you will have seen the call for nominations of candidates for Vice-President, and hence realised that the resolution was passed, to introduce the new Vice-President post, to be held over a two-year term, alternating with the President Elect year. The mechanism of appointment is as for the other executive posts (Secretary and Treasurer), namely that the BPS Council will vote, and the result will be announced at the AGM on 23rd June in Edinburgh, when we will also have the results of the Society election of candidates for Council membership (three vacancies).

**Research Award and legacies**

The research fund has received a significant further legacy from another member of the Clulow family, Elaine Clulow, for which the Society is most grateful. You will recall the ‘Mildred B Clulow’ awards that we have made in alternate years. In due course, the Science and Research Committee, chaired by Mick Serpell, and Council will let you know how we intend to progress our research grant programme in the light of this large donation.

I would also like to publicly express the Society’s thanks to Ed Charlton’s family, for their kindness in asking for donations to the Society in place of flowers on the occasion of Ed’s funeral.

**Appointment of National Lead Clinician for Chronic Pain**

On behalf of all of us, I would also like to warmly congratulate Steve Gilbert, based in Dunfermline, Fife on his appointment for a term of two years from 9th May 2011 as Lead Clinician for Chronic Pain in Scotland. This is a part-time secondment with the Scottish Government and Healthcare Improvement Scotland, and of course follows on from Pete MacKenzie’s excellent start as the first holder of this important post.

**Joint ASM with Canadian Pain Society in Edinburgh, 21st-24th June 2011**

All is set in place for a wonderful event with over 620 participants already registered, ahead of the usual numbers at this stage, one month before the meeting. We are pleased (and relieved) to say that both the online poster submission and registration/payment systems have served us well.

I look forward especially to presenting Sir Michael Bond with the new premier award of the British Pain Society, ‘The Medal of Distinction’ during the Opening Ceremony of the ASM. This is to recognise his towering service and achievements both in the field of pain management and to the British Pain Society.

At the AGM, the Society is bestowing Honorary Membership on Ms Nia Taylor, Chair of the Patient Liaison Committee 2006-10; Dr Peter Evans, Honorary Treasurer 2008-10; and Dr William Campbell, Honorary Secretary of the Society 2008-10, for their outstanding contributions.

This ASM promises to be a meeting not to be missed, and I look forward very much to meeting you there.

With kindest regards,


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**From the Honorary Secretary**

**Dr Pat Schofield**

Here we are well into spring with a promise of summer approaching. Only a few weeks now until we are joined by colleagues from the Canadian Pain Society at what promises to be an exciting Annual Scientific Meeting. Remember to sign up now and come and join us in the beautiful city of Edinburgh.

**Membership**

At the time of writing this report, the membership stands at 1467 and is represented by 771 anaesthetists, 266 nurses, 95 psychologists and 84 physiotherapists with other disciplines accounting for 251 members. Other disciplines include occupational therapists, rheumatologists, neurologists, pharmacists, general practitioners and basic scientists. As usual, we encourage members to promote our Society to their colleagues and the prize for recruiting most members in 2010 was awarded again to Dr Simon Davies. Information on joining can be found at [http://www.britishpainsociety.org/join_home.htm](http://www.britishpainsociety.org/join_home.htm) and the benefits of joining are many. But not least that we have a true multidisciplinary Society.

**Election of Council Members**

Remember that we will be holding our Annual General Meeting at the ASM and members are invited to attend to vote on any changes planned within the Society. As many of you know, at the AGM we announce our new members who have put themselves forward for council. We will be expecting 3 new members this year along with our new post of Vice President.

**Updates**

Thanks go to Mike Basler who has been editor of *Pain News* and has been highly successful in producing a really excellent representation of the work that goes on within the British Pain Society in terms of news, research and importantly clinical practice. I know that Mike has been grateful to everyone out there who contributes to make it the journal to be proud of and I am sure we all welcome Thanthullu Vasu who has recently taken over as editor and I am sure he will take on the mantle and continue to grow and develop *Pain News*.

Apart from all of the activity around the ASM, which is the focus over the next few weeks, remember we still have a lot of work ongoing within the Society. Publications and study days are continuing. We have a study day planned for 21st September entitled ‘Crises in chronic pain’ which is the 21st study day organised by the Society – keep an eye on the website for further information.

The British Pain Society provides a range of contemporary publications for healthcare professionals and patients alike. It is important that we continue to produce publications that are topical and relevant to both our membership and the patients that we care for. If you have any ideas of a publication, why not get in contact with the Communications Committee and talk it through with them. They can advise you on the process of gaining approval and development of the publication.

Finally, I would like to wish all the best to Rikke Sugaard-Vigon who will be leaving us very soon to go on maternity leave. Rikke as with Jenny and Ken who are the Secretariat does a huge amount of work in supporting the Society and Council. Unfortunately, in spite of helping organise the ASM she will not be there with us in Edinburgh; so I am sure you will join me in wishing her all the best.
The editorial by Prof Allen Burton in *Pain Medicine* 2010; 11: 635-636 titled "Palliative care and Pain Medicine come together to optimally treat cancer pain: What can we learn from the British Pain Society" has applauded the Cancer Pain Management (Jan 2010) publication from our Society.

Prof Burton mentions: "The breadth of the document is enormous, yet there is an economy and depth in each section - most importantly - without apparent bias of one group to another, as it appears that all groups "cobbled" together the final piece. It appears that these groups have placed the "turf" issues aside in an effort to piece together the "state-of-the-art" best practices across the spectrum of cancer pain and related symptom issues".

In conclusion, the editorial states that "this is one of the best contextual overviews ... seen on the topic of multidisciplinary cancer pain care".

This publication was a perspective from the British Pain Society, supported by the Association for Palliative Medicine and the Royal College of General Practitioners. It can be freely downloaded from our website [www.britishpainsociety.org](http://www.britishpainsociety.org).

**Pain News** thanks all those involved in the production of this document on behalf of the members of our Society.

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**Pain Patient Pathway Mapping - progress to date**

**Andrew Baranowski**  
BPS and GWA PPPM

Since my last report in Pain News, the five committees have been very active in drawing up draft pain patient pathways. As you will remember, a range of experts in the field have contributed to this pathway, which represents the multidisciplinary nature of our Society. As well as the professional input, each pathway has a patient representative.

The pathways are:

- **Primary Pain Assessment and Management (Chair- Ann Taylor)**
- **Spinal Pain (radicular and non radicular, lumbar and cervical) (Chair- Sanjeeva Gupta)**
- **Musculoskeletal pain (non spinal, non-inflammatory) (Chair- Benjamin Ellis)**
- **Neuropathic Pain (Chair- John Lee)**
- **Pelvic Pain/Visceral (Male and female) (Chair- John Hughes)**

It is likely that by the middle of May, the pathways aimed at Primary Pain Assessment and Management, the Neuropathic Pain and the Musculoskeletal Pain will be handed over to the Map of Medicine. As a consequence, we hope to have some draft models available in the Maps of Medicine format by the middle of June. As we expected, the Spinal and the Pelvic Pain pathways will take a longer time.

The executive team are working towards having some posters available to illustrate the nature of the pathways for the Joint Annual Scientific Meeting in Edinburgh. Please keep an eye out for these and all your comments would be very much appreciated.

We are also planning to have discussions around the pathways at the BPS Primary & Community Care SIG’s workshop session ‘Map of Medicine: an update’ at 11am on Thursday 23rd June at the ASM in Edinburgh. All are welcome to attend and we look forward to a lively discussion.

We have been fortunate with the involvement of patients in the production of these pathways. Douglas Smallwood, Chair of our Patient Liaison Committee, has been working towards supporting the patients who are currently sitting on the various committees, including Chris Hughes, Liz Killick, Heather Wallace, Edith Mowatt, Judy Birch, Neil Betteridge and Jo Cumming. These patients are extremely experienced and associated with a number of patient support groups. Douglas is also in the process of setting up a reference group of patients and the plan is to present our pathways to them at their annual meeting.

We continue to build on our relationships with the Chronic Pain Policy Coalition, the Faculty of Pain Medicine, the Department of Health (in particular aimed at influencing commissioning) and the Royal College of General Practitioners (RCGP). I am pleased to announce that Martin Johnson, who sits on the BPS executive PPPM committee, has been appointed by the RCGP to lead their "Pain as a Clinical Priority" Programme. As a result, the PPPM will form the cornerstone of GP education over the next three years. This is a huge step forward for the BPS in its aim to improve standards of care for those suffering with chronic pain.

I look forward to meeting you all at the the Joint Annual Scientific Meeting in June.
Start to unlock severe chronic back pain with Palexia SR

Palexia SR (tapentadol prolonged release tablets) is indicated for the treatment of severe chronic pain in adults, which can be adequately managed only with opioid analgesics.

Visit http://bps.palexia.co.uk for more info

References
2. Palexia SR. Summary of Product Characteristics. 06 August 2010

Introducing a New Class in Pain Relief®
**2012 Clinical Excellence Awards**

The ACCEA is currently under review by the DDRB, which is expected to report to Ministers in July 2011. We have heard from ACCEA that the 2012 round may be limited to only applications of renewal of existing awards, with the exclusion of any new applications. This would in fact mirror what occurred in Scotland and Northern Ireland in the 2011 round. We will of course keep you informed of any further developments and will send an all member email should we in fact be requested to conduct the round as per normal.

Meanwhile the ACCEA website for England is still showing the date for final online submissions as 5pm, Friday 9th December 2011. **Please note that this timescale is approximate and may be subject to change depending on the result of the DDRB review.**

Specialist Societies such as the British Pain Society are asked to submit a ranked list of candidates to ACCEA by the same deadline along with a citation for each candidate. In the event that the 2012 round does go ahead we will of course put out a call for nominations in the usual way and the timeframe as in previous years will be:

- Closing date for electronic submission of forms to the BPS is **30th September 2011.**
- **BPS Sifting Committee meeting – mid October 2011.**
- Closing date for electronic submissions to ACCEA is **9th December 2011.**

Please DO NOT send forms to the Faculty. The BPS Sifting Committee will meet in mid October 2011 after all the applications have been scored using the uniform ACCEA scoring system.

Welsh candidates should submit their forms to the BPS. They will be ranked along with all the candidates from England and Wales and the BPS will provide a citation to the separate Welsh Secretariat. Welsh candidates must submit their final online forms to the Welsh Secretariat by the same closing date of 5pm on Friday 9 December 2011. Candidates from Scotland and Northern Ireland have separate arrangements.

ACCEA expects the results of the current (2011) round to be published by the end of July 2011. If this happens it will certainly save a lot of unnecessary effort. ACCEA is expecting to launch the 2012 online application system in September. Please check the ACCEA website for updates at [http://www.dh.gov.uk_AB/ACCEA/index.htm](http://www.dh.gov.uk_AB/ACCEA/index.htm). A set of the forms can be obtained from the BPS Secretariat if they are not available online from ACCEA. [info@britishpainsociety.org](mailto:info@britishpainsociety.org)

It is likely that ACCEA will continue with the arrangements introduced for previous rounds with separate, optional, forms for (i) Research and Innovation (ii) Teaching and Training and (iii) Leadership and Management. Please read the instructions on the ACCEA website so that you submit the correct forms. Also please read the instructions so that you apply for the correct award.

Pain specialists and anaesthetists often fail to progress in the awards process because their forms are poorly prepared and do not reflect accurately the work that they actually undertake. Please read very carefully the advice provided by ACCEA so that you understand fully what it is they are seeking. Please ask for advice from current award holders or people such as the Regional CEA Co-ordinators for the Royal College of Anaesthetists. At the BPS sifting committee, and at every step thereafter, the ranking process will be conducted by a mix of medical and lay people. Almost certainly, many of them will not be familiar with your reputation and achievements. The only way that you can make a case for yourself in this competitive process is through the forms that you submit. Therefore care and attention to detail is vitally important.

**Friday 30 September 2011**
Closing date for electronic submission of forms to BPS. [accea@britishpainsociety.org](mailto:accea@britishpainsociety.org)

**Friday 9 December 2011**
Closing date for electronic submission of forms and citations to ACCEA.

**National day against acute pain-16th September 2011**

As part of the IASP Global Year against Acute Pain, the BPS Acute Pain Special Interest Group will be leading the National Day against Acute Pain on Friday 16th September.

This will provide an opportunity for inpatient pain teams to raise their profile and to highlight the importance of treating acute pain, both to ward staff and to patients. With this in mind, there is a downloadable poster available on the Acute Pain SIG section of the BPS website inviting patients to “speak out” if they are in pain.

Inpatient pain teams are invited to organise events in their hospitals and are encouraged to share and advertise their plans via the website.

Please email janequinlan@btopenworld.com with your ideas. We look forward to hearing them!

**Pain News congratulates Dr Chris Wells...**

On behalf of its readers and all members of the Society, Pain News congratulates Dr Chris Wells for being elected as the next President-Elect for the EFIC (European Federation of the IASP Chapters).

We wish him well for all his efforts in improving the profile of our specialty of pain management.

**...and wishes all the best to Rikke Susgaard-Vigon**

Rikke Susgaard-Vigon, Communications Officer in our Secretariat at BPS would have gone on a maternity leave when this issue reaches you. We wish her all the best on behalf of our members! Leila Taleb, will be covering Rikke's maternity leave for the next year. We are sure you will all welcome her to the team. She can be contacted on leilataleb@britishpainsociety.org
Global Year Against Acute Pain
OCTOBER 2010–OCTOBER 2011

Healing doesn’t have to hurt

Patients in pain can take longer to get better, so if you are in pain while you’re in hospital, tell us.

The British Pain Society
International Association for the Study of Pain (IASP)

Working together for pain relief
BPS research/audit survey report

MICK SERPELL
GLASGOW

During the autumn of 2010, BPS members were surveyed on their own research or audit activities, and also asked to suggest topics for possible future work. The response rate was 166 out of approximately 1500 (~ 11%). However, this is not unusual, as an audit by the Royal College of Anaesthetists had a similar response rate. The next phase is the important one, we will refine around 400 suggestions down to about 8-20 specific research/audit questions. We would hope that members will be more interactive with the second survey (as happened in the survey of Anaesthetists) in order that the BPS can prioritise a selection of topics which could offer a spectrum of low and high cost projects.

The following are a breakdown of the areas of current members’ audit or research activity. Most responses were recorded as audit or research in an equal proportion. The most common topic suggestions concerned neuropathic and musculoskeletal pain, mainly regarding the management (drugs, psychology & interventions).

### Pain Subject

<table>
<thead>
<tr>
<th>Subject</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult humans</td>
<td>94%</td>
</tr>
<tr>
<td>Elderly</td>
<td>60%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>36%</td>
</tr>
<tr>
<td>Animal</td>
<td>15%</td>
</tr>
</tbody>
</table>

### Pain Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuropathic</td>
<td>73%</td>
</tr>
<tr>
<td>Low back pain</td>
<td>64%</td>
</tr>
<tr>
<td>Acute</td>
<td>51%</td>
</tr>
<tr>
<td>Other musculoskeletal</td>
<td>44%</td>
</tr>
<tr>
<td>Mixed</td>
<td>36%</td>
</tr>
<tr>
<td>Arthritis</td>
<td>34%</td>
</tr>
<tr>
<td>Visceral</td>
<td>34%</td>
</tr>
<tr>
<td>Cancer</td>
<td>30%</td>
</tr>
<tr>
<td>Ischaemic</td>
<td>26%</td>
</tr>
<tr>
<td>Others</td>
<td>14%</td>
</tr>
</tbody>
</table>

### Aspect of pain

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management</td>
<td>72%</td>
</tr>
<tr>
<td>Assessment</td>
<td>55%</td>
</tr>
<tr>
<td>Education</td>
<td>52%</td>
</tr>
<tr>
<td>Guidelines/Policy</td>
<td>49%</td>
</tr>
<tr>
<td>Mechanisms</td>
<td>46%</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>40%</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Management specific aspects

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacology</td>
<td>63%</td>
</tr>
<tr>
<td>Psychology/Behaviour</td>
<td>61%</td>
</tr>
<tr>
<td>Interventions (injections, SCS etc)</td>
<td>59%</td>
</tr>
<tr>
<td>Physiotherapy/Physical (TENS etc)</td>
<td>54%</td>
</tr>
<tr>
<td>CAM (Acupuncture, Herbalism etc)</td>
<td>36%</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>27%</td>
</tr>
</tbody>
</table>

- 90 Valid proxy votes were received, of which:
  - 66 Agreed to all of the proposed changes to the M&A
  - 1 Disagreed to all of the proposed changes to the M&A
  - 22 gave their vote to the Chair to vote on their behalf
  - 1 Agreed to all of the proposed changes bar Article 55.

### Extraordinary General Meeting, 17th Feb. 2011

The British Pain Society held an Extraordinary General Meeting (EGM) on the 17th February 2011 to put forward a Special Resolution for the introduction of a new Officer position of Vice President as follows:

**To add a new Article 19.3 as follows:**

19.3 Vice President. The Vice President shall hold office for the period during which there is no President Elect in office. The Vice President shall hold office for a period of one year (or such longer period as prescribed in Regulations) at the end of which he shall retire and not be eligible for re-election to that office. The Vice President shall not be eligible to stand for re-election to any office previously held by him but may be elected to another office unless the Regulations provide otherwise. In the event that the Vice President has had to resign or is no longer in office for some other reason the procedure set out in the Regulations will apply.

The vote was unanimous with all members present voting in agreement.

**To amend Article 55 as follows:**

55 The President, if any, or in his absence, the Vice President or one of the other Officers present shall preside as the chairman at Annual General Meetings and Extraordinary General Meetings, but if neither the President nor any other Officer be present within fifteen minutes after the time appointed for holding the meeting and willing to act, the members of Council present shall elect one of their number to be chairman but if there is no member of Council present and willing to act, the Ordinary Members and Honorary Members present shall elect one of their number to be chairman.

### Votes

- 90 Valid proxy votes were received, of which:
  - 66 Agreed to all of the proposed changes to the M&A
  - 1 Disagreed to all of the proposed changes to the M&A
  - 22 gave their vote to the Chair to vote on their behalf
  - 1 Agreed to all of the proposed changes bar Article 55.

In addition to the proxy votes, 17 Members were in attendance at the EGM.

The Special Resolutions were voted on with a unanimous vote of agreement by those present. All Special Resolutions were passed.
COOLED-RF TECHNOLOGY FOR BETTER OUTCOMES IN CHRONIC PAIN MANAGEMENT

- TransDiscal™
- S1nergy™
- ThoraCool™
- LumbarCool™

BVM 24 hours a day
Do you know how patients’ notes are used to form the basis of the income for your Trust? If the answer is ‘no’ then you need to read on…

The process of developing the national tariff is complex and time consuming but is essential to allow accurate funding for the NHS. Under Payment by Results (PbR), Trusts receive payment against currencies known as Healthcare Resource Groups (HRGs) depending on how much activity is carried out within each HRG.

**Healthcare Resource Groups (HRGs)**

HRGs are standard groupings of clinically similar diagnoses or treatments which use common levels of healthcare resource. They give organisations the ability to understand their activity in terms of the types of patients they care for and the treatments they provide.

The Casemix Service at the NHS Information Centre (NHSIC) designs and refines HRGs to describe healthcare activity so that they are accurate and up to date. These classifications underpin PbR from costing through to payment, and support local commissioning and performance management.

Procedure and diagnosis codes are allocated to individual HRGs by assessing whether they have similar implications in terms of resource to the Trust. A clinically meaningful name is then given to the HRG which describes the group of clinical codes within it. To derive certain HRGs, a combination of procedure and diagnosis is required, for example many pain management HRGs require a specific procedure code as well as a diagnosis code to confirm that this was used to treat pain. This is because some procedures can be performed to treat other conditions; the pain diagnosis is required to ensure the record maps to the correct HRG. A piece of free software is available on the NHSIC website called the HRG Grouper. This enables you to see which HRG would be derived by inputting specific patient record details and clinical codes into the software.

The HRGs for Pain Management are as in Table 1.

The clinical codes which comprise these HRGs can be viewed on the NHSIC website by looking at the ‘Code to Group’ workbook.

---

**Clinical Management of Chronic Pain Course**

7-11 November 2011

An advanced practical course in clinical pain management for those with some experience of treating chronic pain. Limited to 30 participants at The Pain Relief Foundation, Liverpool, UK

- **Demonstration Clinics**
- **Practical Pain Imaging**
- **PMPs—How to assess and treat patients managing common pain problems**
- **The Pain Clinicians Role in Palliative Care Implants for Chronic Pain**
- **Practical Pharmacology**
- **Demonstration Theatres**
- **Case Presentations**
- **Setting up and running a pain clinic & PMP**
- **Course dinner**

**FEE £750 - 2006 price held**

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

www.painrelieffoundation.org.uk

Registered Charity Number: 277732

In association with The Walton Centre for Neurology & Neurosurgery NHS Foundation Trust
Importance of Clinical Coding

Coding of activity is done by trained clinical coders based in coding departments within Trusts. They translate information in the patients’ notes into alphanumeric codes representing diagnoses and procedures that can then be entered onto the hospital’s computer systems e.g. the Patient Administration Systems (PAS). In some trusts, clinical or administrative staff may do their own simple coding for standard outpatient clinics as coding of outpatient activity is normally very simple (e.g. selecting a code from a list). Diagnosis coding is not mandatory in an outpatient setting so often only procedures are recorded, whereas diagnosis coding is mandatory in an inpatient setting. In an inpatient setting, procedures should also always be coded if one is carried out on the patient.

There are over 9,000 procedure codes and over 16,000 diagnosis codes. Clinical coders use patients’ clinical documentation to identify all of the detail needed to allocate codes to a patient’s record. Therefore more accurate and comprehensive patient notes and other documentation will lead to better recording by the clinical coder. Clinical coders have very little time to work through the clinical documents and many rarely have an opportunity to speak to the clinician who made the notes for further clarification. This means that the role of clinical staff is extremely important as accurate and clear patient notes are a vital part of ensuring the correct codes are recorded on patients’ records, which are then grouped to derive an HRG for payment to the Trust.

The accuracy of clinical coding is so important because these codes are then grouped together to allocate an episode of care to a specific HRG which all carry different tariffs. This is essentially how clinical coding is linked to the amount a Trust will be paid for its activity.

The Role of the Expert Working Group

To develop Casemix groupings the NHSIC needs to obtain expert help from professionals working in the field. This involvement is important to ensure that the content of any new Casemix groupings appropriately reflects the full range of activity undertaken and are fit-for-purpose. Therefore an Expert Working Group (EWG) of healthcare professionals who are experts in pain management works closely with the Casemix team to undertake this work. The group includes specialist nurses, consultants and members of the British Pain Society.

The EWG for Pain Management have worked closely with the DH PbR team to ensure appropriate tariffs are published, but the long term solution is to encourage detailed and correct information recording and coding, which will provide more accurate reference costs, leading to more representative tariffs.

If you wish to contact any members of the EWG details please do so via the British Pain Society Secretariat:

Ola Olukoga (Joint Chair); Catherine Maddock (Joint Chair); Sam Eldabe (Council Liaison); Polly Ashworth; Mike Bailey; Carol Davidson

For more information please visit www.ic.nhs.uk/services/the-casemix-service

The Local Payment grouper can be found here www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment/hrg4-2011-12-local-payment-grouper-documentation

Reference Costs & National Tariffs

The first stage in developing a national tariff is to collect data from the NHS to find out how much it costs to carry out their activity. This is known as the reference costs data collection. Trusts submit data annually (around July), and the costs will include buildings, theatre time, staff wages, drugs, equipment used, etc. These cost components are added together and a unit cost submitted against each HRG. The Department of Health (DH) then use an average of these unit costs to form the basis of the national tariff. During the period between collecting the reference costs and arriving at a national tariff, the HRG groupings and the estimated tariffs go through two assurance processes: sense check and road test. The sense check process lets all of the detail needed to allocate codes to a patient’s record.

The Local Payment grouper can be found here www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment/hrg4-2011-12-local-payment-grouper-documentation
The National Pain Audit

A message from Dr Stephen Ward, Project Board Chair

“The NATPAT team is currently analysing results. It has completed the validation of the service questionnaire. You can find your service on www.nationalpainaudit.org.

We very much hope that these will highlight:

- the variation in care
- evidence that clinicians can then use to argue for better support and resources

We have amassed an enormous database from the audits and would like to invite any BPS member who has an interest in and expertise on standards to join us in analysis and writing so that this work might have the maximum possible impact.

We are auditing against:

- Faculty of Pain Medicine Standards for provision of services – this includes staffing, facilities and support – details of this can be found on the Faculty website.
- International Association for the Study of Pain definitions of Pain Services and waiting times. Details of these can be found on the IASP website.

If you feel that there is something important that we are missing please email the national pain audit team using the website as above.

Once again thanks for your support, something that has already been duly noted by the Department of Health in England. We will keep you informed of developments as and when they occur.

Dissemination of the National Pain Audit reports

Over recent weeks, we have been busy verifying all of the data from Phase 1. This has been a truly onerous task with the team chasing centres and data daily. Even so, some centres have yet to respond. We would urge you to do this as otherwise we cannot guarantee accuracy of your data and will be obliged to mention this.

The reports will be sent to all 246 Acute Trusts, and Primary Care Clusters, Health Boards and Registered GPCC's in the UK. The reports will also be sent to key stakeholders, including HQIP (Healthcare Quality Improvement Partnership - the body, which is now responsible for commissioning national clinical audits) and the team developing the forthcoming National Pain Summit at the Department of Health.

NHS Atlas

Following Richard Langford from the BPS and Beverley Collett from the Chronic Pain Policy Coalition’s visit to Sir Bruce Keogh, Medical Director of the NHS, the National Pain Audit was invited to submit what they felt were key indicators to the National Atlas of Variation. This has been successful in highlighting how care differs across the UK and a powerful driver for change. The scientific committee decided that the key indicators that were strongly representative of good quality care were timeliness - using access to care at less than 8 weeks based upon IASP’s work in this area - and multidisciplinary care based upon services self rating using IASP definitions. Both of these have been collected through the National Pain Audit.

We will wait to hear whether we are successful.

Goverance of the National Pain Audit

The National Pain Audit group is divided into:

Project Board:
- Stephen Ward, BPS Chair
- Cathy Price, Chair, Scientific Committee and clinical lead
- Barbara Hoggart, Chair, BPS Clinical Information SIG
- Ellen Klaus, Operational Lead Dr Foster
- Douglas Smallwood, Chair, BPS Patient Liaison Committee
- Roger Taylor, Dr Foster

Scientific Committee
- Cathy Price, Chair

Operational Team:
- Robert Douce, Project Manager Doctor Foster
- Ellen Klaus, Operational Lead Dr Foster
- Alistair Johnson, Website co-ordinator Dr Foster
- Dr Cathy Price, Clinical Lead, BPS
- Stephen Ward, Project Board Chair

For governance and oversight we have:
- Julian Brookes, South West SHA
- Douglas Smallwood, BPS Patient Liaison Committee
- Richard Langford, President BPS

We have oversight of the project through HQIP.

Permission and consent:
The National Pain Audit conforms to standard procedures as laid out by the Department of Health in obtaining healthcare data, the team at Dr Foster is very experienced at doing this. We frequently get asked if it has been through an ethics committee. The answer to this is that as it is not a research where we are trying to test out a hypothesis, then it does not fall under research governance.

More in the next newsletter.
All these publications are available to download free of charge from our website www.britishpainsociety.org

Recently completed publications:
- Understanding and managing pain: information for patients (2010)
- Cancer pain management & Cancer pain management: information for patients (2010)
- Managing your pain effectively using "Over the Counter" (OTC) Medicines (2010)
- Spinal cord stimulation for the management of pain: recommendations for best practice & Stimulating the spinal cord to help with pain: information for patients (2009)
- The recognition and assessment of acute pain in children-Royal College of Nursing (2010) endorsed by BPS
- Best practice in the management of epidural analgesia in the hospital setting: Faculty of Pain Medicine (2010) endorsed by BPS

Publications in progress (completion 2011/2012):
- A core curriculum for preregistration healthcare education (Nick Allcock)
- Recommendations for the management of chronic non-malignant pain in children and young people (John Goddard)
- BGS/BPS Guidelines for the management of pain in older adults (Pat Schofield)
- Recommendations for GPs-Management of persistent pain in primary care (Joan Hester)

Publications currently under review:
- Use of drugs beyond licence & Using medicines beyond licence (William Campbell)
- Pain management programmes (Paul Wilkinson)

The Society is looking for proposals for new publications. If you have any interesting ideas or topics, please do not hesitate to contact our secretariat at: publications@britishpainsociety.org


FRIDAY 11th NOVEMBER 2011

5th GUYS & ST THOMAS’ HOSPITAL SYMPOSIUM ON PAIN PRIMUM NON NOCERE SED OPTIME AGERE

THE FACULTY
Ms Judith Kelbie, Solicitor Representative of MPS
Prof Turo Nurmiiko, Liverpool UK
Prof Richard Langford, London UK
Prof Anthony Dickenson, London UK
Prof Stephen McMahon, London UK
Prof Tara Renton, London UK
Prof Irene Tracey, Oxford UK
Dr Andreas Goebel, Liverpool UK
Dr Connal McCrory, Dublin IRE
& the team from St Thomas’ Hospital

TOPICS TO BE COVERED
- Staying safe/medical negligence
- What is new in the medication armamentarium
- Future development of pain medicine
- Immunology and pain medicine

VENUE
Governor’s Hall
St Thomas’ Hospital
Lambeth Palace Road
London SE1 7EH

FOR FURTHER INFORMATION
Tel: +44(0)20 7631 8804/8
Fax: +44(0)20 7631 4352
Email: gsttpain2011@aagbi.org
Medically unexplained pain

There has been much debate amongst members about the NHS ‘new IAPT (Improving Access to Psychological Therapies)’ programme. Here Mr Neil Berry gazes into the future to offer views as to some of the long-term implications of this programme.

Neil Berry
Southampton
neil.berry@nhs.net

It is 2015, and we are in England. GP, Dr Thoughtful, is looking back on the week’s surgeries and reflecting on the fact that she has seen quite a few patients who present with persistent pain conditions which she has been unable to get to the bottom of or effectively relieve. As always, there were several patients with low back pain and varying degrees of buttock and leg pain. She also saw that chap again who has neck, shoulder and arm pain dating back to an RTA over a year ago when his car was hit while stationary at traffic lights. The X-ray on his neck showed only “mild spondylosis”. There was also that lass with the abdominal pain that she has had since her mid-teens. She has had both GI and gynae investigations... Then there’s the woman who seems to be standing on her head. She has had both GI and respiratory investigations and has been on and off oxygen for several years. “Perhaps I do need to be more confident of my own clinical judgements”, Dr Thoughtful tells herself and goes on to reassure herself that she has the “MUS” guidance and to varying degrees, she has seen patients respond. “Many patients with unexplained symptoms just need reassurance. Most people with MUS who see their GPs will improve without any specific treatment, particularly when their GP gives an explanation for symptoms that makes sense”(1), the guidance says. Yet, for many, the pain has persisted and they continue to struggle in their efforts to maintain their physical function, psychological wellbeing and quality of life. Giving “an explanation for symptoms that makes sense” has often been quite challenging. What else can she do for these patients?

Her thoughts inevitably turn to the IAPT services that the Department of Health has continued to champion over the past four years. She has seen the government invest £470 million into its Improving Access to Psychological Therapies programme over a five year period when many health services have struggled to stand still. “Medically unexplained symptoms... are physical symptoms caused by psychological distress”. That is what the Department of Health’s four-year plan for IAPT(2) had boldly stated in 2011.

Since then, Dr Thoughtful has made many referrals of patients with medically unexplained pain to IAPT but she has learned to be more discriminating as time has gone on. She no longer refers patients who present as not significantly distressed because too many of them have returned more distressed than when they went. If a patient is significantly depressed or anxious, she only now refers them to IAPT if the patient understands that the referral is to address their distress rather than the pain condition and so long as IAPT understands that the referral has been made on that basis.

The mere fact that a dutiful civil servant had included the simple statement: “Medically unexplained symptoms... are physical symptoms caused by psychological distress” was not likely to persuade Dr Thoughtful that anything in medicine could be as simple as that. She recognises, of course, that, as a group, her patients with medically unexplained pain are not strangers to psychological distress but so too are many of her patients with other chronic conditions. No-one argues that the physical symptoms of her patients with COPD, psoriasis or Crohn’s are “caused by psychological distress” - exacerbated by psychological distress, perhaps, but not “caused by psychological distress”.

Four years ago, IAPT’s enthusiastic proponents had heavily promoted the view that patients with “medically unexplained symptoms” should be referred to IAPT services rather than to specialist medical services:

“Reducing referrals for medically unexplained symptoms (MUS) – up to half of all GP referrals for acute specialist opinion are estimated to be for people with no clear physical health problem, where the underlying condition is likely to be psychological. By appropriately diverting these flows to IAPT services, there is a potential for making significant savings, as well as providing a more appropriate service that meets the needs of patients.”(3)

Patients with chronic pain conditions had been caught up in this. Commissioners and clinicians were encouraged to include under the broad MUS umbrella, the patient who “complains of pain in multiple different sites”(4). To help patients to understand the way that psychological distress can lead to physical symptoms, the example of “depression causing pain in the face”(4) was suggested and GPs were encouraged to actively search for patients who may be suitable for IAPT: “including those with chronic pain, multiple pain, using opiates, gabapentin or pregabalin, or where all investigations have failed to show a cause for the symptoms”(4).

Dr Thoughtful also reflects on the contrasting voices that she had heard around the same time. Her concern for her patients with persistent pain had led her to a conference on “Medically Unexplained Symptoms” at The Tavistock Centre in February 2011 and she
had been particularly impressed by the content of a presentation by Dr Amanda C de C Williams entitled: "Pain: Unexplained or Misunderstood"(5) The fact that the presentation was by a psychologist had struck her as particularly interesting because Amanda had highlighted the evidence that chronic pain has a neurobiological basis. She remembered one phrase in particular: "There are multiple mechanisms, all capable of plasticity." Chronic pain had never struck her as simple and straightforward.

"Complex conditions", she thinks, "may need complex solutions" and her thoughts move on to the specialist multidisciplinary services for pain from which some of her patients have gained significant benefit. She recalls the findings of a survey by The Patients Association at the end of 2010:

"[O]f those having suffered from chronic pain in the past five years... 65% were aware that seeing a specialist to relieve the symptoms was an option. Only 23% had been referred, however."(6)

"The past few years have been challenging for pain patients and for pain services", she reflects, and her thoughts return to that presentation by Amanda Williams. Amanda had captured her attention very early on with a quote from one of Dr Thoughtful's old medical school professors and she had since gone on to hunt out the original. She reflects on the fact that the writer, Professor Patrick Wall, was writing about medically unexplained symptoms two decades ago and she searches through her filing cabinet until she finds the photocopied pages: "Pain without peripheral pathology". She sits down with a cup of tea and reads it once more:

"Modern medical diagnosis is firmly based on a 200-year development of pathology: initially on morphological pathology and, since the turn of the century, on chemical pathology. Furthermore, classical neurology taught that pain was initiated by impulses in nociceptive peripheral afferents activated by a pathological state in peripheral tissue. However, we are faced with a crisis: epidemic of painful states where no peripheral pathology has been discovered or, if apparent, is clearly secondary to some primary change. These conditions now include tension headaches, migraine, temporomandibular joint syndrome, trigeminal neuralgia, the majority of neck and back pains, fibromyalgia, interstitial cystitis, etc. To add to this problem, it is emerging that, even where overt pathology is clearly present, the extent of the peripheral pathology is poorly related to the amount of pain. These conditions include myocardial ischaemia, arthritis, amputation, neuropathies, etc. The extent of this paradox is emphasised in the same individual where successive episodes of cardiac ischaemia fail to indicate the amount of ischaemic muscle in terms of pain and even worse where a patient, with two unequally osteoarthritic hips at the same time, complains only of the less damaged hip.

The standard response to this problem is given by the great majority of doctors in two stages. First, the normal sensory nervous system is a reliable accurate witness to currently observable peripheral pathology. Second, any deviation from this first rule is a mental aberration. These two rigid rules are simple restatements of Cartesian dualism. I firmly believe that there are three alternative possibilities. First, I find it unwise arrogance to believe that our present techniques of diagnosis are capable of detecting all relevant forms of peripheral pathology. Second, we are now beginning to realise… that a peripheral event may trigger long lasting changes in the spinal cord and brain by way of nerve impulses and transported substances. This means that overt peripheral pathology is capable of initiating a cascade of changes which may persist in the central nervous system long after peripheral pathology has disappeared. Third, we are now beginning to discover that sensory systems are not dedicated and hard wired but are normally held in a stable state by elaborate dynamic control mechanisms. The rules of the physiology of these control mechanisms allows them to be pushed outside their normal working range in which state they will oscillate or fire continuously. As with all known mechanical and biological control systems, it is also possible for them to drift idio pathically into an unstable state… The contemporary custom of assigning the cause of pain either to peripheral pathology or to mental pathology is too simple because it ignores the subtle dynamic properties of peripheral tissue and of the nervous system of which three examples have been given, which could explain many of the diseases listed and which have previously been attributed to mental disorders."

"It is the condition! Pain is the disease!" exclaims Dr Thoughtful and her dog, Lansley, woken from his snooze, gives a soft woof of affirmation. It isn’t exactly a life-changing moment but it does leave her feeling that bit more confident. She recognises that years of training and of viewing pain-as-a-symptom has left her with some sense of unease and inadequacy when facing "medically unexplained pains". Dr Thoughtful is well aware that the research to date has yet to lead to potent new treatments but she can point to many other chronic health conditions where that is also the case. This is familiar territory for her and she is confident of her ability to support her patients in their efforts to maintain their physical function, psychological well-being and quality of life.

REFERENCES


You may have had this experience. But, strangely it occurred to me four times in a clinic. Four patients— a retired cardiologist suffering from diabetic neuropathy, a young lady with multiple sclerosis, a factory worker with chronic low back pain and a chronic pelvic pain sufferer— brought reams of printed papers with downloaded information from the internet about treatments claimed to be successful. ‘L-Arginine is the best treatment for diabetic peripheral neuropathy’ claimed a few websites selling natural products; ‘Diabetic patients lack this nutrient, so, taking L-Arginine as a supplement, as a transdermal drop, helps the patients with diabetic neuropathic pain’ claimed a website as the reason for trialing the transdermal drops of arginine! The list of the treatments and the reasons for using them went on. Patients asked me one question ‘Doc, what do you think?’

It got me thinking… very unusual in my day-to-day life…. I meant thinking… My serious thinking led to two questions – Why do patients look for more information outside (other than what we give)? Is there any regulatory structure for controlling the quality of information available outside the hospital from non–medical bodies?

Patients seek information about their disease and the available treatments from either health professionals or others. As health professionals, it is our duty to inform the patients about their diseases and the available treatments from our limited knowledge and experience. This process may not happen because of time constraints, lack of knowledge and limited experience of the health professional in that particular problem as well as other patient factors. Patients may not assimilate all the information given to them by the health professionals especially if it is life changing. Chronic pain management poses its own problems– the search for a diagnosis and the difficulty in finding an easy solution. Frustrated, looking for answers, patients do resort to neighbours and relatives to get their private matters to the media. Patients have to divulge their health problems to the information given to them by the health professional in those limited knowledge and experience. This process may not happen because of time constraints, lack of knowledge and limited experience of the health professional in that particular problem as well as other patient factors. Patients may not assimilate all the information given to them by the health professionals especially if it is life changing. Chronic pain management poses its own problems– the search for a diagnosis and the difficulty in finding an easy solution. Frustrated, looking for answers, patients do resort to neighbours and relatives to get their private matters to the media. Patients have to divulge their private matters to the neighbours and relatives to get answers they are looking for. On the other hand, the world wide web helps them with free information at the stroke of mouse click without this concern. ‘They Google it’!

Let alone patients, doctors also search for information on the net. I am not talking about PubMed here! How many times have we heard ‘Google it? How many times have we googled medical questions? As professionals, hopefully we have the knowledge to tease out the correct information from the rubbish. Unfortunately, in the case of patients, they are not armed with such prior knowledge and are trapped to believe whatever they see on the internet. Desperation for the cure or even pain relief lead them to believe, try and even buy various spurious treatments claimed to be successful on the internet.

I googled the word ‘diabetic neuropathic pain treatment’. The main section of the Google results gave reliable information on scientific knowledge and evidence for the existing treatment. But on the ‘ad’ section of the search results there are websites claiming to be selling products, which are supposedly very effective in diabetic neuropathic treatment including L-arginine (accessed on 2nd April 2011).

The Internet lends itself as a superb tool for dissemination of information across the world. There are no cultural or political boundaries. The language barrier can be easily overcome by simple digital software. It is relatively cheap to publish on the web and inexpensive to access. But, there is no quality control on the published information on the web. Anyone can claim a treatment to be successful in the web world. Professional societies, governmental and non-governmental organisations publish factual information about the diseases, pathways and guidelines with scientific evidence. Private companies mostly advertise treatments for medical conditions. Patients tend to believe any information from a website that may look authentic. I have heard patients buying various expensive TENS like machines for different types of pain. There is no legal framework to cover the contents of the websites. This took me back to my next question - Is there any way to control the quality of medical information available from the so-called medical and non-medical websites? I set out with this question in the digital world and after several hours of enquiries, I landed on ‘HON’.

HON is abbreviation for Health On Net (http://www.healthonnet.org/) (http://www.hon.ch/). It is a non-profit, non-governmental organisation created to ‘promote and guide the deployment of useful and reliable online health information, and its appropriate and efficient use’. It was created in 1995 and accredited to the Economic and Social Council of the United Nations. In the last fifteen years, HON claims to have ‘focused on the essential question of the provision of health information to citizens, information that respects ethical standards. To cope with the unprecedented volume of healthcare information available on the Net, the HON code of conduct offers a multi-stakeholder consensus on standards to protect citizens from misleading health information’. In simple words, it provides a
voluntary governance framework for the voluntary health/medical website owners and managers.

Anyone signing up to the HON code voluntarily agrees to adhere to certain ethical and moral codes. It is a voluntary certification system based on an "active seal" concept. The subscribing sites are provided with the blue-and-red HONcode seal. This helps users to identify sources of reliable information. The HON claims that it is not an award system; it also does not intend to rate the quality of the information provided by a website. It addresses, among others, the authority of the information provided, data confidentiality and privacy, proper attribution of the sources, transparency of financial sponsorship and the importance of clearly separating advertising from editorial content.

Once accredited, the websites will be visited by the HON team regularly at least once yearly or sooner if there is reported violation of the codes.

Website owners and managers apply voluntarily for the HON seal of approval. For certification, the website should provide and adhere to the eight principals of the HON code - it should provide health and medical information, have the name of the person who is responsible and contactable, should have a mission statement, clearly provide intended audience (general public, health professional), have privacy and confidentiality policy, information must be referenced and dated and should disclose advertising and funding policy. Once the HON team satisfies themselves that the criteria are met, the website is provided the seal of approval.

At the time of the visit, more than 7300 websites and 10 million pages from 104 countries uses the HONcode. Every day, the HON website gets 27000 visitors worldwide. It has been translated and is used in 35 different language versions. The homepage of the HON website is well organised. There are three icons for directing patients/individual, healthcare professionals and web publishers.

The HON web site also gives valuable advice and tools to the general public and professionals regarding safe navigation on the web if they are looking for health information. In addition to the commonsense advice of not obtaining online consultation, it also provides an innovative tool called WRAPIN- Worldwide online Reliable Advice to Patients and Individual (http://www.wrapin.org/index.html). It is an interconnected knowledge base which helps the individual to compare information regarding health matters which are available in any digital format or length. It includes major medical databases like pub med and HON certified commercial websites, which provide reliable and trustworthy information. It helps to determine the reliability and quality of the published documents.

I think HON is not the complete answer, but at least a starting point!

Intractable pain in patients with diabetic neuropathies

Dr Tsvetanka Ivanova-Stoilova
Newport Gwent

Diabetic neuropathies are the most frequent metabolic neuropathies and represent one of the microvascular complications of diabetes. They affect approximately 50% of people with 15-20 years duration of diabetes. 10-20% of them will have pain and 5% will risk ulcerations in each calendar year. 75% of all non-traumatic amputations are due to diabetes. Diabetic neuropathies (DN) tend to get more severe with time and have negative impact on quality of life, physical functioning and vitality. They include focal (entrapment neuropathies, III nerve palsy, trunkal neuropathy) or diffuse (autonomic, distal symmetric diabetic polyneuropathy (DSPD), proximal amyotrophy). They may have an insidious onset or present acutely.

We established a specialised diabetic polyneuropathy pain clinic in conjunction with the secondary care and the Wound Healing Institute in May 2004 to try and manage these patients more comprehensively. The team consists of a consultant in pain medicine, clinical psychologist, clinical nurse specialist, physiotherapist and occupational therapist. We allow 45 minutes for assessment and score BPI, HADS, BMI, and “Timed Get-up-and-Go” (GUGO) test. Our patients had restricted functional ability (mean GUGO was 26 seconds, normal 10 seconds). 25% of them were in wheelchairs; morbidly obese (mean BMI of 43); their mean age was 54 years; male: female ratio was 1.3:1.

We found that in patients having intractable lower limb pain, diffuse sensory neuropathy can be combined with metatarsalgia or tarsal tunnel syndrome. 83% of all our patients had developed secondary musculoskeletal pain, 12% had other neuropathy and 10% have vascular pain. We optimised their pharmacological treatment according to specific needs of the patient. 73% of our patients had interventional techniques: digital nerve blocks, caudal block, sacro-iliac joint blocks, and facet joints blocks. This was followed by individualised physical exercise programmed to reduce disability. We provided urgent expertise in cases of acute diabetic polyneuropathies. Quick reduction of symptoms required a complex multimodal pharmacological treatment.

We strongly support the view of patient centered approach and patient empowerment via education and group work. We also held annual seminars for healthcare professionals (diabetologists, diabetic nurses, dieticians, physiotherapists) and patients in a successful way.

Outcomes after 18 months: 11.6% discharged on stable medication without any need for follow up. 100% of patients were satisfied with our seminars. 15% had improvement in mobility without any new ulcers. Our expertise as pain specialists is vitally needed in the management of patients with intractable pain due to diabetic neuropathies.
Unrelieved pain is a global problem
Pain relief should be a human right

PROFESSIONAL PERSPECTIVES

Professor Sir Michael Bond
Professor Emeritus of Psychological Medicine, Glasgow and Past President of the IASP

During my time as the President of the International Association for Study of Pain (IASP), it was apparent that there had been an enormous amount of research on pain management in the affluent countries but very little in the developing world. IASP set up a developing countries working group to improve this situation.

In 1949, the World Health Organisation (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". There are other definitions of health but none of them make any reference to pain. This is a problem because we have to persuade health providers, particularly in developing countries, that service provision for pain is very important. We realise that unrelieved pain and suffering is a global problem and pain, especially chronic pain, destroys the quality of life. In 2004, the IASP, the WHO and European Federation of IASP Chapters (EFIC) held a meeting in Geneva. In this meeting, it was agreed that pain treatment should be a universal human right (the original wording was ‘pain relief’ but then it was changed). This statement can represent a clinical desire or a moral statement; this is not enshrined in law as far as I am aware, except in South Australia where there is a law which does state that pain relief is a human right.

Developing countries
In developing countries, poverty, geography and attitudes of doctors are significant obstacles in pain management. In case of cancer pain management, we have found that intravenous morphine which costs only few cents can do miracles in pain management. Still, getting access to pain relief is very poor in these countries.

Are things better in Europe?
The 2004 EFIC study of 30,701 respondents revealed that 18% had moderate to severe pain with a median duration of 7 years. 62% were less able or unable to work outside home and 22% suffered depression because of pain. 20% said their doctor did not regard pain as a problem and only 22% saw a pain specialist. Of this, only 1% had pain due to cancer. We know that 67 million die of cancer in Europe annually and 80% of them have severe pain. So, there is a lot of work to be done.

If we look at the total amount of opiates used in Europe (which includes some developing countries), 80% is used in the Western European Countries.

2006 IASP survey of education in pain management in developing countries
We don’t know the prevalence of acute and chronic pain in the developing countries. We also know that the resources for pain relief in these countries are a low priority or do not exist. Governments are much more concerned about infection, such as malaria and Tuberculosis. The prevalence of pain in AIDS (40% of which is neuropathic) is 30 - 80% and equals figures for cancer; its severity is equal to or greater than that of cancer pain. 85% of patients are undertreated although the need for analgesics is similar to cancer, and women are less likely to get appropriate treatment than men. This is a common pattern in these developing countries.

The IASP surveyed all our members in developing countries. Over 90% said that pain control was a problem in their country. Undergraduate pain education was likewise widely considered inadequate to allow newly qualified doctors to deal with the sort of pain problems they were likely to encounter as a houseman or resident. Unfortunately, a recent BPS survey of medical and nursing training in the UK showed similar results. The IASP produced the pain curriculum for medical, nursing, pharmacy and dentistry students 20 years ago but its uptake has been very limited. We are clearly not doing nearly enough in the West, let alone in the developing countries.

IASP members were also asked if they had been trained as pain specialists: only in Latin America, Asia and Eastern Europe this applied to a majority. When they were asked to rank the frequency of the types of pain they treated, neuropathic, cancer and musculoskeletal pain came on the top; AIDS related pain came right at the bottom below genito-urinary pain despite it being a problem in the countries surveyed. Cancer pain came out near the top and the establishment of palliative care in India and other countries is spreading very rapidly, with oncologists and pain specialists coming together.

Barriers to good pain management in developing countries
Lack of education of healthcare professionals is a significant barrier to good pain management in developing countries. Government policies are often not favourable, not only because they set their priorities in different directions, but also because of reluctance to provide opiates. There is a huge fear of addiction, not only among administrators but also among doctors and nurses.

The IASP funded a grant to Nigeria with regards to education of opioids in pain relief. This education involved police and legal authorities as it was very important to get the authorities onside and counter their very hostile attitude to opiates. A grant was also given in Kenya to teach obstetric nurses how to control pain in childbirth. The high cost of drugs might be an obstacle. In Kerala, South India, they got over this by importing the materials to make their own drugs at a fraction of the cost. Poor patient compliance is another factor: there are a variety of reasons including cultural factors.

There is an enormous amount of suffering totally untouched, but having said that there are parts of the world like Kenya, Uganda and Kerala, where people are pouring their energies to change the situation. We need to improve the coordination of these services. One positive factor in our efforts is the enormous energy seen in the carers in these developing countries. People really want to do something to change the situation.
National In-Patient Pain Survey (NIPPS)

Pain relief should be a human right

Dr Stuart Gill and Dr David Counsell
NIPPS Phase 1 co-ordinators

We would like to draw attention to the imminent launch of Phase 1 of the National In-Patient Pain Survey (NIPPS). Phase 1 aims to survey the current provision of acute pain services nationally using an updateable web based questionnaire.

The NIPPS project is led by members of the Acute Pain Special Interest Group (APSIG) of the British Pain Society who have developed the NIPPS website. The website has been adapted from the critical incident reporting website used for NAP3, with permission of the Royal College of Anaesthetists (RCoA) supported by additional funding from APSIG.

Using what we believed to be a comprehensive list of Acute Hospitals in the UK, generated by the Royal College of Anaesthetists as part of the NAP 3 project, we plan to invite all hospitals anticipated to have an Acute Pain Service to participate in the NIPPS project. Pain teams will be invited by letter to take part and will be provided with a unique password to allow access to their profile on the website. Entered information will remain anonymous but pooled data will be collated and reports generated to allow comparison of individual services with a national average. Phase 1 is due to launch by the end of May 2011.

Phase 2 of the project is currently in the pilot phase with seven hospitals participating. This is an attempt to develop a national benchmarking system for Acute (In Patient) pain management along the lines of the Intensive Care National Audit of Results and Complications (ICNARC).

To date there has been little information available on the provision of acute pain services in the UK other than occasional surveys, none of which are recent or contemporaneous. Similarly there has been no national system for benchmarking acute pain effectiveness and complication rates, other than the snapshot provided by NAP3 which mainly focussed on the neuraxial complications associated with epidurals. With your support, NIPPS hopes to address both of these issues over the next few years. Regular updating of the NIPPS website will allow up to date real time information to be collected and made available via the website to all acute pain services across the country. The data collection considers manpower, the drugs, equipment and standard techniques used in your hospital and will already be collected as part of internal audit. The collation of this data should provide a powerful resource to inform future service provision and developments at both local and national level.

How to Get Involved in Phase 1

Your individual questionnaire is accessible on line via the password protected NIPPS website at www.nipps.org.uk and is designed to facilitate easy data entry where possible with drop boxes etc. though some free text is required. Most of the questions are readily answered if you have good knowledge of your service though the odd one may require a little thought or research.

Each of the identified hospitals will be contacted and a password provided over the next few weeks. We do not have a comprehensive list of direct contacts, so mail will be addressed C/O The Acute Pain Team- so keep an eye out for it. Once you have it, check out the NIPPS website and start entering your profile. You can go back on at any time to complete or update your data but don’t forget to hit the update button to confirm any changes. We hope that participants will keep their profile up to date in order to provide accurate information in the long term and regular e-mail reminders will be sent out to encourage this.

Once sufficient data has been returned, a live feedback section of the website will provide anonymous data to reflect the national picture. We hope this will prove useful in informing local decisions regarding service configuration and provide some form of standard against which you can compare the resources available to your local service.

More about Phase 2

Phase 2 is working to develop a national benchmarking system based upon a simple dataset to which all hospitals will be invited to contribute in due course. Minimum data collected includes the effectiveness of a range of commonly used analgesic techniques and the frequency of associated complications and side effects. Results will be stratified for inpatient pain work (non-surgical vs. surgical), surgical site (thorax, upper abdominal, peripheral etc), emergency vs. elective surgery, patient age and ASA. The closest parallel is the ICNARC system used for several years now in Critical Care. A pilot feasibility study is currently being undertaken using the Medicus Acute Pain Audit System; a central database with palm top computers allowing ease of data collection at the bedside and reducing time required to input such data.

Preliminary results from seven hospitals have provided data on circa 10,000 patients. This is already a large data set from just a handful of centres. The potential power of the information gathered by this project, given the volume of data likely to be available when Phase 2 goes live nationally is staggering and should provide a rich resource for informing future service provision as well as discussions with patients. We anticipate presenting a synopsis of these results at the BPS acute pain symposium in Chester this September but early analysis is already suggesting higher than expected occurrences of respiratory depression that would not have been evident without amalgamating the data. This may be due to the more widespread use of intrathecal opioids in some of the pilot hospitals but whatever the cause, this observation underlines the need for safety and effectiveness surveillance that NIPPS Phase 2 hopes to provide.

In the future, we hope to develop other portals to the system and are in the process of applying for funding to secure the development of the long term project. We hope you will support us in this exciting endeavour. For more information regarding the Phase 1 launch, contact stuartgill@doctors.org.uk

The standardisation of care?

Dr Jane Quinlan Oxford, Vice-Chair Acute Pain SIG, BPS

Each year, IASP, the International Association for the Study of Pain(1), leads a yearlong initiative to raise awareness of a different aspect of pain. Last year was the Global Year against musculoskeletal pain; the year before, cancer pain. This year is the Global Year against Acute Pain.

Acute pain should be straightforward: it is the most common type of pain experienced and usually responds well to simple analgesia. The most important skills needed to treat it are compassion and common sense. For the more complex patients (including those at the extremes of age) and the less straightforward pain, we need acute pain teams with specialist knowledge of pharmacology and physiology, who then lead their institution to maintain
high standards of care through education and audit.

The Care Quality Commission (CQC) conducts yearly surveys of adult inpatients in England covering all aspects of their care. Since 2002, the number of patients describing pain during their hospital stay has stayed remarkably constant at 66-68% (this includes all specialties, not just surgical). Of these, a similarly consistent 5-6% feel that staff did not do everything they could to control their pain. With replies from 69 000 patients, this suggests that almost 2500 patients suffered poorly-treated pain. If this is then extrapolated to the 14 million patients who were admitted to hospital across the UK last year, there could have been around 450 000 patients who were left in pain(2).

We know that patients in pain are more at risk of complications and having a longer length of hospital stay. Inconvenient for most, but catastrophic for some. The NICEPOD report released in November - Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010) (3) - makes a sobering reading. Of the elderly patients who died within 30 days of surgery, only one-third were judged to have received good care; while one quarter of the hospitals involved in their treatment had no acute pain service. One of the authors, Dr Kathy Wilkinson, commented that “Pain is not being … monitored, let alone addressed and controlled. It is shocking that the survey has revealed organisational failures to respond to the suffering of elderly patients.”

People aged over 65 make up around 17% of the population and use 65% of acute hospital bed-days. The UK population is ageing rapidly - by 2033, almost a quarter of the population will be over 65. Finbarr Martin, president of the British Geriatrics Society suggests that, rather than see the older population as an anomaly and a challenge to the NHS, it needs to accept that older people constitute “core business”(3).

There is often a reluctance to prescribe pain medication to older patients. The pre-existing multitude of tablets treating an array of comorbidities creates concern over drug interactions, and vulnerable renal and hepatic function complicates metabolism. Add to this the fear of causing or exacerbating confusion, sedation and unsteadiness and the easiest option is not to prescribe analgesia at all.

The 1999 NICEPOD(4) report, “The Extremes of Age”, also found that pain management in the peri-operative period was often deficient. A key recommendation back then was that “Elderly patients need their pain management to be provided by those with appropriate specialised experience in order that they receive safe and effective pain relief.”

In any patient, untreated acute pain can convert into a chronic neuropathic pain state, with its accompanying personal misery and societal economic cost. The estimated costs of chronic pain run into millions of pounds per year, encompassing money spent on primary care and hospital appointments, investigations and treatments, and benefits paid for those unable to work; as well as money lost from decreased productivity due to absenteeism or presenteeism (reduced work performance)(5).

In 1998, a review of over 5000 patients attending chronic pain clinics found that 22.5% of patients attributed their pain to earlier surgery, while 18.7% of patients linked their pain to previous trauma(6). There is currently a wealth of investigation into the predictors and precipitants of chronic postsurgical pain. The likelihood is that there is a complex interplay of factors – psychological, genetic, surgical, anaesthetic, hormonal, immunological – which change the milieu of acute nociception into a pathophysiological neuropathic state(7). Severe untreated acute pain has repeatedly been flagged as a major component of this mix(8,9) so there is logic in striving to maintain high quality acute pain treatment in an attempt to reduce some of the chronic pain burden.

We know we need acute pain services. Specialist bodies have made recommendations(10), governmental organisations have highlighted failures, charities have raised concerns(11). Yet there is uncertainty as to what constitutes an acute pain team. In the 2010 NICEPOD report, many of the hospitals claiming to have an acute pain service had no specialist pain nurses, nor funded consultant sessions. It is notable that these were particularly absent in the independent sector. “People who are paying for their medical care are entitled to be as comfortable as those who are not.”

Acute pain services were developed in the late 1980’s and are now felt to be an established and essential component of medical practice. They provide a role in coordinating and delivering quality care to hospital patients in pain, as well as providing education and guidelines to ward staff to enable the early identification and treatment of pain. In the Guidelines for the Provision of Anaesthetic Services from the Royal College of Anaesthetists(12), delivering high quality acute pain management is described as “a basic requirement of a modern health service and meets minimal expectations of patients and their carers.” Of course, the title “acute pain service” isn’t particularly accurate: “inpatient pain service” is better. Inpatients with pain are a far more heterogeneous and complex group than just those with acute pain.

In 2001, Furrow, a professor of law in Philadelphia, wrote a paper entitled “Pain Management and Provider Liability: No More Excuses”(13). In it he states that “Pain management needs to be an institutional priority, supported with resources and leadership” and that “Failure to properly manage pain - to assess, treat, and manage it - is professional negligence.” The system in the USA is very different to our own, where they have a carrot and stick approach. The Joint Commission on Accreditation of Healthcare Organizations use an institution’s standards on pain management as part of the accreditation process. A hospital may also apply for the advanced certification for disease-specific care and achieve a Gold Seal of Approval. There’s the carrot. And then they have a very big stick.

“Malpractice litigation drives institutional practices toward convergence on validated standards of practice… Proof of malpractice thus slowly moves from elastic expert opinion toward more empirically validated clinical practices. This means that the defense has less wiggle room in the average malpractice case and, as a result, the law indirectly forces physicians toward heightened awareness of standards.”

In the same year, Harmer wrote an editorial entitled “When is a standard, not a standard? When it is a recommendation”(14) in which he described his search for “clear standards … against which Trusts and regions could measure their [acute pain] service provision.” He found no such standards but instead found vague recommendations. The joint report of the College of Anaesthetists and the Royal College of Surgeons(10) in 1990 highlighted the need for improving standards of postoperative pain management. This led to a proliferation of acute pain teams but, it was noted, the extent of medical cover and designated sessions varied. The Pain Society (as was) produced a booklet in conjunction with the Association of Anaesthetists of Great Britain and Ireland, ‘ Provision of Pain Services’(15) in 1997 which suggested “there is no definitive pattern for the structure...
and funding of an acute pain service. Each unit must consider its individual requirements and constraints.

So is that the problem? By having recommendations not standards, we leave enough "wiggle room" for non-compliance by Trusts, or for a perfunctory interpretation.

In the United States the Joint Commission uses standards which are developed with professional bodies. "Health care professionals, professional groups and associations, including the American Pain Society … were involved in the development of the [pain management] standards." Similarly, the Australian Council on Healthcare Standards collaborates with Australian and New Zealand medical colleges, associations and societies to develop clinical indicators.

The CQC in England has taken a different approach, preferring to assess hospitals using an "outcome-based approach" based on patients' feedback as a primary source of information, in contrast to "the previous regime for regulation, the DoH [who] set out the standards to be met (16)" Its focus is to identify failing hospitals or services and "provide a swift and effective response to concerns."

All apparently laudable, but surely it plays to the lowest common denominator? Rather than aspire to the highest quality of service, hospitals can concentrate instead on 'not failing'. And by dismissing paternalistic standards in favour of asking 'service users' about their experience, we are not letting down patients who may not be getting high quality, evidence-based, specialist society recommended care, but appear to be satisfied when the questionnaire asks if the toilets were clean?

The comparison may be unfair due to the national differences in the healthcare systems, with the American and Australian accreditation systems optional, while the English CQC system is not. However, in 2008 Lord Darzi asked for a review of the British NHS by three international organisations(17). One of these, Joint Commission International, the worldwide arm of the United States accreditation body, identified "the absence of an improvement imperative within the Department of Health" and, as one of its suggestions, recommended the "creation of an independent, private-sector, voluntary national accreditation programme".

In his paper, Furrow stresses the importance of having standards with which to judge the level of care: "The development of practice standards and guidelines by national medical organizations has accelerated the process of moving all medical practice toward national standards ... and the fact that they are produced by national medical specialty societies and the government means that they will be influential."

Should we then, as Harmer suggests, start to set our own standards by defining what we mean by an acute (or inpatient) pain service: how many specialist nurses, and of which grade, and how many consultant sessions would be needed per 100 beds, for example, to provide an acceptable service?

Dave Counsell, Chair of the BPS APS SIG has made a start by proposing in the Royal College of Anaesthetists "Raising the Standard" audit document that there should be an APS in every hospital with one whole time equivalent pain nurse per 250 patients and a minimum of one consultant session per week for acute pain (21).

We have excellent resources available on how to assess(4,18,19), and treat(12,20), patients in pain. We have guidelines for auditing our service to ensure the best care(21). Should we wait for another disappointing NCEPOD report before we declare and seek to enforce standards? Or - during this Global Year against Acute Pain - is that time now?

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Debate: Is pain medicine the last bastion of the nineteenth century medicine?

Yes!

In the first place, I rather admire the nineteenth century with its myriad of inventions, innovations, developments and discoveries; and I struggle to understand why one would not want to be associated with such an exciting era. The United Kingdom came into being. Nelson sank, or took, the combined fleets of France & Spain. Wellington defeated the tyrant Napoleon at Waterloo. The British Empire expanded and consolidated. Brunel built the Thames tunnel, designed the Clifton suspension bridge, made the first steam ships capable of crossing oceans and created miles of track for the Great Western Railway. Victoria’s glorious reign began. Davy (of nitrous oxide and safety lamp fame) isolated potassium, sodium, calcium, magnesium, boron and barium. His protégée, Faraday, laid the foundations for the later work of James Clerk Maxwell and so modern physics. Morphine was first isolated and Merck began selling it. Inhalational and spinal anaesthesia were born. Bacteria were proven to be agents of disease and Lister sprayed. Rifle cartridges with integral primers were invented: the breech-loader was perfected. Public Health systems evolved. Benz built the first vehicles powered by internal combustion. The hypodermic syringe appeared.

I challenge my readers to look about themselves and identify a modern artefact that could exist if the advances made in the 19th century had not occurred. What a time it must have been for the enquiring mind! If the acceleration of understanding and discovery between the end of the eighteenth century and the beginning of the twentieth does not mark the birth of the Modern Age, then what does?

After the final defeat of Napoleon, Europe settled down to the halcyon years that led to the terrible conflict of 1914. Science came of age and mathematics, physics (natural philosophy) and chemistry reached a state recognisable to the modern scholar. If biology lagged behind, it was not for want of application: by then taxonomy was nearing an apotheosis and all that was lacking were the steps that allowed us to see that biology has its basis in chemistry, itself a matter of physics, which in turn can be seen as applied mathematics. Such intuition was quite alien in the early nineteenth century. It was not until 1828 that we saw Wöhler’s synthesis of urea. Origin of Species was not published until 1859 and Rutherford’s idea of a dense atomic nucleus was not published until 1911. Before 1867, when Lister published in the BMJ, the idea of “miasma” held sway and only then did modern ideas of antisepsis begin to take root within our profession.

My point is that the nineteenth century saw a phenomenal, exponential growth of scientific understanding. This explosion of knowledge then grew in the twentieth century. Medicine, because of the complexity of the underlying physiological, biochemical and pharmacological sciences, has been a relatively late beneficiary. The island of Pain Medicine has yet to see much of the tidal wave of scientific understanding; we are therefore demonstrably still practising according to the principles of bygone times.

It is unsurprising that our specialty should be amongst the last to be properly understood. We acknowledge that pain is complex, our patients are heterogeneous and our diagnoses are vague. The hierarchies and rationales that we construct to contain our disorganised knowledge are essentially arbitrary. In the study of artificial intelligence, it is said that 200 pieces of knowledge are needed to create an expert system. I shall be surprised if twenty of my internal certainties survive the scrutiny of the next hundred years.

If the main similarity between the modern pain clinic and nineteenth
It was in 1872 that Mitchell wrote: "Perhaps few persons who are not physicians can realize the influence which long-continued and undurable pain may have on both body and mind... Under such torments the temper changes, the most amiable grow irritable, the bravest soldier becomes a coward, and the strongest man is scarcely less nervous than the most hysterical girl. Nothing can better illustrate the extent to which these statements may be true than the cases of burning pain, or, as I prefer to term it, Causalgia, the most terrible of all tortures which a nerve wound may inflict." Can modern pain physician read this without immediately understanding the suffering of Mitchell's cases? Mitchell, amongst others, experimented with faradism for neurogenic and phantom pain. Are we really so very different with our TENS & PENS, pulsed RF and spinal cord stimulators?

Hypnosis, still used in pain management today, evolved into a recognisable modern form from its roots in "Mesmerism" and "Animal magnetism" during the nineteenth century. Wilhelm Wundt founded the first laboratory for psychological research at Leipzig in 1879, following his work in earlier decades. Professional bodies representing physiotherapy emerged from the early to the late nineteenth century. Occupational therapy waxed and waned in various forms throughout this time. All of the disciplines and practices of the modern multidisciplinary pain team can be traced back to the nineteenth century; the elements of what we do today would be familiar to many doctors in practice before the twentieth century.

I do concede one significant change. Whereas the 19th century doctor would have been content to rely on his (his, and not his-her) authority, today we do have to discuss our advice with our patients. When the evidence base is weak, as it often is, or simply does not exist, I do explain this. I feel obliged to make my patient aware of the risks, including failure, and I try to make her (or him) understand the imprecise nature of my diagnosis, particularly as it relates to the uncertain outcome of the treatment that I can offer. I hold this new honesty with patients to be a genuine advance, but I am not sure that I am not soothing my own conscience, rather than engaging the sufferer.

"Oh, I have faith in you, doctor." My patients will say: just as their great-great grandfathers had faith in their doctors. I think we can see that in the nineteenth century the evolution of scientific understanding began to spawn myriad treatments which practitioners rationalised by reference to that new understanding. Often the reasoning proved to be flawed because of confounding factors then unknown. On occasion, history proved these novel approaches to be correct. Is this not exactly the situation in which we, as pain physicians, find ourselves today? Every year, I listen to the fundamental sciences lectures at the BPS Annual Scientific Meeting with a sense of wonder and excitement. New pathways discovered for this, receptors for that, elegant experiments showing the existence of the other... then I return to my real NHS pain clinic and dispense a sympathetic ear, some hard advice and a cocktail of analgesics based on my own prejudice, experience and flawed understanding.

Do I, then, stand by my statement? Does the pain clinic really represent the last bastion of nineteenth century medicine? I believe so. I consider that for all of the many reasons given above, we represent its very epitome. I would also maintain that this is not necessarily a bad thing. My enthusiasm for that age is, of course, made with the benefit of hindsight, from the warmth and comfort of my soft 21st century life. I have said nothing about grinding poverty, cold, filth, disease, starvation and inequality. I have ignored massacres, taxation, revolution and the seeds from which sprang death and oppression every bit as evil as that wrought by Napoleon. I can legitimately do this because I can see the great advances that came from that time. The world, the West at least, has largely thrown off the negative aspects of nineteenth century life, but its great advances endure.

I am, in short, looking forward to my own demise. In the decades to come, we will understand. We will have useful diagnoses and meaningful treatments. We will be able to treat the "psychological" and "physical" simultaneously without feeling schizophrenic.

Once, at a scientific meeting, a colleague waved his hand to the scientific programme and said: "Soon they'll have all of these receptors sorted out, there'll be drugs for every pain and they'll be prescribed by neurology registrars. It'll be 'thanks boys, we can do it now' and you and I will be out of a job." For the sake of our patients, I hope that this happens. For now, I shall continue to do the best that I can with what I have available, just as our nineteenth century forebears did with their mercurial ointments, with asafoetida and with henbane and mandragora.

AUTHOR'S BIOGRAPHY:

Nick Hacking is a consultant anaesthetist in Preston; he has worked in the pain clinic there since the end of the twentieth century. His main area of interest is pain intervention. He is married with expensive teenage children who believe that he can describe the nineteenth century from personal memory. This article is based upon a talk first delivered to an emptying bottle and a quizzical Labrador.
Debate: Is pain medicine the last bastion of the nineteenth century medicine?

No!

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In the 18th century, François-Marie Arouet (1694–1778), better known as Voltaire, a French writer and philosopher who was well-known for his wit, said “doctors pour drugs, of which they know little, into bodies of which they know less, for diseases of which they know nothing at all.”

By the 19th century, medicine had hardly improved. Doctors understood little of disease mechanisms and the underlying conditions that they were treating. Many still believed the Galen theory of the four humours - blood, phlegm, black and yellow bile. Medical practices were often barbaric, employing methods that had been used for centuries, which were of little or dubious benefit and which produced a multitude of side-effects, including death. Leeching (or blood-letting), emetics to produce vomiting, multiple purgation, and cold water dousing were common practices up until as late as the 1850s.

Surgery led to death rates of up to 80% in some London hospitals until the advent of anaesthesia, but was performed anyway. Undoubtedly, anaesthesia was one of the great breakthroughs of the time. Hopefully, good pain medicine can be one of the 21st century advances, but not if we cling to old and dubious beliefs.

Despite many significant breakthroughs in medicine in the 19th century led by luminaries such as Pasteur (the discovery of germs), Lister (antisepsis) and the advent of public health and vaccinations, doctors often failed to move with the times. They clung to superstitious beliefs, doubting the effectiveness of such advances, and were basically unwilling to try anything new (see www-personal.umich.edu/~jonsmith/19cmed.html). I feel a romantic view of this being an era of wonderful change and medical breakthrough is far from the truth.

So, whilst some outstanding observational breakthroughs were hailed from suitably recognised and acclaimed medical heroes, at the same time, the majority of 19th century clinicians caused more harm than good. As well as the weakening of the already debilitated patient with bleeding and purging, they were doling out cocaine and morphine for coughs (even to children), alcohol for period pain and indeed almost anything (Lilly the Pink, the Scaffold, 1972, see insert), and arsenic, mercury and lead were also frequently used. Asthmatics were given ipecac and seneka, cancer deaths were unintentionally hastened with arsenic and hemlock, and deafness was successfully treated (according to Grahams Domestic Medicine) by inhalation of tobacco fumes. The best thing to suffer from was colic, for which you were given warm baths, brandy and opium! Reasonable treatment, presumably by serendipity.

Sometimes, when reading the comments on our pain specialists’ blog, I feel that little has been learned. Treatments are recommended without due consideration of the multi-factorial nature of chronic pain and without inquiring into the history of the patient. Old, unproven or frankly dubious recipes based on personal taste are trotted out again and again, and even after numerous treatment have failed, many others are mooted without questioning why none have worked previously. A plethora of interventional techniques is aimed at unknown or unlikely targets. There seems to be little understanding of the fact sometimes that many conditions fluctuate or remit spontaneously in spite of our misguided treatments, whilst some limited and occasional benefits are perhaps the result of a placebo effect. Some are impressed with a response in 25% of patients from their potions (below the average placebo rate). Young consultants, viewing these false pearls, are persuaded to repeat these non evidence-based treatments in their isolated practices.

Other groups of therapists (and indeed the Audit Commission and NICE) ignore interventional treatments altogether, and treat conditions generically. No diagnosis is attempted (it’s just a bit of muscle pain, or even that mystic syndrome, fibromyalgia). Therapies may be weak and generally ineffective drugs (think Codeine, NNT 10+) and manipulation, of limited clinical benefit. Eventually they are discharged to become one of the hundred thousand or so chronic back pain sufferers that burden our benefits system each year.

Ashish Jha, MD, MPH, Associate Professor of Health Policy and Management at the Harvard School of Public Health, wrote in February “We deliver 21st century medicine using 19th century practices …today, in the year 2011, in the vast majority of American hospitals, doctors write their orders by hand on triplicate forms. The carbon copies are then faxed to the pharmacists, who likely puzzle over the handwriting to ensure they
dispense the right drug at the right dose. This way of delivering care leads, by some estimates, to tens of thousands of deaths and serious injuries each year, and is easily costing us billions of dollars in unnecessary spending. To really transform healthcare, we need a 21st century health care system where incentives encourage sharing of data and collaboration between providers, not just care in silos”. How have we let this happen?

In these times of austerity, when it is clear that medical rationing will have to prevail, we must all become more truthful with ourselves and our patients, and cease to give treatments of limited value to poorly understood patients. Whilst I fully endorse that groups like NICE and the Audit Commission, who understand neither the sharp end of medicine nor indeed evidence, should be abolished, I have to question myself about the validity of all the treatments that I consider and deliver. We should all be mindful that good assessment comes first, and that includes for all disciplines, not just interventionists blindly carrying out interventions, but also “pain management” physicians and psychologists failing to appreciate specific treatable pathologies. This never happened 200 years ago!

All treatments available have limitations but some are clearly (from studies and observation) of benefit when given to the right person. We have some good (but not great) drugs. Spinal cord stimulation can be of value. Some judicious interventions, correctly targeted, produce much appreciated relief, whilst the right person on the right pain management programme can have their life turned around. Many treatments could be safely discarded, though some of us still advocate them. Also multiple further treatments when many have already failed are illogical and wasteful of time, resources and money. It might be prudent to discharge the patient and see someone that we might treat more effectively.

As a multi-disciplinary society, we now need to provide proper training and a structure for assessment of all those practising in pain treatment disciplines, to make sure that they understand the complex factors involved in the development of the pain sufferer’s syndrome and how to recognise them. We all need to have knowledge of the benefits and limitations of our own and others’ therapies. Anaesthetists are at the core of pain services throughout Europe, and indeed in much of North America, and interventions are an important - nay essential - part of appropriate management in a Pain Clinic, but a 19th century approach of ‘poke and hope’ should no longer be tolerated.

Table 1: Anaesthesia in 19th Century

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1842</td>
<td>Crawford W Long (America) used ether as an anaesthetic while operating on a neck tumour (but did not publish details of his operation)</td>
</tr>
<tr>
<td>1845</td>
<td>Horace Wells (America - no relation!) tried unsuccessfully to demonstrate that laughing gas would allow him to extract a tooth painlessly</td>
</tr>
<tr>
<td>1846</td>
<td>Dr J C Warren (America) removed a tumour from the neck of Gilbert Abbott, using ether</td>
</tr>
<tr>
<td>1846</td>
<td>Robert Liston (Britain) removed a leg using ether - “this Yankee dodge”</td>
</tr>
<tr>
<td>1847</td>
<td>James Simpson (Britain) discovered chloroform</td>
</tr>
<tr>
<td>1884</td>
<td>Carl Koller (Germany) discovered that cocaine is a local anaesthetic</td>
</tr>
</tbody>
</table>

We’ll drink a drink
To lily the pink the pink the pink
The saviour of our human race
For she invented, medicinal compound
Most efficacious in every case

Mr Freers had sticky out ears
And it made him awful shy
And so they gave him medicinal compound
And now he’s learning how to fly

Brother Tony was notably bony
He would never eat his meals
And so they gave him medicinal compound
Now they move him round on wheels

Chorus

Lydia Estes Pinkham (February 9, 1819 – May 17, 1883) was an iconic concocter and shrewd marketer of a commercially successful herbal-alcoholic “women’s tonic” meant to relieve menstrual pains.

"Lily the Pink" is a modification of the older folk song "The Ballad of Lydia Pinkham"; the modifications were not extensively due to The Scaffold - a similar version was the unofficial regimental song of the Royal Tank Corps. It was a surprise hit for The Scaffold, becoming the Christmas #1 in the UK singles chart for four weeks, in December 1968 for the UK comedy group.

Lydia Estes Pinkham (February 9, 1819 – May 17, 1883) was an iconic concocter and shrewd marketer of a commercially successful herbal-alcoholic “women’s tonic” meant to relieve menstrual pains.
The different angles of pain

The importance of this perspective is that it views an individual as being a combination of strands that are specific to that person. One person may have a high threshold for pain, a helpful family set up but poor mobility and is easily frustrated. Another may have a high pain threshold but have few social support systems and be more vulnerable to feelings of distress.

The biospsychosocial model is a conceptual one that advocates a shift when viewing pain from a singular biomedical perspective to a more inclusive one. It was initially given attention by George Engel in 1977 and the emphasis is not on which of the three factors has greater importance or significance (although they should be rated according to the condition and situation) but rather that all three should be taken into account as influencing or maintaining the condition. It does not prescribe a blanket cause-and-effect relationship or promote the idea that one automatically leads to any other. Its aim is to view the condition within the context of the person and not only as a medical condition with associated symptoms.

By acknowledging and addressing the condition from all angles, it can provide opportunities for barriers to be eased and facilitating factors to be encouraged and enhanced. For example, if a person has a poor body image or feels shame about his or her body due to previous experiences then this may prevent the person from engaging in physical interventions that could impact on recovery or pain management. This in turn may influence the person’s ability to return to work, social or sexual relationships, financial stability and mood as well as increase the likelihood of, say, isolation, depression or anger. The example can have numerous variations and consequences, but the issue at hand is that the person’s quality of life may be adversely affected.

The NICE guidelines (National Institute of Clinical Excellence [NICE], 2009) recently recommended screening for depression amongst patients with chronic physical health conditions due to their impact on mental health and wellbeing. People with chronic conditions are estimated to be two or three times more likely to be depressed than those who do not have such conditions. Many chronic conditions produce pain, such as cancer, multiple sclerosis, rheumatoid arthritis, fibromyalgia and the interaction of pain and depression can increase both morbidity and mortality (NICE, 2009).

These guidelines are a product of the growing body of evidence that supports the move towards both a biospsychosocial view of pain and pain management and how, for example, pain can increase the risk of depression as well as depression (and other emotional factors) being a risk factor in developing chronic physical health problems (Gatchel, Peng, Peters, Fuchs & Turk, 2007; NICE, 2009). In addition, emotional responses such as anxiety, fear, depression and anger can increase pain levels whereas better mood and happier mental states can assist in reducing them (Gatchel et al., 2007 provide an extensive overview of this concept; NICE, 2009).

This emphasises the mind/body connection and how a physical condition can influence a psychological one, and vice-versa. Inconsistent consideration is sometimes given to the psychological effects of pain and patients are not routinely asked about symptoms that may be pertinent to emotional distress (such as depression, anxiety, stress or even anger and hopelessness). Few questions are asked regarding the impact of chronic pain on relationships, whether sexual, familial or social, substance misuse or traumatic stress symptoms, and those referring to emotional or physical neglect or abuse of any kind are frequently avoided altogether. Considering how pain can impinge on all areas of one’s life it seems limiting to view it from the physical angle alone.

If we can bring together the divide and view ourselves as mind and body, rather than mind or body, then we can respect the idea that people work as one system of integrated mechanisms. An illustration is the impact psychological stress has on the physical body. Our bodies are geared towards survival so when we are stressed it leads to the secretion of cortisol (and adrenaline) which prepares the body for the fight or flight response because it assumes we have to run or fight. However, if cortisol is secreted when such a state is not required but is due to the likes of psychological stress, anxiety or...
pain, then there is too much or too little of it in our systems as it is out of its regular/normal cycle of secretion. Stress, particularly severe or chronic stress, weakens the immune system, slows down healing and the ability of the body to repair itself, strains the heart, damages memory cells in the brain and deposits fat at the waist rather than the hips and buttocks (which can increase the risk factor for heart disease and cancer). It is implicated in IBS, aging, depression, chronic heart disease, hypertension, rheumatoid arthritis, diabetes and many other conditions (Gardner-Nix, 2009).

The ripple effect scenario regarding poor body image, or even stress for that matter, is not an uncommon one seen in clinical practice, albeit in multiple forms. The implications of chronic conditions can be far-reaching and pervasive. This can readily be seen in those who have suffered a personal injury, such as from a road traffic accident, work incident or in combat. The primary injury may have healed to some extent but there is frequently residual chronic pain and emotional distress that lingers, often for many years after the event, and it is this that can chip away at their quality of life, sense of control, resilience and wellbeing. It is not unusual to see individuals for psychological therapy two or three years after a traumatic incident and to uncover a life that is now fraught with ongoing physical pain, depression, hopelessness, anger and despair. Work lives and family relationships have been affected, substance abuse may be evident as a means of self-medication (more often for the emotional disruptions than the physical pain), explosive anger or increased isolation could be present and, in general, a number of unhelpful and even destructive features are noticeable. Not only have their lives changed but also their sense of identity, esteem and respect.

Younger individuals can sometimes turn to drugs, alcohol or harmful behaviours as they may not yet have developed sufficient coping mechanisms or had ongoing life experiences upon which to draw due to their age. However, adults too don’t automatically have the skills to manage such life-changing and enveloping alterations in their lives. It becomes apparent how much distress people attempt to hide and how their long-established means of dealing with issues tend to be more entrenched under stress. Alternatively, their coping mechanisms for past matters may not be sufficiently robust or inclusive to allow them to deal with such a disruptive, chronic or intense situation and so they look for other means, some of which may not necessarily be in their best interests.

Personality factors may well influence how one deals with pain. They affect everything else in our lives so it is inevitable that they will have some bearing on how we react to health issues and pain. If one has a tendency to be abrupt and dismissive or to struggle in accepting assistance it is likely that these factors will impinge on any treatment interventions or social support needs.

Over my many years of clinical experience, predominantly in mental health settings but also in areas such as hospice and working with addictions, perhaps one of the most important things I have learnt is that we are all the same but inexplicably different. We are a combination of layers upon layers developed over the years with each experience. Each layer will contribute, in one form or another, to who we are today and how we manage our lives. The burgeoning of neuroscientific evidence is providing invaluable knowledge of how our physiological and psychological structures are intertwined and are determined by biological, emotional and experiential factors. This remarkable information can readily assist us in becoming more open, reasoned and inclusive in our approaches.

All interventions are important but perhaps at the heart of it is how these are combined. A cohesive and boundaried mix allows people to feel safe and cared for, from all angles. It is when discreet interventions are provided by disparate professionals that necessary and sometimes essential factors can be lost. It’s the difference between being provided with separate items of eggs, flour, sugar and butter as opposed to a homemade cake made from those same ingredients.

Chronic conditions can shift and change over time, and whereas a psychological issue may have less impact at one time it may increase further down the line. What we think and feel (emotionally) will impact on what we feel physically. It’s about learning to manage the pain with one’s own internal resources and resilience, in addition to any medication or other intervention. The more tense and distressed/depressed one is the more pain one may feel and we know that pain can cause people to feel agitated, anxious, distressed, despairing, angry and many other things. It has a powerful and diffuse effect on our emotional and physical states, as well as on our quality of life, relationships, work and level of functioning. People in pain often lose faith in their bodies and feel emotionally worn down by it (Rezek, 2010). The less robust one feels to deal with this ongoing situation the more hopeless one may feel, and hopelessness is a strong predictor of suicide. The implications of pain shouldn’t be dramatised or dismissed. However, the fact that every social or psychological effect is not overtly evident in each patient does not diminish their presence or importance.

The drive behind this article is to emphasise the advantages of viewing and addressing chronic health and pain conditions from a biopsychosocial perspective. It touches on some of the benefits of using an integrated approach of mind and body rather than a divisive one that splits people into camps that can only accommodate a mind or body view. The aim is to encourage an openness to the extent to which our physical and emotional mechanisms are entwined and to question the once rigid and inflexible precepts of the physical and emotional being entirely separate units. An emphasis has been placed on psychological factors which is not only due to my professional bias but because it is an area that is often complex and difficult to understand.

Pain, like people, is complex and multidimensional and this perspective is only one offering. The desire is to provide an opinion that may benefit our approach to pain and that may influence not only the quality of care we provide but also our attitude towards those who may be suffering in ways of which we have no knowledge. If keeping in mind one additional concept that could assist in reducing distress and increase quality of life, then something of value has been achieved.

REFERENCES


The patient with a non-cardiac implanted electronic device (IED) – an overview

It all started with a phone call. A patient was listed for a day surgery unit procedure and he had an implanted electronic device (IED) in situ. He had slipped through all existing protocols in place and presented himself on the morning of surgery. None of us were sure about the implications and interactions, so this case was postponed. This also triggered us to seek existing literature on the subject mainly the implication of an IED in situ with regards to anaesthesia, surgery and pain procedures.

We found that there are a number of non-cardiac implanted electronic devices available including [1] Spinal cord stimulators (SCS) which have been around for more than a decade. These are indicated for conditions like FBSS (failed back surgery syndrome), refractory angina pectoris, CRPS (complex regional pain syndrome), neuropathic pain and for the relief of vascular ischaemic pain. [2] Other devices like Deep brain stimulators which are used to treat tremors and Parkinson’s disease. [3] or Sacral nerve stimulators for conditions like neurogenic bladder. [4] As well as the above there are others like vagal nerve stimulators, phrenic nerve stimulators and diaphragmatic stimulator.

There are different components of an IED like the spinal cord stimulator are implanted electrodes in the epidural space, connecting leads, and an implanted pulse generator (IPG) which is battery-powered (similar to a cardiac pacemaker). The electrodes can be bipolar or multipolar and multiple electrodes can be used. Depending on the particular area that needs to be stimulated, the electrodes may be sited either in the cervical area for headaches, thoracic region for refractory angina and upper limb CRPS and the lower thoracic/upper lumbar region for lower limb or FBSS pain. The sacral nerve stimulators are sited close to the sacral nerve as they emerge from the sacral foramina. The patient has the flexibility to switch the device on and off with a hand held programmer and may vary voltage and frequency within physician determined limits.

Interestingly, this reminds me of a consultation that I had with a chronic pain patient who had an IED in situ. She bought a special bed, where the head end, the middle and the leg end could be moved separately by a remote control. Whilst she was using the remote, she felt a flutter in her chest; she thought that she was having an anginal attack. Then she realised that it was an interaction between the bed mechanics and the SCS in situ. With lots of worries, she returned her special electrical bed. This shows the ignorance surrounding IED and electromagnetic interference (EMI) in day-to-day life applications. Most sources of electromagnetic interference are non biologic and few are capable of causing clinically significant interference. In our rapidly driven technology environment, new devices that could theoretically cause interference with implanted device appear both within and outside the hospital environment. The biologic source of interference could be extremes of temperature and irradiation that can cause the pulse generator to malfunction. Contemporary pulse generators are protected from most sources of interference because the circuitry is shielded inside a stainless steel or titanium case and the body tissues provide some protection by reflection and absorption of external radiation.

We should advise patients that when the SCS is switched on, they should not drive, climb, or operate dangerous machinery/ equipment; they must take care with their choice of activity, in case an unexpected surge from the IED causes distraction or motor activity(4). This is particularly important when they travel through an airport; The MHRA have clarified that they are not aware of any evidence of interference problems between airport security body scanners and implanted electronic medical devices. The patients should always carry relevant information about their IED to present if needed (7).

IED and pacemakers: Electronic devices implanted in a patient may be affected by other IEDs or medical equipment that a patient may come in contact in a health care facility. These devices may include cardiac pacemakers, which are a relative contraindication to IED implantation and vice versa. The cardiac pacemakers usually operate in the demand mode. They monitor intrinsic cardiac activity and may be inhibited by spontaneous extra cardiac electrical activity. The extraneous electrical activity from IED may be sensed and interpreted as appropriate cardiac activity. The pacemaker may then either respond by inhibition of pacing or by reverting to asynchronous pacing mode. Inhibition of
pacing can be potentially dangerous for the patient whilst the asynchronous pacing is less dangerous but still compromises the pacemaker function (4).

**IED and MRI scanners:**
The interaction of MRI and IED is complex. The magnetic field may produce lead movement with loss of effect or neural damage, heating of the components resulting in discomfort and tissue damage, or software malfunction (6). In addition, the location of the leads in relation to the site of interest may cause image corruption. Though there have been a small series of cases of MRI with IED without any problems, other imaging modalities should be used if possible (5). The advice of a radiologist should be sought and commonly they would not advise a MRI with an IED in situ. Sometimes if a MRI is needed it may be necessary to remove the IED prior to the investigation.

**IED and diathermy:**
Treatment modalities like short wave diathermy, microwave diathermy, and therapeutic ultrasound diathermy are hazardous to a patient with an IED and can cause nerve or tissue damage, which is permanent even if the device is switched off. (1).

The electrocautery used in routine surgical practice continues to be one of the most common potential of EMI for patients with implanted device. It involves the use of radio frequency current to cut or coagulate tissues. It is usually in a unipolar configuration between the cauterising instrument (cathode) and the indifferent plate (the anode). Bipolar cautery used for coagulation has a frequency between 300 and 500 kHz (at frequencies of less than 200 kHz muscle and nerve stimulation may occur). It is a similar situation with radiofrequency denervation procedure where radiofrequency lesioning involves the passage of very high frequency current (about 300kHz) down a 27G thermocouple probe. Electrocautery can damage the leads and cause temporary suppression of neurostimulator output and may even cause reprogramming of the device; hence bipolar electrocautery should be used. If a unipolar electrocautery is required, the ground plate should be kept as far away as possible from the IED and the leads.

**IED and radiofrequency lesioning:**
In the 24th annual meeting of the ‘American Academy of Pain Medicine’, Ryan Zolett et al presented a case report of a 49 year old woman scheduled for radiofrequency denervation of right L4 to S1 medial branches using ‘Bipolar radiofrequency ablation in the presence of pacemaker and peripheral sacral nerve stimulator’. They used two radiofrequency cannula placed 4 to 5 mm apart adjacent to each other at all levels. After doing sensory and motor stimulation, radiofrequency denervation was done at 65-700 C for 3 minutes. There were no problems with either of the IED. This is the first report of the use of bipolar radiofrequency ablation in the presence of a sacral stimulator.

**IED and peripheral nerve stimulators:**
Nerve stimulators used for localisation during peripheral nerve block may interfere with the performance of IEDs. Hence several precautions should be taken: the electrical current should be applied in such a fashion that it would not cross the pulse generator and lead system. High pulse duration and high frequency setting should be avoided. The use of ultrasound guidance for localising peripheral nerve is highly recommended (1).

**IED and surgery:**
Prior to any procedure, a thorough preassessment is essential. Details and documentation of any IED in situ should be noted and the details of product information card confirmed. During surgery, all perioperative team members should be aware that the patient has an IED in situ. There are several precautions that we need to adhere to: the theatre temperature should be maintained between 200C and 240C and the humidity maintained at 50% to 60%. This reduces the possibility of build up of static electricity in the environment.

**IED and defibrillators:**
For patient with IEDs in the chest area who require defibrillation, the anterior posterior type paddles are recommended. The position of paddles should be perpendicular to the IED and the anterior paddle should be placed as far away from the pulse generator as possible. The lowest defibrillator current setting possible should be used and it needs to be checked that the IED is functioning properly after defibrillation.

The choice of providing spinal anaesthesia to patients with an IED or sacral nerve stimulator is also debated. But before attempting spinal anaesthesia, the clinician should obtain an X-ray, as the stimulator entry site and the course of the connecting cable may be in the spinal needle insertion region. However the situation is different for an epidural catheter, which can potentially reach a higher level above the needle insertion site (1). So, great care should be taken if a neuraxial block is considered, as there is a risk of damaging the leads or causing infection, necessitating removal of the device (2).

The implanted electronic devices are invaluable to patients with complex chronic pain. The possibility of such patients presenting for other surgical or pain procedure will become more common. It is important to realise the interactions and ways to improve safety.

**REFERENCES:**
7.  www.mhra.gov.uk/safetyinformation/general/safetyinformationandadvice/
In 2001, the British Medical Journal produced a themed edition on integrated medicine. The ‘Editor’s choice’ had the title ‘Restoring the soul of medicine’. In it he wrote, ‘it might not be too pretentious to say that the full richness of what might be achieved through the growth of integrated medicine might restore the soul to medicine. The soul being that part of us that is the most important but least easy to delineate’.

‘Integration’ was interpreted here largely in the limited terms of bringing complementary medicine into the mainstream, but the best understanding of the concept is that medicine should be ‘integrative’, that is, whole-making. It must make health care whole - bringing its diverse professions, disciplines and techniques together into a true community of care. And it must be whole-making for patients – acknowledging and respecting all that makes them a unique and complex person and gives meaning to their lives; and by responding appropriately to whatever of these mixed dynamics is contributing to their illness or their pain.

I have used homeopathy for many years, and been aware of the spiritual dimension of healthcare for even longer. The biomedical paradigm is not conducive to a holistic perspective and certainly does not accommodate the soul; and the modern medical model does not recognise its importance. But the truly holistic and integrative spirit I have found here encourages me to tackle the matter of the soul directly – as just as much part of the reality of human experience in health and illness, as the body and the mind.

Two things led me to seek a better understanding of the soul as a clinical reality: One was an emerging sensitivity to certain psychic phenomena and awareness of the psychic dimension of human nature. The other was the realisation that there are wounds to the psyche that are not accessible to psychological help alone. Over the years, I have seen patients who have clearly benefited from the psychological skills of others, but without their wounds being healed or their suffering relieved.

I interpret these as wounds to the soul, and have found that a greater degree of healing is achieved when this is recognised.

After seven years as a GP, I set up a new practice providing routine 15 minute appointments to a smaller number of patients. This allowed me to attend more closely to the mixed dynamics of illness in individual patients. In this process, I created a diagram (Figure 1) to represent my understanding of what it is to be human. The traditional dimensions of human nature – body, mind and soul - have attributes shown in the respective circles; subject to the influences shown around the perimeter. The overlapping areas show the interaction of each aspect of our being, emphasising the intimacy with which each relates to the whole. Its essence is the complete integration of every aspect of human nature. Whatever the focus of

Figure 1 What it is to be human
illness, pain or disability, or the circumstances from which it arises, it affects the person as a whole and must be treated as a whole.

Soul and psyche:
We know a lot about the body and the mind, but the soul, if we take it seriously at all, is a mystery. We may always be unable to comprehend it fully, but I'm sure we must try to do so as best we can. I believe this is a clinical duty for health care professionals; and a task for science, as far as science will take us, as well as for philosophy and theology, part of its 'unending quest'.

The soul has been described as 'the information bearing essence' that expresses our unique identity as a person. In the diagram, it comprises psyche and spirit, and deciding what we mean by psyche is a problem.

It must accommodate the concepts of psyche in modern psychology, and the phenomena that are commonly described as psychic. The psychic dimension of our nature has been called 'the intermediate dimension' - intermediate between mind and spirit. It embraces the unconscious elements of our personality, and the collective unconscious described by Carl Jung. It includes those attributes described as extrasensory or paranormal. We inhabit a complex network of relationships – electromagnetic, gravitational, ecological, emotional, and psychic. We all possess psychic sensitivity and psychic attributes to a greater or lesser degree.

The psychic dimension is a normal aspect of human nature and the world we inhabit. It is psychic rapport, in addition to empathy and psychological insight that assists a healing relationship with another person, whether within a professional relationship or in everyday life. It is through the psychic dimension that prayer promotes healing, by the agency of the Spirit, usually in the absence of any overt psychic gifts in those who pray.

Homeopathy has provided insight through the use of medicines, indicated by psychological wounds. Whatever may be their function within the therapeutic 'black box', I have found helpful in treating the long term consequences of those wounds. Michael Bond's story of the beld girl whose handsome red wig was snatched off on the dance floor, who immediately developed abdominal pain and progressed to a history of recurrent and chronic pain, is a perfect example of this. Her chronic pain will never be relieved until the pain of that psychic wound is healed.

Wounds that have severely damaged a person's sense of identity, self-worth, or meaning, even of the right to life, and left such an indelible imprint may prove resistant to psychological healing skills, constituting a wound to the soul that needs to be understood and treated accordingly.

Spirituality and spiritual experience
What do I mean by spirituality? Spirituality is an aspect of our common humanity; rooted in the soul, expressed through our personality, and reflected in our aesthetic and ethical sensibilities, our social and cultural milieu, and the quality of our relationships - with others, and our world. Above all, it has to do with our sense of value and meaning as a unique individual, not just in terms of our material existence, psychological attributes and personal relationships, but of our significance and value within a bigger picture that has to do with some sense of a transcendent reality, or God-consciousness.

Spiritual experience is represented by observable patterns in the brain, but as with other aspects of mind is not convincingly explained by them. Spirituality and spiritual experience are embodied aspects of our psychosomatic unity. But they are not epiphenomena of neurological states. Unless we accept the reality of our spiritual nature we will not be able to do full justice to one another in our personal relationships, and particularly in our therapeutic relationships.

Spirituality and depression
The pain requiring a spiritual response that I am best acquainted with is mental pain, though it may also have some physical expression. Let me illustrate link between spirituality and depression:

Any cause of depression may affect a person’s spiritual equilibrium, just as it may affect physiological and intellectual function, personality, or behaviour. But factors directly affecting the soul may include –

• Doctrine abuse: religious teaching or attitudes that distort or deny a person’s innate spirituality.
• Psychic ‘infection’: harmful influences in the psychic environment.
• Psychic wounds: destructive experiences of the kind I have already described.
• Psychic sensitivity of a heightened degree: causing increased susceptibility to these other influences.
• Spiritual burdens: such as guilt, shame, hatred, fear or doubt, not readily accessible to psychological help alone.

Differential diagnosis: This needs to be as subtle and wide ranging as for any psychological illness, but open to the possibility of a spiritual component; requiring close attention to the narrative of the illness and the patient’s life, empathy, and intuition, and possibly discernment - actual spiritual insight, prayerful awareness of the condition of the other person.

Treatment: Sensitive and perceptive use of psychological skills may themselves assist healing at the spiritual level, without necessarily sharing the patient’s spiritual perspective, although authoritative acquaintance with the relevant religious tradition, may be needed. Care must be rooted in the evident integrity, insight, intelligence and compassion of the carer. Intercessory prayer may be necessary to deal with psychic interference. Deliverance (exorcism) is too often evoked in popular and some religious thought, but rarely needed. It is seriously abusive and damaging when misused, requiring the wisest, most competent and most discerning diagnosis. In the Christian Church, these healing acts may be reinforced by sacramental means – in the Eucharist (Communion), with laying on of hands or anointing.

Conclusion
This brief ‘clinical’ analysis of spiritual aspects of depression may apply equally to pain of any kind that has some resonance in the soul. It could apply to other forms of mental illness or to physical pain, whether psychogenic or having an actual physical component. Or disorder in the soul may be a complication of a pre-existing physical disorder. And it is certain that any chronic pain will inevitably have some resonance in the soul if, as I maintain, every human experience has that resonance; if the wholeness of every one of us is indivisible.

Medicine is deeply embedded in the culture of its society and its time. My challenge to the health care community is to recognise that restoring the soul to medicine will help to restore the soul to the wider community that it serves as well; to recognise that this responsibility is inseparable from medicine’s healing vocation.
These thoughts started as reflections on an inspiring talk last year on maintaining hope to the end of life in the dying. But hopelessness in chronic pain patients may perhaps sometimes be even more of a problem than in the dying. People with advanced cancer whose symptoms are unrelieved may hope or even long for death as an escape from their suffering, and this may not be a distant prospect. Though the severity of chronic pain may sometimes be comparable to that from cancer, for many there seems only the prospect of many years, indeed a lifetime of an existence dominated by constant pain. Hopelessness is a dominant feature of depression, and in chronic pain it may sometimes seem the only realistic reaction to the situation. So it is clearly incumbent on us to do all we can to restore and maintain hope. But can we always achieve this without a measure of deceit?

When I started my pain clinic back in the 70’s, I tried to be cheerfully optimistic with patients. When I became more and more confronted by therapeutic failures, I began to wonder if this was very honest, and whether by raising false hopes I might be doing my patients a disservice. There have been many advances in treatment since then but I am sure that this is a problem you all still confront.

Is it axiomatic that hope is always a good thing? The ancient Greeks apparently considered hope to be one of the most dangerous of all the world’s evils: when Pandora opened her box, she let out all the evils except one: hope. Friedrich Nietzsche described it as “the most evil of evils because it prolongs man’s torment”. I suppose we might agree with him about a single-minded hope for cure. But although acceptance is generally regarded as positive, resignation perhaps as too passive, and hopelessness as thoroughly undesirable, I would imagine that for some patients the distinctions may be blurred – “she is asking me to accept my pain and stop fighting it – does that mean I have to give up all hope?” Is hope the same as optimism? Is it necessary to be optimistic to be hopeful? We can at least address unwarranted pessimism and reasonably honestly reassure people that they are not going to grow inexorably worse, as many seem to assume. Are honest realism and optimism often compatible? Or do we have to look elsewhere for hope?

If there might be some ambivalence about hope that we may not always be aware of, there cannot be any ambivalence about false hope, and raising false hopes - of course, it is always a bad thing. Or is it? It is only in my medical lifetime that attitudes to truth-telling, especially about dying, have changed diametrically. We cannot but be aware of the damage some of our surgical and other colleagues have done in raising false hope, and the consequent cynicism and hostility to the medical profession some of our patients come to us with, but it could be argued that an optimistic tone in ‘selling’ treatments may enhance the placebo content of their effect. We probably all agree that one of the first steps in pain management is to wean people away from a single-minded but futile search for cure and guide them towards acceptance and a positive attitude to living with their pain. The difficult part is replacing false hope with a more realistic one. Outcomes of pain management programmes are by no means 100% successful, where they are not, the situation may seem even more hopeless than before -especially when despite our best efforts patients may have had false expectations about them and unrealistic hopes of what could be achieved. Some pain, especially neuropathic and central pain may be not only truly intolerable, but nothing to do with fear-avoidance behaviour and the other things we try to correct in PMP’s. Where is hope to be found for these sufferers?

In case of failure to relieve pain, I used to talk to patients about possible future advances in pain science and therapeutics; as time went on, I found it more and more difficult to do this with any conviction. Has the situation changed in the decade since my retirement? Will medical science one day ‘conquer’ pain, or at least give biomedical therapeutics a much sharper cutting edge that it has now? -or is the big breakthrough as elusive as ever? Is there any brighter light on the horizon? Is the nature of the beast such that biomedicine will never hold many of the answers? - Or are the biomedical guns simply trained on the wrong targets?

Another obvious problem is that not only doctors, but the majority of patients are stuck in a biomedical mindset – or culture. You might think that my asking the last question suggests that I am not entirely free of it myself.

So if there is some ambivalence about hope, can we conclude that hopelessness may be sometimes and in some ways acceptable? Surely not! Hopelessness must be among the worst features of depression, and where depression is associated with chronic pain the darkness must be blacker than ever.

I suspect very few of us would feel comfortable to bring the subject of religion in the pain clinic, but it is undoubtedly relevant. For a lot of people, it may seem the only source of hope. A quick whizz through a concordance revealed 166 mentions of hope in the Bible. In the OT, a lot of these seemed to be either in the Psalms, and, perhaps surprisingly, in the book of Job, whose situation might have seemed hopeless indeed but was able to say “Still I will hope in God”. Surprisingly there were no references in the gospels but there are countless uses of the word in the Epistles. St Paul famously listed hope among the three cardinal virtues. Speaking personally, I have always found faith difficult but have found much consolation in the thought that I can always hope for that of which I am uncertain, and may even seem improbable, without compromising intellectual honesty too much. The word hopeless, incidentally, doesn’t seem to appear in the whole bible. I only know of one clergyman directly involved in a pain clinic, although all hospitals acknowledge the need for chaplains – perhaps there should be more? But we still have to find a secular equivalent of religion that will not cause difficulties for either patients or therapists who find belief in God impossible and religion meaningless. In her talk at our 2007 meeting on “Spiritual Care in a Secular Society,”* Eileen Palmer emphasised the need to help people find meaning and purpose in their otherwise apparently hopeless lives.

Of course, there are no “one size fits all” answers to these questions. The art of pain medicine is to find a language which may be different for each patient which we can use to keep hope alive.

* The transcript of the meeting: Suffering and the World’s Religions: the search for meaning in pain, is available as a download from the Philosophy and Ethics SIG page in the BPS website.
Work-related learning for acute pain management

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The survey conducted on behalf of the British Pain Society (Briggs et al, 2009) drew attention to the limited pain education within undergraduate curricula for healthcare professionals. A key recommendation was to identify and share good practice of undergraduate pain education and facilitate wider availability of pain education resources.

The following is an illustration of an innovative approach to develop the knowledge and skills for acute pain management. Brighton and Sussex University Hospitals (BSUH) NHS Trust has been working in partnership with the School of Nursing & Midwifery at the University of Brighton to create a robust work-related learning package. It can stand alone as an in-house course or be integrated into an ‘Acute Care’ pathway through a post registration undergraduate degree.

The BSUH Trust runs an in-house acute pain study day and following attendance, staffs are encouraged to attend a half day update every two years. Evaluation data collected between 2005 and 2009 showed more than 70% of staff who attended were interested in learning more about acute pain management and using this knowledge towards a post-registration degree programme. At the time, the University did not run an acute pain module and the financial climate had restricted the number of nursing staff who could be released by ward managers to attend study sessions. The provision of a work related learning package was viewed as an opportunity for gaining academic credit at times to suit both staff and their ward managers.

The Trust study day is included within the work-related learning experience. Staff can then complete the course for interest or as part of their personal development programme identified at appraisal and informed by the NHS Knowledge and Skills Framework (KSF), which has recently been simplified to encourage greater use by employers (NHS Employers, 2011).

Fifteen nurses have completed their secondment with the APS, the workbooks and skills. Six members of staff are not enrolled on a degree pathway but have used the knowledge gained to support their position as ward pain link nurses: a pain link nurse provides a link between the APS and the wards/units throughout the Trust.

Academic credit using RAWL

At the conclusion of the work related learning package, staff can attend a University of Brighton Recognising and Accrediting Work Related Learning (RAWL) workshop to learn about the process for claiming academic credit. Similar to accreditation of prior experiential learning (APEL), RAWL is used to capture recent learning over the last year in particular, in-house education. It values that experience and fosters partnership working between the employer and higher education institution without the member of staff having to sign up to a part-time degree course delivered over several years.

Continuing professional education poses a challenge in these times of reduced public sector spending. Discrete courses in the form of pain management modules will only be viable if the number of applicants is sufficient to ensure a good student learning experience. Employers must look to innovative and cost-effective ways for continuing education. The coalition government sees local employers driving workforce training and education in health and social care (DH, 2010a and 2010b). Education and training should therefore be responsive and flexible, offering value for money. RAWL is one way of meeting these requirements.

After attending the RAWL workshop an ‘educational adviser’ is identified...
who is usually a member of academic staff at the School of Nursing & Midwifery. The adviser provides guidance on submission of a 2,000-word assignment based on the work-related learning and course materials.

**Academic rigour**

Six of the fifteen nurses have attended the University RAWL workshop; four are studying at undergraduate level (level 6) and two at postgraduate level (level 7). One has already achieved the 20 credit module at level 7 and further achievements are anticipated in the summer. A student has seven months between enrolment onto the module and submission of the 2,000-word assignment.

Higher education institutions are guided by national standards and best practice guidelines such as those published by the Quality Assurance Agency (2004) and SEEC (2003). With the increasing use of less expensive accreditation modules in these austere times, the validity and reliability of assessment has been questioned (Stenlund, 2010).

**Future direction**

Participant evaluation has been useful in guiding revisions of the workbooks and standardising format. It has also highlighted an increasing demand for this type of learning. Managers have requested staff to pursue this course as part of their professional development.

The partnership with the School of Nursing & Midwifery continues to develop and more nurses have expressed an interest in gaining academic credit for the in-house acute pain management course.

The aim of this innovation is to promote the development of knowledge and skills leading to more effective acute pain management. It is accessible to staff who work in a busy clinical environment and allows them to gain academic credit in recognition of their learning if they so wish. The collaboration between the APS at BSUH and the School of Nursing & Midwifery has encouraged a productive work-related learning approach. This model could be considered by other Trusts nationally and in specialties that work in a similar way.

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**DANIELLE LAM**

**INFORMING PRACTICE**

**Art and chronic pain: Mr A’s chronic pain**

This piece of art is a representation of the pain experiences of Mr. A, a 46 year old gentleman. He is an ex-intravenous drug user and the source of his chronic pain is from a broken needle in his right groin, which cannot be surgically removed due to its location. He has had this pain for 18 months.

I met Mr. A at an acupuncture clinic once a week, a total of three times. After initial discussions of the project with him, I came up with the idea of having a tree to represent the patient himself. We subsequently built upon this idea together.

I liked the idea of a tree, because it shows growth and strength. With growth comes transformation, and with regards to Mr. A, he came across as a very optimistic character, though he was initially depressed by the pain. The tree signifies his growth of acceptance. He also had to make a number of lifestyle changes, which I will elaborate later. The strength and sturdiness of the tree represents Mr. A’s groundedness and reluctance to let his chronic pain get him down.

Mr. A feels different types of physical pain. He described the most severe one as feeling like a lightning bolt or electric shock. This pain occurs spontaneously and results in him getting white flashes before his eyes. The split in the base of the tree represents this pain, as if struck by lightning. The split also divides the trunk into left and right legs, which is
significant as his pain is mainly in his right leg.

He describes the constant pain as being pulsating, dull and hot; which is represented by the red and yellow fire. This pain is located from his right groin to the base of his right foot as well as his back, as shown on the tree. In contrast, another type of pain, he described as being like a drop of water running down the inside of his right leg. This is represented by the stream of white and blue.

Mr. A came up with the idea of the breaking away of the bark; this is to portray his feelings of ageing. He described himself as being an outgoing and active person before the incident. The pain has led to lifestyle changes such as the discontinuation of active sport and the temporary break from his job as a marine construction worker. The cut in the tree exposes its core, and this signifies the feeling of pain to the bone.

At the second meeting, we improved the top half of the tree. My initial idea was to have a bare tree with no leaves, to signify exposure of the external layer. But Mr. A wanted the tree to have green leaves. The top of the tree represents Mr. A’s mentality and emotions; the green leaves represent positivity. The yellow bird was one of the final additions to the artwork and depicts his zest for life. The bird, being alone, also represents how the pain can sometimes cause him to isolate himself from his friends and family.

I also wanted to show some of Mr. A’s pain management methods. On the tree, there are plasters, pins and wires to represent lidocaine patches, acupuncture needles and a TENS machine respectively. Overall, I wanted to show that although the tree is damaged, it is still grounded and sturdy and still has a head of green leaves.

Mary Ray, PLC member and Communications Committee member summarises the event as: “I really liked Paul’s helpful realism. He outlined things BPS needs to do to get more and better media coverage. We need to build a relationship with a small group of journalists in the specialist and mainstream press. He described how BPS can be helpful and provide stories they will want to publish or broadcast. And he gave a good, punchy summary of what makes a good story. BPS has work to do to get there but he gave lots of tools to help us on the way. Most important is that we need case studies so every BPS story is about real people.”

The Communications Committee will work hard to follow these principles and help raise the profile of our Society. If you have an effective press release that was successful, please email them to Leila Taleb, Communication Officer at leilataleb@britishpainsociety.org as we are trying to compile model press releases for the benefit of our members.
Exploring chronic pain with patients - Medicine meets art

Heidi Lempp, Jennifer Potter, Pascale Petit and Joan Hester

Context and Setting
The undergraduate medical curriculum at Guy’s, King’s and St Thomas’ (GKT) School of Medicine in London is divided between a compulsory core curriculum and optional special study components (SSCs). Students select SSCs from a wide range of disciplines across health and non-health schools, including philosophy, mathematics and modern languages. This in-depth study of a special interest is intended to enhance students’ professional development and broaden their horizons.

Why the idea was necessary?
Three inter-related factors underpinned the SSC linking medicine with art. Firstly, out of almost 200 SSCs offered by the medical school to Year 3 students, only 11% have much non-medical content (1). Secondly, a decade ago, Heidi Lempp, the first author, offered a very successful SSC to Year 4 students which explored the humanity of medicine by linking the body in art and medicine (2). Thirdly, qualitative interviews with patients living with chronic pain highlighted the intrusiveness of pain into their private and public lives, which was often expressed in powerful metaphors.

A new SSC was offered that would integrate medicine and art, and would focus on people living with chronic pain. The module is jointly led by Joan Hester as Consultant in Pain Medicine, and Jennifer Potter, a medical sociologist. Year 3 was chosen because the medical, surgical and psychiatric rotations that take place in it provide good contact opportunities with patients.

How the SSC is organised?
Students devote one day per week to the SSC over three months. Supported by a detailed introduction and extensive biographical and medical literature on pain, students are encouraged to explore a variety of locally offered art, including films, exhibitions, dance, readings, local art groups and patient groups that use art therapeutically. Three sessions are held with artists and the course organisers. In addition students attend out-patient pain clinics, hospices, wards, pain management programmes as part of their rotations or on their SSC days. Assessment is based on a reflective diary written through the module and an artwork created collaboratively with a patient to represent the patient’s specific chronic pain and its impact.

Results and impact
The results have been remarkable. All students have passed the module over the past three years. The majority have created paintings with patients which reflected either common metaphor of pain or individual “journeys” involving unbearable pain. The artwork highlighted the dark side of living with pain and the dawning of hope. Students attested to the importance of taking time to listen to patients in pain to understand its real impact on their lives. Moreover, art opened a dialogue with patients who had previously been reticent.

Some students have created poems, stories and, in the recent module, a short animated video clip depicting the day to day life experiences of a patient with severe arthritis. This is most beautifully presented with a backing track of music played by the student’s sister.

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This video is available via the link http://www.youtube.com/watch?v=uEDiwvLINhs

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Transforaminal steroid injection for lumbar radicular pain.

Pain Medicine 2010; 11: 1149-1168

Dr Norman Kufakwaro
Anaesthetic trainee
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Lumbar radiculopathy is caused by foraminal stenosis and space occupying lesion in the lumbar spine but the most common cause is disc herniation. Laboratory findings point to inflammation around the affected nerve root as the mechanism of pain. It is the presence of inflammation that attracted the use of steroids to reduce inflammation and thereby relieve the pain. Hence epidural steroid injection by translaminar, transforaminal or caudal route is widely used.

Prior to this study evidence of efficacy of transforaminal epidural steroid injection has been inconclusive and at best conflicting. Transforaminal epidural steroid injection has been shown to be more effective than interlaminar or caudal injection. Ghahreman et al sought to establish if the transforaminal route of injection was critical for its effectiveness, or whether the agent was critical.

To achieve this, they undertook a five armed randomised control trial that included 150 patients. Patients included were: Adult patient capable of providing consent and capable of complying with the outcome instruments used, with pain radiating to the lower limb, of a lancinating, burning, stabbing or electric quality; associated with limitation of straight leg raising, and demonstration of a disc herniation by computerised tomography or magnetic resonance imaging at a segmental level consistent with clinical features. All patients had been classified by their referring surgeon as eligible for surgery should the pain interventions fail to relieve the pain.

Exclusion criteria were: Foraminal stenosis, severe motor deficit, history of substance abuse, inability to consent or comply with instruments for outcome assessments, previous surgery at the affected segmental level, or conditions that rendered the conduct of an injection unsafe, referred pain.

The 5 groups were: Group 1-Transforaminal injection of steroids, Group 2-Transforaminal injection of local anaesthetic, Group 3-Transforaminal injection of saline, Group 4-Intramuscular injection of steroid and Group 5-Intramuscular injection of saline. All the 5 groups were well matched in terms of demographic data. Patients were followed up by personnel blinded to the procedures.

The primary outcome measure was the number of patients who achieved more than 50% of pain relief at 1 month after treatment. Other secondary measures included measures of function, disability, use of other health care, duration of relief beyond 1 month and patient specified functional outcomes.

The results revealed that 54 % of transforaminal epidural steroid injection achieved more than 50% pain relief after 1 month (whereas it was between 7 to 21% in other groups). These results are clearly impressive and were accompanied by improvement in functionality and reduction of other health care requirements.

Over time, the number of patients who maintained relief diminished. Only some maintained relief beyond 12 months. The proportion of patients doing so was not different significantly between these groups.

Compared to previous studies, the team analysed their data categorically instead of using mean values. This principle is useful for studies to establish and analyse which patients respond to a particular interventional pain procedure. This might be the reason why previous studies on transforaminal steroid injection failed to demonstrate superiority over controlled injections of local anaesthetic or placebo.

In spite of the impressive results obtained in this study, I raise this question: Is it likely to lull interventional pain physicians into a false sense of security with transforaminal epidurals undertaken as per ISIS guidelines?

Erratum

Dear Member,

The Spring issue of Pain News included a review of a publication entitled ‘Life Happens. Waking up to yourself and your life in a mindful way’.

The author has pointed out that in the review, the reviewer misconstrued the intention of the sentence on the cover of the book ‘A thoughtful and effective approach to life, wellbeing and symptoms associated with physical illness or emotional distress such as stress, depression, anxiety, chronic pain, arthritis, cancer and addiction’ by describing in the review the ‘unfortunate classification of chronic pain as an emotional disorder...’

It was in fact intended that chronic pain be considered along with the other medical conditions such as arthritis and cancer, rather than being considered an emotional disorder.

We therefore apologise for any misrepresentation of the intended meaning of this sentence as detailed above.

REFERENCE

**Principles and Practice of Managing Pain -A Guide for Nurses and Allied Health**

**BOOK REVIEW**

This is a text book that sets out its aim and intended audience very clearly from the outset. It also states what it is not and I think that is important. The book is designed to be an overview of the principles and practice of managing pain – and as such will be an extremely useful addition to any university or Hospital library for student nurses and other allied health care students.

The book is very easy to read and each chapter is well referenced and includes various learning activities, concluding with a useful summary of key learning points. The book is organised in a very logical way and succeeds in making the complexities of pain physiology easier to understand.

I welcome the inclusion of a chapter on dilemmas in pain management as this is something that can be overlooked but is of great significance and relevance in health care. I also found the chapter on pharmacology included answers to questions that students always ask regarding how drugs work, half lives and dose conversions. The chapter on acute pain is an overview and limited to the post –operative experience and does not include discussion of some of the techniques that can be utilised.

Overall, I would recommend this book to both student and qualified nurses and allied health professionals. It does what it says it is going to and provides the reader with a taste for further exploration into the sometimes mystifying realms of pain management.

**BOOK REVIEW**

**Chronic Pain and Cancer Pain**

**Review by Arumugam Pitchiah**

Anaesthetic Registrar, Wales

The well established "Fast fact" series has published has published this handbook on chronic and cancer pain. It provides a clear and concise overview of a variety of chronic pain syndromes and their management.

The book is slim and can be easily carried around as a companion in everyday clinical practice. This book intends to be a useful ‘pocketbook of pain’ not only for the trainees in pain medicine and anaesthesia but also for other health professionals who are involved in managing patients with chronic pain.

The sections on musculoskeletal pain, complex regional pain syndromes are well supplemented with high quality photographs and radiological images. The illustrations used to explain the natural course of migraine attacks, neuronal reorganisation following nerve injury and neuropathic pain are vivid and impressive.

The pathophysiology of post stroke pain and post spinal cord injury pain concisely lays out the neurological, biochemical mechanisms with a clear illustration, which would be helpful for trainees in understanding the basis in this complex subject.
BOOK REVIEW

Living with chronic pain – review of website and CD
www.paincd.org.uk

Review by Bernadette Bustin
Pwys

How do you help the person who won’t, or can’t, attend a Pain Management Programme or clinic? What is an effective way to provide follow on support for someone who has already attended? How do you give understandable advice and instruction to someone who may not currently need a Pain Management Programme but who is, nonetheless, at risk of developing chronicity? How do you ensure that the advice you give is remembered and followed when your client is at home? The answer for all the above is Neil Berry’s free, downloadable CD, ‘Living with Chronic Pain’.

Presented over 10 tracks with a total running time of around one and a quarter hours, this is a comprehensive overview of practical information for people with chronic non-malignant pain which culminates in a highly effective 20 minute relaxation. In fact, it took all my effort to remember that I was meant to be reviewing the content and resist the seduction of the imagined tropical paradise! Each of the preceding nine tracks is an easily manageable ‘bite-sized’ chunk of between three and ten minutes length – perfect if your concentration is poor.

The first track, ‘Living with Chronic Pain’, abounds with key messages that pain clinicians repeatedly try to get over to their clients, respectfully reassuring the listener that ‘just because we can find nothing wrong, doesn’t mean that there is nothing wrong’. It introduces ideas of the biopsychosocial complexity of pain yet without any unnecessary complication and helpfully equates the pain system to traffic lights being stuck on red. Whilst promoting a self-help approach, it emphasises that this does not mean going it alone. It invites listeners to seek a positive future for themselves but, in encouraging them to concentrate on the things that are affected by their pain, the track may have missed an opportunity to move away from a ‘fixing approach’ towards a more ‘life-building’ approach – but this emphasis does not significantly detract from the quality of the content.

‘Regaining Control of your Body’ beautifully sums up the typical process of pain leading to reduced activity and subsequently to reduced enjoyment in life. Particularly appealing was the way it completely normalises the process and dismisses any sense of blame from the chronic pain sufferer. It quickly moves on, however, to describe simple, manageable exercises and explains how to begin incorporating them into a daily routine. Listeners are invited to notice the ‘boom and bust’ cycle in their activities and to balance their activity and rest periods. Some listeners may be inclined, however, to selectively attend to the instruction to ‘rest’ and clinicians may choose to emphasise the greater importance of ‘varied activity intensity’ rather than rest per se. That said, the CD continues by reminding people not to panic if they notice an exacerbation of pain but to learn from experience. They are helpfully reminded that it may just be their pain system ‘acting up again’.

The ‘Sleep and Diet’ track explains in simple terms the relationship between weight gain, demand on joints, increased pain and reduced confidence. This is then followed by non medical, common sense advice on eating, whilst confirming the lack of evidence for special diets for chronic pain. Advice on managing sleep with chronic pain is equally level headed and easy to follow. Ten simple suggestions that, yes, could be found anywhere on the web but hearing them all together gives them a completeness and authority that is likely to gain the listener’s interest and, hopefully, commitment.

‘Medication: Friend or Foe’ is a beautifully balanced and empathetic track recognising the pain sufferer’s fear of reducing their medications – a fear held in tension with their dislike and disgust at their continued dependence. With a compassionate understanding of the listener’s dilemma, this track carefully outlines the difference between acute and chronic pain from a medication viewpoint and explains the reduced effectiveness for chronic pain. Encouragingly, it also comments that some people cease medication use entirely and acknowledges the body’s natural endorphin mechanism. Medication use and reduction is a challenging area of pain management and this track sympathetically, yet with encouragement and positivity, gives the listener balanced and realistic guidance.

Like the preceding tracks, ‘Setting Goals’ is empathic and encouraging. It explains the benefit of being future oriented and then introduces the ‘nuts and bolts’ of goal setting with some helpful viewpoints such as acknowledging your achievements, not comparing yourself to others, breaking goals down into stages and keeping them realistic and precise. My preferred approach for working with people with chronic pain is to take a more global, values oriented view and perhaps Neil will consider this in any updates of the material. Despite this, the material presented is of the same clear and thoughtful quality as the remainder of the CD and, as such, is highly valuable. Whilst not termed as such, the CD continues with some suggestions about assertiveness and communication with family and begins to introduce the CBT (Cognitive Behavioural Therapy) ideas around ‘negative thoughts’ and ‘thought barriers’, seemingly in readiness for the following track.

Track six, ‘Managing Negative Emotions’ is unashamedly CBT based. With easy to understand explanations and recognisable examples, it brings to life the experience of thoughts, emotions, behaviours and physical reactions being unavoidably interdependent. Again, with empathy and understanding born of years of experience with chronic pain sufferers, Neil demonstrates sympathy of the predicament whilst unfailingly refusing to let the listener ‘off the hook’, challenging them instead to consider a list of six straightforward ideas to aid the self-management of their mood. He directs them to a more positive, appreciative and kindly way of being with themselves – reminding them that even listening to the CD is a constructive activity. To (mis)quote Neil’s own words, he offers people the small torch to light their possibly ‘very dark tunnel’.

Tracks seven, eight and nine start to prepare people for the 20 minute relaxation practice that concludes the CD. In ‘Learning to relax your body’ we learn about the relationships between physical tension, pain and negative emotions and are invited to learn to ‘reverse the reactions of the body’. The benefits of relaxation are well explained and there is, as you would by now expect, plenty of gentle encouragement to move towards the ‘relaxed end of the scale’. The CD reiterates a point often missed by clients in relation to relaxation: the fact that relaxation has to be practiced and waiting until you need it is too late! Basic strategies are outlined simply and clearly – of course. Listeners are urged to adapt the session in whatever way suits them and are given permission
to shift position – two things that are often overlooked, or misunderstood, by newcomers to relaxation. Despite this excellent introduction and delightful guided script, clinicians working from a mindfulness and acceptance base might find the language of ‘control’ in relation to pain and emotions less palatable. Furthermore, greater clarity between the use of relaxation for its inherent benefits and relaxation to induce sleep would be a welcome enhancement to the material. Despite these minor comments, the tracks on relaxation are on the whole excellent and, as self-help material, will give any listener a thorough and encouraging introduction.

This CD is not new. In fact it was first launched in 1999/2000 with a slight revision in 2001. What is new is the fact that all the tracks are now available, singly or as a complete package, for download from Neil’s site, www.paincd.org.uk, at absolutely no charge. You can also listen online or, from Neil’s site, www.paincd.org.uk, at absolutely no charge.

The purchased version is the CD for the princely sum of £2. The purchased version is the CD for the princely sum of £2. You can also listen online or, from Neil’s site, www.paincd.org.uk, at absolutely no charge.

The recent editorial in Anesthesiology (Anesthesiology 2011; 114: 243-6) starts with a quotation that “in United States, most pain physicians will just retreat to operating rooms as anaesthesiologists if pain medicine disappears”. The editor feels that we fail chronic pain patients because we promise more than we can give. She comments that the model for economic survival is not the model for good care. She insists on selecting right patients for long term opioid treatment carefully and thus helping primary care; she also stresses importance of outcomes research coupled with basic science that will allow us to identify who is helped by what means.

Dutch researchers carried out an economic evaluation (BMJ 2011; 342:d1110) shows that the two most efficacious ways to prevent this pain is using the antecubital vein and lidocaine pre-treatment (with venous occlusion). This was based on a data analysed from 177 RCTs with 25260 adult patients.

A recent systematic review (Br J Anaesth 2011; 106(3): 292-7) found that when paracetamol, NSAIDs or COX-2 inhibitors were added to patient controlled analgesia, there was significant reduction in the dose of morphine. There was no difference between these three groups themselves with regards to reduction in use of PCA dose. The NSAID group had less postoperative nausea and vomiting compared to placebo group.

PAIN SHORTCUTS

Essence

The Cochrane library has done a meta-analysis of 102 RCTs of coeliac plexus block for pancreatic cancer pain in adults recently (The Cochrane database of systematic reviews 2011 Issue 3, published March 2011). It concludes that the statistical significance of superiority of pain relief over analgesic therapy is minimal; however it reminds us that the adverse effects are fewer compared to opioids.

Various studies have been done to prevent pain on injection of propofol, the commonest anaesthetic induction agent used. Recent meta-analysis (BMJ 2011; 342:d1110) shows that the two most efficacious ways to prevent pain on injection are fewer compared to opioids. It reminds us that the adverse effects are fewer compared to opioids.

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Future BPS SIG Meetings

Pain Management Programmes Special Interest Group
http://www.britishpainsociety.org/members_sigs_pmp.htm

Bursaries available
8th & 9th September 2011, The University of Bath

Plenary Sessions:
Next generation psychologically-based approaches to chronic Pain Dr Lance McCracken
A prevention context for chronic pain: what can health care providers do? Professor Steven Linton
Virtual reality for pain and rehabilitation: help, hope, or hype? Dr Maureen Simmonds
Do psychological therapies really work? Professor Christopher Eccleston

Day 1 Seminars
Educational technology in pain management
Pain and suffering – perspectives of the young and the old
Returning people to work – it can be done

Day 2 Seminars:
What did the RCT ever do for us?
Improving access to good pain management: challenges and pitfalls
Working creatively with cultural difference

Plus interesting and informative workshops

Pain Education Special Interest Group
http://www.britishpainsociety.org/members_sigs_education.htm

Bursaries available
Interprofessional Working and Learning: Rewards and Challenges
29th November 2011, Churchill House, Red Lion Square, London

Keynote Workshop
Interprofessional Working and Learning
Helena Low, Vice Chair, Centre for Advancement of Interprofessional Education
Jayne Slonina, Interprofessional Education Lead, King’s College London

Seminars
Developing case studies for pain education: sharing practice and using the Breaking Barriers programme
Evaluating the effectiveness of pain education in practice and university settings
Pain education initiatives, exemplars and enigmas
An exploration of the undergraduate, postgraduate and patient education initiatives
Advancing pain education in your area: panel discussion and Q&A

To apply for either of these meetings or for more details please visit the website or email
kerobbard@britishpainsociety.org
Thanks to Mike Basler

We wish to dedicate this issue to all the hard work of the outgoing editor Mike Basler. His enthusiasm and dedication has made Pain News interesting to read by all our members. Here are few words of thanks from our members (Due to limitation of space, we had to print only a few!)

“It has been a pleasure to work alongside Mike on Council, and even more enjoyable and useful to receive each issue of Pain News, so ably edited by him.” Celia Manson, Independent Nurse Adviser

“Your energy, creativity and encouragement have been much appreciated, Mike. I can’t imagine what you are going to do with all that surplus time and energy but I’m sure you’ll find something!” Neil Berry, Psychologist, Southampton

“Mike Basler – Enthusiasm, wide network of contacts” John Goddard, Treasurer, BPS

“Thanks to his incredible hard work and endless supply of enthusiasm, Mike Basler has taken Pain News to new heights. His patience and willingness to explain the essence of the articles to the Pain News team of designers and proofreaders is a mark of his intelligence as a project leader and a testament to his generosity as a human being” Yves Lebrec, Designer, Pain News

“I would like to congratulate Dr Mike Basler for his excellent editorship. Apart from raising the standard of the Pain News by publishing articles representing multidisciplinary view, he himself has significantly contributed to the newsletter with his editorials which were topical, interesting and thought-provoking. Dr Basler encouraged all the aspiring authors and was easily approachable. He has set a good precedence and we are looking forward to see the popularity of the Pain News maintained.” Shyam Basesubramanian, Coventry

“Mike did a fantastic job as editor for Pain News. He had a great eye for a story and a good head for themes important to the BPS membership.” Mick Serpell, Glasgow

“Mike Basler has been an outstanding and energetic editor of Pain News. He has encouraged new articles and has not been afraid to air controversial issues. Pain News is now one of my favourite ‘pain reads’.” Joan Hester, Immediate Past President, BPS

Further Information

In our last issue (Pain News, Spring 2011, Pages 33-34), we had an article “Cultural perspectives of pain from rural New Zealand” by Steve Main. Peter Wemys-Gorman, Philosophy and Ethics SIG, informs us that there is a video linked to this available on request from Steve at steve.main@hokiangahealth.org.nz.

He further comments: “this is to be highly recommended: the wisdom and insight displayed by these people was not only enlightening but moving, and an experience long remembered by the audience.”
ACTIQ® 200 micrograms, 400 micrograms, 600 micrograms, 800 micrograms, 1200 micrograms compressed lozenge with integral oromucosal applicator (fentanyl)

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

Presentation. ACTIQ® compressed lozenge with integral oromucosal applicator containing 200 μg, 400 μg, 600 μg, 800 μg, 1200 μg and 1600 μg fentanyl.

Indications. Management of breakthrough pain in patients already receiving maintenance opioid therapy for chronic cancer pain. Dosage and Administration. See SmPC for full information. ACTIQ should not be chewed. Adults: Initially 200 μg, titrating upwards as necessary. Titration should be carried out under health professional supervision. During titration if adequate analgesia not obtained within 30 minutes after starting the first unit (i.e. 15 minutes after the patient completes consumption of a single Actiq unit) then a second unit of the same strength may be used. No more than 2 units in any treatment episode. Once maintenance dose established then use should be limited to 4 units per day. Children: Posology and safety in children and adolescents have not been established; use in this patient population is therefore not recommended. Elderly: Titration needs particular care as the elderly have been shown to be more sensitive to the effects of fentanyl. Patients over 65 years may require lower doses of Actiq. Special patient populations. Special care needed in titrating patients with kidney or liver dysfunction. Contraindications. Hypersensitivity to fentanyl or any of the excipients contained in the formulation. Patients without maintenance opioid therapy, simultaneous use of MAO inhibitors, or within 2 weeks of stopping use of MAO inhibitors. Severe respiratory depression or severe obstructive lung conditions. Warnings and Precautions. Background persistent pain should be controlled by opioids prior to commencing Actiq therapy. As with all opioids, tolerance, and physical and/or psychological dependence and abuse of fentanyl may occur. There is a risk of clinically significant respiratory depression. Particular caution should be used when titrating patients with non-severe chronic obstructive pulmonary disease or other medical conditions predisposing them to respiratory depression. Actiq should not be given to opioid-naive patients. Actiq should only be administered with extreme caution in patients who may be susceptible to the intracranial effects of CO2 retention. Opioids may obscure the clinical course of a patient with a head injury. Actiq should be used with caution in patients with bradycardia, hypotension, liver or kidney dysfunction, hypokalaemia and/or hypocalcaemia. Diabetic patients should be advised that Actiq contains dextrates. Patients with fructose intolerance, glucose-galactose malabsorption or sucrose-isomaltase insufficiency should not take Actiq. Normal oral hygiene is recommended to avoid any potential harm to the teeth. An evaluation of each out-patient concerning insulin requirements should be undertaken. No more than 2 units in any treatment episode. Occupational hazards. Withdrawal symptoms may be precipitated through the administration of drugs with opioid antagonist activity or mixed agonist/antagonist analgesics. Pregnancy and lactation. There are no data on the use of fentanyl in pregnant women. Actiq should not be used in pregnancy unless clearly necessary. It is advised not to use fentanyl during delivery because fentanyl passes through the placenta and may cause respiratory depression in the foetus. Fentanyl passes into breast milk, therefore women should not breast-feed while taking Actiq and should not restart until at least 48 hours after the last administration of fentanyl. Driving and use of machines. Opioid analgesics may impair mental and/or physical ability. Patients should be advised not to drive or operate machinery if they experience somnolence, dizziness, blurred or double vision while taking Actiq. Undesirable effects. Please see the SmPC for complete list of adverse effects. Typical opioid side effects are to be expected with Actiq. The most serious adverse events are respiratory depression (potentially leading to apnoea or respiratory arrest), circulatory depression, hypotension and shock and all patients should be closely monitored for these. Application site reactions, including gum bleeding and irritation, have been reported in post-marketing use. Very common effects (>10%) – nausea, constipation, somnolence, dizziness. Common (>1% - 10%) – asthma, headache, accidental injury (for example, falls), vasodilatation, vomiting, dry mouth, abdominal pain, dyspepsia, mouth ulcers/stomatitis, tongue disorder (for example, burning sensation, ulcers), confusion, myoclonus, anxiety, hallucinations, abnormal thinking, pruritis, sweating and taste perversion. Overdose. See SmPC for full information. Immediate management includes removal of Actiq unit via the applicator, if still in the mouth, ensuring a patent airway, physical and verbal stimulation of the patient, assessment of level of consciousness, ventilatory and circulatory status, assisted ventilation if necessary. Basic UK NHS Costs. Actiq all strengths £3 £17.54; Actiq all strengths £30 £97.34. Legal Category. CD (Sch2), POM. Marketing Authorisation Numbers: Pl 162900003-6 (UK), PA 827/21-1-6 (Ireland). Marketing Authorisation Holder: Cephalon UK Limited, 1 Albany Place, Hyde Way, Welwyn Garden City, Hertfordshire AL7 3BT. Date of revision of SmPC. November 2010. Actiq and Cephalon are registered trademarks. Further information, including SmPC, is available from Flynn Pharma Ltd, Henlards House, Old Stevenage, Herts, SG1 3EE. Medical Information (medinfo@flynpharma.com). Telephone: 01438 727822. Date of Prescribing Information. Jan 2011 Code: ACT3110

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk Adverse events should also be reported to Cephalon Medical Information via email to UKMedinfo@cephalon.com or on 0800 783 4869.

References
8. © Flynn Pharma Ltd. ACT/ADV/031/009 March 2011

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