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Australian Pain Society

Newsletter

THE AUSTRALIAN PAIN SOCIETY

BLOG WEB

Contents

Editor's Note

Joanne Harmon

Hi everyone,

We have a winter warming action-packed newsletter for you all. Plus- great news, the dates for the next APS 2024 conference have been released. Darwin, here we come! As a starter, topical and abstract submissions are now open, as well as your nominations for the Rising Star and Distinguished Member awards. If you are thinking of attending the conference, but not sure of what it can provide for your career, then check out the two great short inspirational articles from travel grant recipients and how much of an impact it was for them to be able to attend the conference.

It is great to be able to showcase some new publications by our APS members in this newsletter, including a detailed overview of pharmacological treatments for low back pain led by Dr Aidan Cashin. The BPR (Basic Pain Research) SIG Journal Watch is back. It is such a fabulous opportunity to be able to communicate on recent publications by our members, and our readers are asked to please be mindful to share their articles as they come to hand as well.

We catch up with our new rugby-loving NSW Director Connor Gleadhill, who discusses the importance of improving care integration, as well as Professor Ian Harris (plenary speaker at the recent ASM in Canberra) and our 2023 Rising Star winner Dr Aidan Cashin. Also find out what Dr Yogen Deo got up to when they attended the 6TH IASP-Southeast Asian Pain Management Camp and 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress.

In more exciting news, the partnership between the APS and Cops for Kids is continuing with the announcement of the seventh Clinical Research Grant Program. Don't miss out on your opportunity to apply for this great initiative.

We also have some great winter reading for you all to catch up on, non-less than two systematic reviews! Check out our FYI section as well, as part of the upcoming National Pain Week our President, Joyce McSwan, will be participating in a live Facebook panel discussion.

Keep sharing your stories.

Until next time, take care
Joanne Harmon

21-24 APRIL
APS2024
2024 AUSTRALIAN PAIN SOCIETY
44TH ANNUAL SCIENTIFIC MEETING
DARWIN CONVENTION CENTRE, NT

Important Dates for Your Diary

Tuesday 27 June 2023
Topical Session Submissions Open
Rising Star Award Applications Open
Free Paper/Poster Abstract Submissions Open

Tuesday 10 October 2023
Rising Star Award Applications Close
Topical Session Submissions Close

Monday 23 October 2023
Free Paper/Poster Abstract Submissions Close

Tuesday 21 November 2023
Registrations Open!

Save the Date

Visit the conference website: www.dcconferences.com.au/aps2024

Should you have queries, please contact the Conference Secretariat

21-24 APRIL
APS2024
2024 AUSTRALIAN PAIN SOCIETY
44TH ANNUAL SCIENTIFIC MEETING
DARWIN CONVENTION CENTRE, NT

Topical Session Submissions Now Open!

Submissions Open: Tuesday 27 June 2023

On behalf of the Scientific Program Committee and the Local Organising Committee, we are pleased to advise topical session submissions for APS 2024 are now open.

The deadline for Topical Session submissions is:
Tuesday 10 October 2023

View the topical session submission guidelines.

The online topical session submission portal will be available via the conference website from Tuesday 27 June 2023.

We look forward to receiving your submissions. Should you have any queries regarding your submission or the process, please contact the Conference Secretariat.

21-24 APRIL
APS 2024
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Abstract Submissions Now Open!

Submissions Open: Tuesday 27 June 2023

Abstracts will be accepted for Free Communication and Poster presentations. Opportunities to be involved in the Rapid Communication Sessions are also available.

The deadline for Abstract submissions is: **Monday 23 October 2023**

Please click here to view the Abstract Submission Guidelines

There are THREE categories for Abstract Submissions.

Please visit these portals below

Experimental Studies & Clinical Trials Abstract Guidelines

Clinical Practice & Service Delivery Abstract Guidelines

Case Reports Abstract Guidelines

We look forward to receiving your submissions. Should you have any queries regarding your submission or the process, please contact the Conference Secretariat.

21-24 APRIL
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Rising Star Award Applications Now Open!

Submissions Open: Tuesday 27 June 2023

This award showcases rising star pain researchers in Australia and may be awarded annually subject to the application of suitable candidates.

The Rising Star Winner will receive a return domestic airfare, accommodation, and complimentary registration to attend the 44th Annual Scientific Meeting, where they will give a plenary presentation to showcase their work and ideas.

The deadline for submissions is:
Tuesday 10 October 2023

Please click here to view the Rising Star Award Submission Guidelines.

To submit an application, please complete the form here.

We look forward to receiving your submissions. Should you have any queries regarding your submission or the process, please contact the Conference Secretariat.

IASP Global Year Lecture: How a Tri Flow Device, Merv Hughes, and a Spoon Represents Integrated Pain Care

The following is a summary from the 43rd Annual Scientific Meeting of the Australian Pain Society, which took place in Canberra from April 2-5, 2023. Since 2019, the Meeting has featured a named plenary lecture drawing inspiration from the International Association for the Study of Pain's (IASP) Global Year Campaign, an advocacy effort to raise awareness of pain. The IASP has chosen 2023 to be The Global Year for Integrative Pain Care. Dr Michelle Harris, a specialist anaesthetist at the Royal Adelaide and Lyell McEwin Hospitals in South Australia, was given the honour of delivering the IASP Global Year Named Lecture in 2023. Keeping in line with The Global Year Theme, Dr Harris' talk was entitled "The Person, not the Pain: Integrated Pain Care in the Acute Setting", where she discussed how an integrated approach to pain management may benefit both patients and broader hospital systems.

What is integrative pain care?

Harris commenced her plenary talk by admitting that when she was first approached to deliver the IASP Global Year Lecture she had to stop and think about what integrative pain care was. Initially, she pictured holistic or complementary modalities that would be more appropriate for a holiday than a hospital, such as yoga, massage, and tai chi.

However, Harris soon realised integrative pain care was so much more: a blend of historical and more novel ideas about how to approach healthcare that places the patient at its centre and focuses on the restoration of function, wellness, and health. Integrative pain care is also individualised, bringing together multiple different interventions (be those physiological, psychological, or lifestyle-based) that are meaningful to the individual that promotes pain self-management.

While Harris noted similarities between integrative pain care and the biopsychosocial model of pain, she also emphasised the differences between the two. A key difference is the incorporation of alternative or complementary approaches such as herbal supplements, vitamins, massage, yoga, aromatherapy, acupuncture, and so on – many of which are valued by patients, potentially leading to better engagement and outcomes – into integrative pain care.

Regardless of the approach, Harris is keen to understand the level of evidence for each potential treatment. Acute Pain Management: Scientific Evidence, a 1300-odd page tome from the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine has been a valuable resource for Harris when considering the use of various treatments in acute pain. And despite there being varying levels of evidence for the range of complementary treatments, Harris' attention was piqued.

"Some of these things are really similar to what I do. Perhaps prescribing someone a supplement isn't that different from prescribing a medication? Or sticking a needle in someone for acupuncture isn't that different from when I stick needles in someone for a regional block?" Harris wondered.

Not trying to reinvent the wheel

There are many challenges to incorporating integrative pain care into an acute pain service; time pressures, occupational health and safety considerations, and logistical considerations, to name a few.

"It's unlikely I'm going to implement a massage and acupuncture service as part of my acute pain round," Harris quipped.

This led Harris to develop an interest in modalities where she doesn't need to do something to the patient. She began by considering what was unknowingly already part of the acute pain service rounds that could be part of an integrative pain care approach. The answer? A tri flow device!

"It's a great device we use a lot on our acute pain rounds to assess pain and help strengthen respiratory function by doing a series of deep breathing exercises," Harris explained.

The motivating and addictive nature of trying to raise all three balls within the device taps into the intricate and bidirectional relationship between pain and breathing, where slow deep breathing has been shown to reduce blood pressure, activate endogenous pain pathways, and decrease pain intensity and pain-related anxiety.

But what other breath work techniques offering potential benefits for pain are there?

Here, Harris suggests meditation as a means of disentangling sensory, cognitive, and affective processes to promote self-regulation in the face of post-operative pain. There is some evidence suggesting meditation has benefits for pain-related outcomes. But again, the challenge is how to integrate this into patient care?

"I'm yet to meet a patient that doesn't have a device that connects to the internet next to their bed. So perhaps I don't need to tell them about mindfulness, but perhaps I give them the tools so that they can begin their mindfulness meditation journey on their own," Harris mused, pointing towards the wide range of meditation and mindfulness apps available to patients, including Headspace, Insight Timer, and Calm.

"Maybe we need to tell them about them, we need to help them download them onto their device, make sure they've got some headphones, and ultimately provide some guidance on what sort of things they might be trying to listen to."

A left-field example of patient engagement

Harris then presented a picture of former Australian cricketer Mervyn Gregory Hughes stretching in the outfield while in front of a large crowd.

Importantly, everyone in the crowd was also following along with the fast bowlers' antics. This phenomenon later became a successful campaign designed to educate and promote movement as a means of managing low back pain.

"Merv Hughes represents the idea of patient engagement," Harris joked. "In this case, getting a whole heap of people to engage and collaborate in their pain management. He's merging the biomedical – that movement is good for pain – with patient empowerment – that the patient can do the stretches, that they have some control, and that results in collaborative integrative pain care."

While Harris and her team at the hospital don't have Merv Hughes on staff, they do have the Central Adelaide Local Health Network PreHab website, which aims to help patients prepare well for surgery to improve their recovery. Harris is a great fan of the pain management section, which states:

Although pain medication may be prescribed, the most effective pain treatments are non-drug approaches (including relaxation, graded activity, mindfulness and goal setting).

"This is really important, as [like Merv and his stretching] it introduces potentially new ways of managing pain to patients and helps them realise that they have some control – these are things they do, not things that I do," Harris said.

Try a little tenderness

Harris then highlighted how motivational interviewing and empathic listening engages and empowers patients to take a more active role in their care by making small changes to the language used in consultations. But while empathy – recognising that someone is struggling and showing that understanding – is certainly important, compassion – the motivation to do something about seeing a person struggling – is even more important.

Harris demonstrated the importance of compassion by sharing the story of a postoperative patient from a recent pain service round. Despite the surgeons being happy with how the operation went and the nurses reporting no problems overnight, the patient looked terribly miserable while propped up the next morning eating breakfast.

The patient seemed disinterested in engaging with Harris and the rest of the pain team, soldiering on in their attempt to eat cornflakes and milk with a fork. Halfway through the consult, one of the nursing staff did something full of compassion and common sense: she went and got the patient a spoon.

"When she handed him a spoon, everything changed. Suddenly the patient engaged with us, he smiled, he was able to answer our questions," Harris recalled.

"I think it's compassion that really drives integrative health. A willingness to look at what a person values, where those values are not being met, and then actively trying to help fill that gap."

Harris concluded the lecture by noting that her examples of integrative pain care are not new. Rather it is the (re)integration of certain modalities or treatment approaches that is new and should be taken on board.

"Opioids and meditation have both existed for millennia and have been used in healthcare. [But] we live and die by one, while we really need to think about and encourage the use of the other."

"But ultimately underlying all of this is compassion. And when seeing a patient with pain, it's important to listen, to empathise and then take action."

Lincoln Tracy is a postdoctoral research fellow at Monash University and freelance writer from Melbourne, Australia. He is a member of the Australian Pain Society and enthusiastic conference attendee. You can follow him on Twitter (@lincolntracy) or check out some of his other writing on his website.

King's Birthday Honours 2023

We are delighted to congratulate the following APS members who received an award in the recent King's Birthday Honours.

Officer of the Order of Australia (AO):

Clinical Professor Ruth MARSHALL AO

For distinguished service to rehabilitation medicine, particularly to people living with spinal cord injury or disorder, as a leader, mentor and clinician.

Member of the Order of Australia (AM):

Dr Matthew CRAWFORD AM

For significant service to medicine, particularly chronic and complex pain management.

Australian Pain Society 2023 Rising Star Award Winner: A Chat with Dr Aidan Cashin

Aidan Cashin, PhD, is a NHMRC Emerging Leadership Fellow at the Centre for Pain IMPACT (Neuroscience Research Australia) and an Associate Lecturer at the School of Health Sciences, University of New South Wales. His PhD research focused on improving the evidence-based management of low back pain. Cashin was recently announced as the Australian Pain Society's Rising Star for 2023, an award showcasing up-and-coming researchers. As the Rising Star Award winner, Cashin delivered a plenary lecture focusing on understanding the mechanisms of interventions to improve efficacy and clinical translation at the 43rd Annual Scientific Meeting (ASM) of the Australian Pain Society, held in Canberra from April 2-5, 2023.

As part of the build-up for the ASM, Cashin spoke with Lincoln Tracy, a researcher and writer from Melbourne, Australia, about his passion for unpacking the mechanisms underlying treatments for chronic pain, what winning the Rising Star Award means to him, and his love of surfing. Below is an edited transcript of their conversation.

Before you pursued a career in pain research, you were an accredited exercise physiologist. What initially drew you to that line of work?

I've always had an interest in health and a desire to try and help people in some way. And like a lot of 17- or 18-year-old kids, I liked the idea of medicine. But at the time, I wasn't keen on spending so much time at university – I didn't think I could handle it. Little did I know that I was probably going to spend that long at university anyway! But I found out about exercise physiology at an open day for the University of New South Wales. It sounded like it was going to tick all the boxes for me: I was really interested in the person-centred focus of the profession and the ability to meet people from all different walks of life.

And I loved it. It was rewarding but challenging at times, particularly the breadth of conditions people would present with. We saw people with complex regional pain syndrome, people with post-stroke pain, people with pain post-amputation... it was quite interesting. I enjoyed working with people who had pain because you got an opportunity to learn their story and their experiences to understand what was contributing to their pain and to try and help them shape their journey moving forward. In some clinics you're quite restricted with your consultations, but the practice I worked at really made time for it.

How did you transition from working clinically to a career in research?

As an undergraduate exercise physiology student, I just thought research was all lab coats and pipetting. It just didn't excite me. But John Booth, my clinical mentor at the time, really inspired and encouraged me to add research to my tool belt. John himself was a part-time clinician and academic – it seemed like a good combination and something I wanted to do. When he introduced me to James McAuley, we got on well and found our interests aligned. The rest, as they say, is history. James became my PhD supervisor and showed me how patient-oriented research can be, and how patients can be involved on a day-to-day basis. That really caught my attention. I took to it and have never looked back.

Many clinicians make the shift into research after noticing something that affects their clinical work and wondering, 'how can we do this better?' Did you have a moment like that in your career?

Definitely. As an exercise physiologist, some of the primary tools we use on a daily basis are exercise- or movement-based strategies, as well as conversations around education and behavioural change. The exercise aspect really struck me, because at one point I noticed that regardless of whether I was providing a resistance-based program with weights or a more aerobic focused program, people seemed to be getting better. That started me wondering whether there was a specific part of what I was doing that was making a difference, or whether

it was a more general effect of just doing something. That really interested both James and I – we had a common interest in wanting to unpack the effects of these interventions and the mechanisms underlying them.

You've done a lot of work around reporting on, and guidelines for, mediation analyses. What are mediation analyses, and why is it important to do these in a structured way?

Mediation analysis is an approach to understand how interventions, such as exercise, cause their effects on patient outcomes. It's a complimentary approach to what trials or observational studies, which are good at telling you if and by how much something changes – but not how they change. Being able to look under the hood would have really helped back when I was a clinician, I could have really pulled apart an exercise to figure out it works by changing not only strength, but someone's mastery of the experience or their confidence to move.

But through my research and trying to synthesise other studies which used mediation analysis, we found they were really poorly reported. This made it hard for us to use their findings in our research or to help inform clinical practice. Therefore, the focus of the AGReMA guidelines, authored by my colleague Hopin Lee, was to address this shortcoming we were seeing. We wanted to create a guideline that had a minimum set of recommendations so that anyone could report the results of a mediation analysis in a transparent way that included all the important and relevant details.

What does winning the Australian Pain Society Rising Star Award mean to you?

It's a huge honour to receive this award. I'm a big fan of the Australian Pain Society and everything they do to help Australians living with pain. So, to be recognised by this group is great. I feel such a privilege to stand amongst the previous winners, who are all amazing researchers. In addition, no research is done on its own or in a vacuum. This award reflects all the support and achievements of the people around me – my supervisors, mentors, and collaborators – because without them I wouldn't have been in the position to apply and be successful in this award. I'd like to give a particular shout-out to last year's winner, Adrian Traeger, who was another of my PhD supervisors and has taught me so much.

Last year you also won the International Association for the Study of Pain's Ronald Dubner Research Prize. Given your success, do you have any advice for anyone out there thinking of applying for awards like these?

I think the best advice I was given is that you have to be in it to win it. And while that bit of advice doesn't guarantee success, it puts you in the mindset of getting out there and having a go. In my experience, putting yourself out there – and the unsuccessful applications that come with it – teaches you something every time you do it. Your ideas and thoughts get more clarity, or you get better at trying to describe your work, achievements, and impact. It's not easy to do, but practicing is a useful exercise.

The other useful bit of advice is to read successful applications if you can. I feel that through reading other applications, you can see where you set yourself apart and how you are different. In some of the bigger schemes, like the NHMRC, reviewers are reading stacks of fantastic applications, so you need to find a way to make yourself unique and memorable. For me, I feel my uniqueness came about because I approached my PhD like an internship. I learnt a lot of different skills, be that research methods or statistical approaches, and through that I could show impact across a broad range of areas rather than staying focused on just one area. But who knows?

What do you hope attendees took away from your plenary lecture at the ASM this year?

I hope attendees gained an appreciation for the role of mediation analysis alongside trials and observational studies, particularly if you're trying to unpack how treatments work – whether they end up being effective or not. To me, this information isn't just useful for researchers when they're thinking about developing and optimising interventions. It's also helpful for clinicians in how they implement these interventions in clinical practice, as they often think intuitively, rather than explicitly, about the mechanisms that are involved. The results of mediation analyses can really inform their decision-making.

For example, knowing how to provide an educational intervention that leads to larger changes in disability could help the clinician design their curriculum in a targeted way to optimise those mechanisms. I've found that targeting self-efficacy and someone's ability

to engage in physical activity despite being in pain is a key target for educational concepts. Knowing that, I can think about how I can give that person the relevant learning experiences to allow them to master the concepts or objectives before I even see them.

You've been involved in a diverse range of research activities throughout your PhD and your career thus far; is there a specific manuscript or project that you are most proud of?

I've always been proud of the work that I do, but if I had to pick one, I'd say I'm quite proud of the RESOLVE trial we had published in JAMA last year, where Matthew Bagg was the first author. I'm particularly proud of this one because I worked on this trial as a clinician during my PhD and made significant contributions to writing the final manuscript. It was a long time in the making – from designing the intervention all the way through to implementing it and then trying to make sense of it – but it was a fabulous project that is only getting started.

Our end goal is for graded sensorimotor retraining to be an intervention that's available for clinicians to provide to patients in their practice. There are a few steps we have to go through to get there, such as comparing the intervention against guideline-based care rather than a placebo, but we're looking for partners and developing grants to try and make that happen.

I'm sure everyone will be watching on with great interest! Changing tact now – if you had an unlimited amount of money to fund your dream research project, what question would you want to answer?

For most of my career I've been focused on trying to help people with back pain, particularly long-term back pain. One of the big roadblocks we seem to be facing as a field is trying to identify and develop effective treatments. This is a challenge, because we don't understand what causes back pain or what causes it to persist. So, if I had all the necessary resources and participants willing to be involved, I would try to understand what causes back pain and determine whether terms like "nonspecific low back pain" are appropriate. If we know what causes pain, and then causes it to persist, we can develop targeted treatments to hopefully reduce the burden of – or even cure back pain.

I don't have a particular theory as to what causes low back pain. But there are some smart people out there with some great ideas. Like Ben Wand, from The University of Notre Dame, who has developed a framework around how he thinks back pain persists. We recently wrote an article together about the Fit-for-Purpose physical therapy model, which explains how information from our environment and our body can lead to the development of persistent pain, while also providing opportunities to change it.

Finally, do you have any interesting hobbies or secret talents?

I don't know if it's a secret, but I try to surf as much as I can. My dad taught me when I was young, and I was just hooked. I competed when I was younger and was the Australian university national longboard champion at one point, which was a quite fun. Now my wife – who is a competitive longboard surfer – and I are teaching our son. He's only 15 months old and although he doesn't know it yet, he's going to be hooked too [laughs].

Lincoln Tracy is a postdoctoral research fellow at Monash University and freelance writer from Melbourne, Australia. He is a member of the Australian Pain Society and enthusiastic conference attendee. You can follow him on Twitter (@lincolntracy) or check out some of his other writing on his website.

Surgeon, Researcher, Author, and Hobby Data Scientist: A Chat with Professor Ian Harris

Professor Ian Harris AM is a Sydney-based orthopaedic surgeon, researcher, and author. In addition to his clinical qualifications, Harris has also completed a Master of Medicine in clinical epidemiology, a PhD, and a Master of Science in Health Data Science. He is interested in trauma care from a clinical perspective, while his diverse research interests primarily relate to surgical outcomes and the appropriateness of medical care. Harris was a national keynote speaker at the 43rd Annual Scientific Meeting (ASM) of the Australian Pain Society, which was held in Canberra from April 2-5, 2023. In the lead-up to the ASM, Harris spoke with Lincoln Tracy, a researcher and writer from Melbourne, Australia, about his path to becoming an orthopaedic surgeon, how a teaching job led to a career in research, and his desire to help inform both professionals and the public about how more medicine is not always better. Below is an edited transcript of their conversation.

What was your path to orthopaedic surgery?

I didn't want to do medicine when I was at school – my interests and talents laid in maths, physics, and science. My parents encouraged me to apply for medicine as my first preference, as it was the hardest course to get into, which made sense to me. I still wasn't sure about medicine when I got the offer, my parents encouragement continued with "well, you don't know until you try." So, off I went. Then when I was doing medicine, I was always interested in the surgical side of things. For me, it was more a matter of what kind of surgery I was going to do. I've always had an attraction towards mechanical and architectural things with a lot of structure and function, which orthopaedic surgery offers.

I was also strongly influenced by an elective I did when I was a student, where I worked with a European orthopaedic surgeon in Samoa. This guy was a workaholic, but he was an absolute dynamo. He ran huge clinics and theatres where there was very little equipment in an incredibly creative way, using a hammer and chisel to remove a piece of bone, and then use that as a peg to fix another piece of bone – normally you would need a metal screw and a power saw to do something like that. His skills were quite inspiring to witness, so I was locked into orthopaedics basically as soon as I graduated.

How did you develop an interest in research?

Although I was never formally trained in it, I've long been interested in science and the scientific method – how it cuts through the crap and leads to logical and rational conclusions. After I was established as an orthopaedic surgeon, I would attend lectures and see people talk very knowledgeably about publications, critically appraising whether it was a good paper or not. I didn't have those skills, nor did I know what that was called, as I got virtually no formal training in the scientific method in my medical degree, but I wanted to be one of those people who could do that.

I got a job teaching critical literature appraisal with the College of Surgeons, and quickly found that everyone on the faculty had done, or was doing, a Masters of Clinical Epidemiology. So, I figured that's what I also needed to do. And doing the Masters was like having the blinkers lifted from my eyes. I realised how poor the evidence was for a lot of what we do, and how good the evidence was that a lot of what we do didn't work. This just fascinated me, because there was a complete separation between what the science was telling us and what we were doing as doctors. And from that point on, I was hooked.

How did this interest in research lead to you working with clinical registries?

About ten years ago I joined forces with Professor Jacqueline Close to start the Australian and New Zealand Hip Fracture Registry, because I thought that was long overdue. Everywhere I travelled around the world I'd seen how poorly neck of femur fractures were treated. And in

Australia, they were always the ones that were bumped, always put off, repeatedly fasted, inconvenienced – and I thought they were the ones that this should be occurring to least. I really felt we needed to do a better job of treating hip fractures, and that's what started me off there. So, that's what started me off with the Hip Fracture Registry.

You've authored two books (*Surgery, the Ultimate Placebo*, in 2016 and *Hippocrasy: How Doctors Are Betraying Their Oath*, in 2021); how did you make the jump from surgeon and researcher to author?

Writing the books came from my awareness that the public perception of medicine was inaccurate. I'd spent a lot of time trying to educate medical practitioners to be more science based. But regardless of what they did, the patients never really had a say in their treatment – what the doctor said went. And the general feeling in the broader community was that medicine is a good thing: we need more medicine, more doctors, and more tests.

But through my studies I came to realise that more medicine wasn't necessarily better – in many cases it was bad. And it's very difficult to get such a counterintuitive message like this across. I was fascinated by these huge, randomised trials I'd see from places like Sweden about mammography screening, that showed either no difference or a slight increase in mortality in the screened group compared to the non-screened group, even though they detected more cancers. But they identified more cancers because they were looking for them – it's then just a question of whether that's helpful or not. However, no one was reporting this – they were just saying, "Oh look, we've diagnosed all these cancers, isn't it fantastic?"

So, I wanted to put a message about overtreatment out there. And there are a lot of times where modern medicine gets it wrong, and what we do is either ineffective or harmful. The first book had a lot of surgical examples, but I wanted to write something bigger and broader about modern medicine in general. So, for the second book, I got together with Professor Rachelle Buchbinder, a physician, and we wrote it together.

Given much of your research focuses on exploring the true versus perceived effectiveness of different surgical procedures, is there a procedure you're particularly suspicious of and would like to see investigated further?

I'd really like to take on spinal fusion surgery, particularly for back pain and degenerative conditions – I think that procedure is definitely overdone. In a lot of countries, including Australia, there are significant disparities between rates of surgeries between insurance systems. For example, about two thirds of joint replacement surgeries are done in the private sector and the remainder are done publicly. While this reflects availability, waiting lists, and the like, there is some evidence that people who have a joint replacement in the private sector will have the surgery a little bit sooner and with fewer symptoms than someone in the public sector. So, you could argue there's a bit of a mismatch in the servicing of the two sectors.

But the rates of spinal fusion surgery are something completely different. There's something like a tenfold difference between the private sector and the public sector, where it's rarely offered in the latter. And it's not like there's a huge waitlist in the public sector – the surgeons just don't think it's a worthwhile procedure in public patients, but they do in private patients. Such an overservicing in the private sector tells me something is wrong. Admittedly, there could also be some underservicing in the public sector, but the evidence for spinal fusion isn't great. We need to study it further, get more evidence, and be doing fewer of these surgeries in the meantime. But the rates of spinal fusion in the private sector have been increasing steadily over the last 20 years.

It seems that because some surgeons have had experiences where they have operated and people have gotten better – and for what they get paid for it – that it's worth a go. But for me, that's a very bad level of evidence. That's what surgeons, and medicine more broadly, have lived on for thousands of years: "I did something to somebody, they said they felt better afterwards, so therefore what I did to them made them better." This is the kind of thinking that kept bloodletting going for 2000 years, despite there being no science behind it. It's a very human, but unscientific, thing.

What's one of the more interesting research studies you've been involved in?

We recently had a paper published in PLoS, looking at the reported treatment effects of pregabalin in clinical trials over time. This paper was somewhat of a follow-up to an earlier paper from the *New England Journal of Medicine* I had been involved in that showed pregabalin was no better than placebo in the treatment of sciatica. I wanted to investigate the effects of this drug because while it was very commonly prescribed, there were some studies questioning its effectiveness, which led me to question whether it really worked.

I wondered if this was an example of what people called the decline effect. This can occur when a new drug comes along and gets a lot of hype because it seems to work well and have a meaningful effect, but then as time passes there is a change in mindset to 'it never really worked' because another new drug comes along. So, we examined the decline effect across a wide range of studies for different conditions using pregabalin and found that irrespective of the condition, irrespective of the dose, irrespective of all the different parameters, that the effectiveness compared to placebo has been steadily decreasing. It was marginal to start with, and now it's become almost non-existent over a period of 20 years. It's quite fascinating – I like doing fun things like that.

If you could offer one piece of advice to a younger you, what would it be?

My path to academia was very slow. Many of my surgical or clinical colleagues would go into academia early and get a PhD during or prior to their specialist training. But I had no idea what I was doing, and it wasn't until after I had been practicing for several years and graduated from orthopaedics that I started my PhD. And because of this, my advice would be to do it all earlier – study clinical epidemiology, evidence-based medicine, the scientific method – than what I had, which would have probably given me a ten-year head start on where I am now.

Lincoln Tracy is a postdoctoral research fellow at Monash University and freelance writer from Melbourne, Australia. He is a member of the Australian Pain Society and enthusiastic conference attendee. You can follow him on Twitter (@lincolntracy) or check out some of his other writing on his website.

Annual Scientific Meeting Travel Grant Recipient Report

Author name: Nell Norman-Nott

Author biography: *Nell is a clinical researcher and a PhD candidate at the School of Psychology, UNSW, Sydney. She is affiliated with the Centre for Pain IMPACT at Neuroscience Research Australia (NeuRA) and is supervised by Prof Sylvia Gustin. Nell's research is centred around creating a novel internet-based psychological treatment for chronic pain based on dialectical behavioural therapy.*

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Report

This was the second Australian Pain Society meeting I have attended, and this year my attendance was possible thanks to the travel grant I received. The grant covered my accommodation and travel expenses to the conference, which would have been difficult for me to manage otherwise.

The conference offered an excellent chance to connect and socialise with fellow researchers and clinicians who are working in the same field. I particularly appreciated the combination of formal presentations and relaxed social opportunities that facilitated networking.

For example, I met Dr Joshua Pate for the first time. I found our interaction fascinating because his area of research focuses on chronic pain in children, which has always been an area of interest for me. Additionally, Dr Pate's observation during his presentation that children with chronic pain frequently mention negative emotions over physical injury was particularly intriguing to me, given my own research focus on investigating emotions in adults with chronic pain.

I was also fortunate to meet some potential collaborators for our upcoming clinical trial, which will examine a new intervention focused on managing the emotional aspects of chronic pain. I found it particularly intriguing to learn from them how frequently they hear about the significant role that emotions play in their clients' level of pain intensity.

During my presentation, I discussed my systematic review and meta-analysis that focused on exploring the effectiveness of interventions aimed at regulating emotions in people with chronic pain to reduce both pain intensity and emotional comorbidities. The study's results indicate that, interventions that enhance emotion regulation significantly lower the intensity of pain and depression, in comparison to usual treatment.

The audience reacted positively to my presentation and posed some thought-provoking questions. In particular, they asked how enhancing emotion regulation can reduce chronic pain, which is a question that our team at the NeuroRecovery Research Hub at UNSW is currently investigating. We believe that since emotional challenges are closely associated with increased chronic pain, acquiring emotion regulation skills might not only enhance emotional well-being but also alleviate pain intensity. This question is at the core of a new research project that we are currently undertaking.

I am looking forward to next year's conference to connect again with peers, academics, and clinicians.

Declaration: Nell Norman-Nott receives support from various sources for her research, including the Australian Government Research Training Program (RTP) Scholarship (administered by the University of New South Wales), as well as a supplementary scholarship administered by Neuroscience Research Australia (NeuRA). She also receives funding from the NeuRA PhD Pearl Program.

Annual Scientific Meeting Travel Grant Recipient Report

Author name: Ria Hopkins

Author biography: *Ria is a PhD candidate and Senior Research Officer at the National Drug and Alcohol Research Centre, UNSW Sydney. Her interests include pharmacoepidemiology, public health, and healthcare policy. Her current work includes projects aimed at identifying and addressing issues in health service utilisation and access by people with chronic non-cancer pain, including those on long-term opioid therapy.*

Author contact details: ria.hopkins@unsw.edu.au; Twitter: @Ria_Hopkins

Report

I was fortunate to have the opportunity to present two pieces of work at the Australian Pain Society Annual Scientific Meeting 2023 in Canberra: my qualitative work titled "We didn't cause the opioid epidemic: The experience of being prescribed opioids for chronic non-cancer pain at a time of increasing restrictions", along with findings from a linked data study describing "Three-year subsidised health service utilisation among Australians prescribed opioids for chronic non-cancer pain".

While using very different research methodologies and presenting different findings, these pieces of work arise from my PhD exploring the various challenges that people living with chronic pain experience as they attempt to access pain management in Australia. Together, I hope that they highlighted the various challenges we face to meet the needs of the three million Australians living with chronic pain.

Having attended previously, I know the ASM tends to be a whirlwind of fantastic research, absolute superstars in the field of pain medicine, and more information than one could reasonably be expected to process in three days, and the 2023 ASM did not disappoint! It was wonderful to see the 'psychosocial' portion of the biopsychosocial model fully on display, with incredible presentations about pain, memory, and trauma. It was also wonderful to hear more about paediatric pain, which is not an area that I am very familiar with.

For me, the absolute highlights of the conference were hearing from Associate Professor Melanie Noel from the University of Calgary, as well as attending the 'Pick the Brain of a Pain Researcher' trainee session, which I highly recommend for any ECRs and students attending future conferences. The session on media challenges was enlightening and I think very much needed in the current media and political landscape, and the session by Dr JP Caneiro on Cognitive Functional Therapy has led me to investigate this further since my return to Sydney. It was also wonderful to catch up with colleagues working on similar projects from the University of Sydney and Monash University. Finally, I must acknowledge the fantastic spread of food - a true highlight of any good conference.

I would like to thank the Australian Pain Society for the opportunity to attend the ASM through a Travel Grant, and for the opportunity to present my research.

While I certainly have enjoyed the ASMs in Hobart (2022) and Canberra (2023), I was absolutely thrilled to see the venue of the next ASM will be a (slightly) warmer location. See you all at APS 2024 in Darwin!

Declaration: Ria Hopkins holds a National Health and Medical Research Council Postgraduate Scholarship and a National Drug and Alcohol Research Centre PhD Scholarship. The linked data study presented at the meeting received funding through National Health and Medical Research Council project grants.

This is to recognise

The Australian Pain Society

on behalf of

2023 Australian Pain Society 43rd Annual Scientific Meeting Delegates

963

for contributing 963

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Thank you for supporting biodiverse reforestation and habitat restoration within Australia's largest carbon sink project.

Ray Wilson | Chief Executive Officer

Issue Date: 11 May 2023

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Announcing the APS/CFK Clinical Research Grant #7

The Australian Pain Society (APS) is a multidisciplinary association whose purpose is to advance pain management through education, research, and advocacy for transformational improvements in clinical care. Our vision is that all people will have optimal pain management throughout life.

Cops for Kids (CFK) is a South Australian based charity focused on supporting initiatives that strive to improve the lives of children in that state. Part of the CFK mandate includes the provision of funds for research to assist in the care of sick children and/or enhance the life quality of a child.

APS is thrilled to announce our partnership with Cops For Kids is continuing with a seventh Clinical Research Grant Program (https://www.apsoc.org.au/aps-clinical-research-grant)

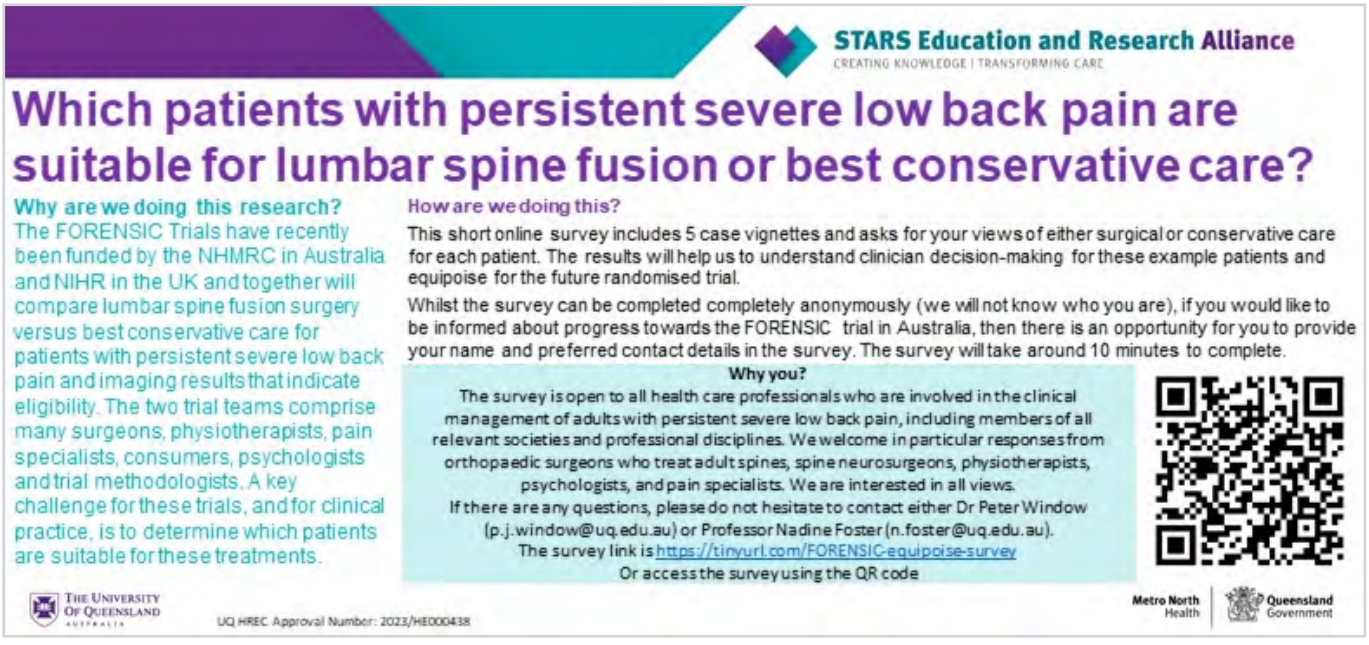
In brief, the award is to enable clinical research meeting the following criteria:

- Approach a meaningful conclusion in one year
- Conducted in Australia and must be relevant to the South Australian population
- The applicant must be an Australian citizen or permanent resident
- The applicant and their supervisor (if applicable) must be members of the Australian Pain Society and its Pain in Childhood Special Interest Group
- The funded project can be related to any aspect of a childhood pain complaint - including theoretical, mechanistic, diagnostic, treatment, epidemiological and/or sociological approaches; and
- The grant funding of $40,000 (inclusive of GST) will be paid quarterly in arrears upon the submission and acceptance of a combined Progress Report-Acquittal Form

Further information about the Clinical Research Grant can be obtained from the APS Secretariat.

Clinical Research Grant Application forms are available online and must be submitted by:

5pm (AEST) on Tuesday 26 September 2023.



Meet a Member

Connor Gleadhill, NSW Director
B.Phty (Hons), PhD candidate

Connor completed his undergraduate training in physiotherapy in 2012. He has since worked clinically in the public and private context. Since 2017, he has been a clinic-researcher with the University of Newcastle, New South Wales Regional Health Partners, and Hunter New England Population Health.

How did you get into pain as a clinic-researcher?

From my time as an undergraduate, I knew that I was clinically interested in pain and chronic pain. There is a significant amount of new and exciting discoveries going on with pain science and research (and I was always a science nerd). I wanted to improve my pain-related knowledge and skills from a clinical perspective because I found the challenge of treating people in pain so rewarding. I also had some great mentors early in my career, and I followed their lead. Pain research was the next logical step for me. I have always been driven by making a lasting impact on my community, and I thought pain research is the best way to do that (although starting a solar farm was – and still is – an interesting option).

What does your current research or clinical practice focus on? Why is this important?

My pain research deals with the problems that I see as priorities in clinical practice:

First, improving the translation and implementation of research among the messy, conflicting, uncertain clinical practice environment. With some fantastic clinicians, I have established and lead (what we think is) a novel practice-based research network of physiotherapists in the Hunter Region of New South Wales. Our aim is to optimise the translation and implementation of research, by bringing clinicians and researchers together to co-produce research. Follow our work, that has been generated for clinicians, by clinicians!

Second, I aim to improve the integration of pain care. Which means helping people in pain move better through the primary, secondary, and tertiary health systems while also ensuring care better manages multiple co-existing chronic health conditions.

What do you think will be the next "hot topic" in your area of research or practice?

From my lens, I think a hot topic will be to understand and optimise the implementation of care integration. More implementation work in musculoskeletal and pain care is needed and should be funded more.

However, the discovery science fields are always 'hot' to me. I may be totally off here, but I am keeping my eye on new imaging modalities that can give a better fine-grained idea of central nervous connections in painful conditions. I think you do have to reduce the complexity of pain on some levels to begin on better targeting treatment.

If you could offer one piece of advice to a younger you, what would it be and why?

Do not have kids. Or if you really want to, wait a while (at least until you've finished your PhD).

How and why did you join the APS Board?

I joined the APS board after an amazing experience during painSTAR. I would encourage any early career pain researcher to apply for the next painSTAR opportunity, because you never know where it will lead.

As to why: being an APS board member aligns perfectly with my values. In this position, I am in a position to make tangible differences for many more people in pain than I can possibly achieve in my clinical practice. APS is an incredibly important organisation and I'm humbled to be able to play a role in helping it thrive.

If you weren't in the pain science field, what would you be doing?

I have always imagined myself playing rugby for Ireland. But if I'm being realistic, I'd probably still be in some health-related career that involves working with people because that is what makes me tick.

Would you like to be featured in an APS member spotlight?

Email the APS Secretariat (aps@apsoc.org.au) if you would like to complete a short interview to introduce yourself and your work to the broader membership.

IASP 2023 GLOBAL YEAR Integrative Pain Care

IASP 2023 Global Year for Integrative Pain Care: The patient lens and what we can learn from Kath and Kim

By Bernadette Smith (APS President Elect), who is a Psychologist working in regional Tasmania. Aside from consulting in private practice Bernadette co-facilitates a federally funded Group Pain Self Management Program on the North West Coast of Tasmania.

Integrative pain care:

IASP has named 2023 the Global Year for Integrative Pain Care. According to IASP President M. Catherine Bushnell, PhD in the wake of the opioid crisis 'the aim of this year's campaign is to increase the awareness of clinicians, scientists, and the public about the use of an integrative pain care approach, which emphasises non-drug, self management care'. As always, the Global Year initiative provides an opportunity to critically-reflect on our own practice, integrate new knowledge and innovate.

Integrative Pain Care - The Benefits

It is widely accepted that pain is best conceptualised in a bio-psycho-social framework. Given the complexity of interactions between the biopsychosocial dimensions and the multiple possible concurrent pathways and mechanisms involved in pain perception [1], a single intervention treatment approach is likely to prove ineffective. This provides the rationale for integrative pain care.

'For the purposes of the IASP 2023 Global Year, we define integrative pain care as the carefully planned integration of multiple evidence-based treatments – offered to an individual suffering from pain – that strives to be individualized (person-centered), mechanism-guided, and temporally coordinated' [2]

Without wishing to diminish the importance of other key elements that make up integrative pain care, for the purpose of this short article I have chosen to explore the person-centred care.

The patient lens vs "Look at moi"

Because patient preferences and values are integral for improving treatment adherence and effectiveness, incorporating the patient lens to better understand the patient preference and their values is pivotal to successful integrative pain care. Reflecting on my own practice I am reminded of the many times I miss the mark, where the interaction balance is tipped toward me as clinician and not adequately toward the person in pain. In a tongue in cheek manner, Kath demonstrates the problem with her mantra,

"look at moi, I have one thing to say.... [insert long winded explanation of evidence-based treatment/mechanisms-driven recommendation, pain neuroscience research here.]"

It is important to acknowledge, that I, like others, can miss the mark with well-intentioned interactions that are evidence-based and mechanism driven. This provides the rationale for a person-centred focus, to **listen** to **and** importantly **learn** what is important to them. Adopting a person-centred philosophy provides the push for clinicians and scientists to be flexible and innovate, both key elements that underpin excellent integrative pain care. While this may seem idealistic, the constant and self-compassionate search for ways to improve engagement with a 'person-centred' approach is, nonetheless, the worthy occupation of excellent pain clinicians, scientists, and educators.

1. Nicholas MK. The biopsychosocial model of pain 40 years on: time for a reappraisal? Pain. 2022 Nov 1;163 (Suppl 1):S3-S14. doi: 10.1097/j.pain.0000000000002654. PMID: 36252231.
2. IASP Fact Sheet: Defining Integrative Care https://www.iasp-pain.org/wp-content/uploads/2023/04/defining-integrative-care-fact-sheet_R4-1.pdf

6th IASP-Southeast Asian Pain Management Camp and 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress

Participant Report (Fiji), Dr. Yogen Deo

It is a great pleasure for me to write this report after attending the 6th IASP-Southeast Asian Pain Management Camp followed by the 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress.

Background Information

The Thai Association for the Study of Pain (TASP) organised the 6th IASP-Southeast Asian Pain Management Camp followed by the 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress. This Pain Camp had been supported by a grant from the IASP and was also supported by members of ASEAPS and SARPS (South Asian Regional Pain Society).

The IASP Southeast Asian Pain Management Camp is an inter-professional residential education program in pain management with the aim to improve the knowledge and practice of pain management and is targeted at young healthcare professionals in Southeast Asia. Previously, since 2011, the program has had a positive impact on pain education and practice to healthcare professionals from ASEAN countries and other LMICs in Asia and the Pacific including Sri Lanka, Bangladesh, Nepal, Bhutan, Mongolia, Timor Leste and Fiji.

Date and Venue

Program	Date	Venue
6th IASP-Southeast Asian Pain Management Camp – Part I	30th April, to 2nd May, 2023	Buddy Oriental Hotel, Pakkred, Nonthaburi province, Thailand
6th IASP-Southeast Asian Pain Management Camp – Part II	3rd May, 2023	Centara Grand at Central Plaza Ladprao Bangkok, Thailand
9th Association of Southeast Asian Pain Societies (ASEAPS) Congress	4th May to 6th May, 2023	Centara Grand at Central Plaza Ladprao Bangkok, Thailand

Outcome of the Conferences attended

I have attended a total of 7 days of conferences as per the above program. In summary, it was the best conference that I have ever attended with the most useful information on pain that I could ever harvest. I made the best of my time during these conferences and have gained really a lot. The following are the highlight of how these conferences have benefitted me:

1. **It helped me to improve my knowledge and understanding of pain.**

Through these conferences, I learnt more about the biopsychosocial model of pain. It provides a simple account of how many factors contribute to pain presentation and how it affects an individual with pain in terms of the suffering and disability in function. I have learnt the correct terminology and types of pain especially for Nociplastic pain which is relatively a new term in pain classification. I have gained knowledge on how to properly assess a patient in pain in terms of getting a good history, doing a proper physical examination and appropriate investigations especially for chronic pain. It has also taught me the International Classification of Diseases 11th Revision (ICD-11) and its importance in diagnosing chronic pain patients. I have also learnt the multidisciplinary and interdisciplinary assessment and management of pain and how to utilise these using the case formulation to address individual pain patients need.

2. **It has updated me with the new research, current recommendations and practice on pain management including new drug and non-drug treatment modalities.**

One of the highlights in this field I have learnt is that exercise helps in the development of a healthy brain and is very beneficial for chronic pain patients. The use of cannabis is not supported by literature in the management of chronic pain. Opioids in long term use for chronic pain can cause more harm than good as it causes cortical loss, tolerance, dependence and even addiction in pain patients. Interventional pain management should be done on patients not responding to conventional therapies with careful

patient selection. Multimodal, multidisciplinary, and interdisciplinary management is most useful in the management of chronic pain including medications, physical modalities and psychotherapy. IASP has also shared the manual on "The IASP Multidisciplinary Pain Center Toolkit Project" which is a guide on how we can develop a local Pain Clinic or Pain center.

3. **It has improved my networking with Pain Specialists and various Pain Societies around the globe.**

Through these conferences, I was able to meet with the various prominent leaders and champions of the world in the field of pain medicine. I have also made good friends with the participants of many different parts of the world and have shared contacts for future endeavors. It was lovely to meet the president of the Australian Pain Society in person and appreciate the great work that she is doing to improve the management of pain patients with IASP. Through these conferences, I have also become a member of IASP and thus I can keep myself updated with the current practice.

4. **It has improved my confidence in managing different types of acute and chronic pain.**

After attending these conferences, I feel much more confident to manage my pain patients back here in Fiji. These conferences have enlightened with so much knowledge and insight in the approach to deal with pain. Management of chronic pain has been a challenge for me but now I am using the biopsychosocial model which serves to provide a better structure in assessment and management of my patients.

5. **I was also able to share my experiences and also clarify my doubts in regard to pain assessment and management practices and protocols.**

There was a lot of opportunities given to me during the whole conferences including group discussions, question and answer sessions, tea breaks and feedback sessions to share my experiences and ask questions regarding what was not clear. I also heard from many others which built my knowledge on how things can be done differently to achieve the same goal which was excellent.

Relevance of the information shared

This training was very relevant and much needed for my current work as I am heavily involved with pain management at my hospital. I have gained new knowledge, updated with the new research, current recommendations and practices on pain management. Currently, we are providing acute and chronic pain service at our hospital, but our resources are very much limited. Lack of human resource (health care givers trained in pain management), equipment and drug shortages, and inadequate training has been the major issues. This training has provided a platform for me to review how we can use the existing resources to best care for our pain patients. It has also provoked ideas on how to develop a better system for provision of ongoing pain services.

I have met many Pain Specialists and some pain fellows during this training and have also realised that there are opportunities available to develop a brighter future in this career. By being a member of IASP, I do have access to a lot of resources that are useful to my current workplace. I have already presented on some of the important lessons learnt from the Pain Camp and IASP conference to my hospital doctors and have received good feedback. Looking into the future, I think there is hope that we can improve our pain management services at our hospital with ongoing education and commitment from our team.

Vote of thanks

I would like to take this opportunity to thank my sponsors, the Australian Pain Society and the Australian and New Zealand College of Anaesthetists, who have generously supported me with travel arrangements, costs, meals, accommodation, registration, and guidance throughout in order for me to attend both the conferences as the sole participant from Fiji. I am so humbled by both organisations and have no words to describe my gratitude. I would just like to say thank you so much.

Feedback

I think this was an excellent opportunity given to me to learn. In fact, I have learnt so much and am very excited to apply this knowledge in my daily practice and give back to my department, my hospital and the utmost to my patients. I do not think that there was anything that could have been done better. I would love to be part of future trainings and join the Australian Pain Society as a member as well.

Compiled and submitted by:
Dr. Yogen Deo
Participant of Pain Camp and ASEAPS Conference, Fiji Islands

Pharmacological treatments for low back pain in adults: an overview of Cochrane Reviews

Thank you to APS members Aidan Cashin, Rodrigo Rizzo, Matthew Bagg, James McAuley and their colleagues Benedict Wand, Edel O'Hagan, Neil O'Connell, Hopin Lee, Christopher Maher, Andrea Furlan and Maurits van Tulder for sharing the following recent publication.

Article first published online: 4 April 2023

Journal Reference: Cashin AG, Wand BM, O'Connell NE, Lee H, Rizzo RRN, Bagg MK, O'Hagan E, Maher CG, Furlan AD, van Tulder MW, McAuley JH. Pharmacological treatments for low back pain in adults: an overview of Cochrane Reviews. Cochrane Database of Systematic Reviews 2023, Issue 4. Art. No.: CD013815.

DOI: https://doi.org/10.1002/14651858.CD013815.pub2

Abstract

Background/Objectives

Pharmacological interventions are the most used treatment for low back pain (LBP). Use of evidence from systematic reviews of the effects of pharmacological interventions for LBP published in the Cochrane Library, is limited by lack of a comprehensive overview. Therefore, this Overview aimed to summarise the evidence from Cochrane Reviews of the efficacy, effectiveness, and safety of systemic pharmacological interventions for adults with non-specific LBP.

Design

Overview of Cochrane systematic reviews.

Methods

The Cochrane Database of Systematic Reviews was searched from inception to 3 June 2021, to identify reviews of randomised controlled trials that investigated systemic pharmacological interventions for adults with non-specific LBP. Two authors independently assessed eligibility, extracted data, and assessed the quality of the reviews and certainty of the evidence using the AMSTAR 2 and GRADE tools. The review focused on placebo comparisons and the main outcomes were pain intensity, function, and safety.

Results

Seven Cochrane Reviews that included 103 trials (22,238 participants) were included. There is high confidence in the findings of five reviews, moderate confidence in one, and low confidence in the findings of another. The reviews reported data on six medicines or medicine classes: paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), muscle relaxants, benzodiazepines, opioids, and antidepressants. Three reviews included participants with acute or sub-acute LBP and five reviews included participants with chronic LBP.

For people with acute LBP, NSAIDs and muscle relaxants may provide small benefits on pain, however muscle relaxants may be associated with unwanted effects. Paracetamol had no effect on pain or unwanted effects.

For people with chronic LBP, opioids may reduce pain but may be associated with unwanted effects. NSAIDs may reduce pain without unwanted effects and antidepressants may make little or no difference on pain.

Conclusions

We found no high- or moderate-certainty evidence that any investigated pharmacological intervention provided a large or medium effect on pain intensity for acute or chronic LBP compared to placebo.

For acute LBP, we are at least moderately confident about the effects of paracetamol, NSAIDs and muscle relaxants on short-term pain and function. For other time points and other medicines (e.g. opioids, antidepressants), we have no evidence to inform treatment decisions. For chronic LBP, we are at least moderately confident about the effects of paracetamol and opioids on short-term pain and function but less confident about the effects of other medicines (e.g. NSAIDs, antidepressants, muscle relaxants, and benzodiazepines).

Implications/Discussion

Physicians should discuss the possibility for a small effect on pain and increased risk for unwanted effects when considering different medicines for treating low back pain. Funders and researchers should prioritise identification of medicines that provide clinically meaningful benefits to people with low back pain.

Declaration

AC, NO, RR, EO and JM have no known declarations. MB's salary was provided by scholarships. MB is first author on the Cochrane Review 'Paracetamol, NSAIDs or opioid analgesics for chronic low back pain: a network meta-analysis' and was not involved in any decisions about this review in the overview. CM has received competitive grants from government agencies and industry to support his research. As an invited speaker at conferences, he has had his expenses covered and also received small gifts such as a box of chocolates or a bottle of wine. He has received honoraria for marking theses, reviewing grants, and preparing talks. CM is on the Editorial Board of the Cochrane Back and Neck Review Group. Mitigation of conflict of interest: CM was not involved in editorial decisions on this review. AF: Google LLC, D/B/A YouTube (Independent Contractor - Other). The institutions where AF works have received various grants from external organisations, including government and public institutions in Ontario, Canada, and the UK. MvT is on the Editorial Board of the Cochrane Back and Neck Review Group. MvT was Co-ordinating Editor until September 2017. MvT was not involved in editorial decisions on this review. MvT has no additional competing interest; all research funding comes from non- profit, governmental funding agencies, and all funding (including travel and stay expenses) were paid to the VU University. HL has consulted for Cancer Council Australia and has received funding from the Australian Health and Medical Research Council (grant no. APP1126767), Center for Effective Global Action (CEGA), and Berkeley Initiative for Transparency in the Social Sciences (BITSS). BW has received payment for lectures on the non-pharmacological management of chronic low back pain. He has received honoraria for marking theses related to low back pain. This research project did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

New Members

New Members as at 27 June 2023:

Mr Wilfred Lax	Psychology
Mrs Alexandra O'Neill-King	Physiotherapy

Objective sleep measures in chronic fatigue syndrome patients: A systematic review and meta-analysis

Thank you to APS member Richard Kwiatek and their colleagues Abdalla Mohamed, Thu Andersen, Sanja Radovic, Peter Del Fante, Vince Calhoun, Sandeep Bhuta, Daniel Hermens, Jim Lagopoulos, Zack Shan for sharing the following recent publication.

Article first published online: 9 March 2023

Journal Reference: Volume 69, June 2023, 101771

DOI: https://doi.org/10.1016/j.smrv.2023.101771

Abstract

Objective

Patients with myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS) often report disrupted and unrefreshing sleep in association with worsened fatigue symptoms. However, the nature and magnitude of sleep architecture alteration in ME/CFS is not known, with studies using objective sleep measures in ME/CFS generating contradictory results. The current manuscript aimed to review and meta-analyse of case-control studies with objective sleep measures in ME/CSF.

Methods

A search was conducted in PubMed, Scopus, Medline, Google Scholar, and Psychoinfo databases. Meta-analysis was performed to investigate sleep measures differences between ME/CFS patients and healthy controls.

Results

After review, 24 studies were included in the meta-analysis, including 20 studies with 801 adults (ME/CFS = 426; controls = 375), and 4 studies with 477 adolescents (ME/CFS = 242; controls = 235), who underwent objective measurement of sleep. Adult ME/CFS patients spend longer time in bed, longer sleep onset latency, longer awake time after sleep onset, reduced sleep efficiency, decreased stage 2 sleep, more Stage 3, and longer rapid eye movement sleep latency. However, adolescent ME/CFS patients had longer time in bed, longer total sleep time, longer sleep onset latency, and reduced sleep efficiency.

Conclusions

The meta-analysis results demonstrate that sleep is altered in ME/CFS, with changes seeming to differ between adolescent and adults, and suggesting sympathetic and parasympathetic nervous system alterations in ME/CFS.

Declaration

The authors report no conflict of interests.

This research was sponsored by The Australian National Health and Medical Research Council (NHMRC) Ideas Grant (GNT1184219) and Mason Research Foundation grants (MAS2018F00019, MAS2018F00024). VDC was partially supported by the National Institutes of Health grant #2112455 and by National Institutes of Health grant #R01MH118695.

Have you had an article accepted for publication recently?

The Australian Pain Society (APS) is keen to share publications from our members with their colleagues via our eNewsletter. If you've had an article accepted or published recently, please contact our Assistant Editor Joanne Harmon via the APS Secretariat (aps@apsoc.org.au) with the title, authors, and reference (i.e., journal, volume, and DOI) of your article and request the submission template. We would love it if you also supply a short commentary (300 words max) to give our readers the gist of the article.

BPR Pain Hour: Spinal cord involvement in diabetic neuropathy

3-4pm AEST, Tuesday 15 August 2023 (via Zoom)

The purpose of our Basic Pain Research Special Interest Group (BPR SIG) is to share, improve, and promote scientific knowledge and understanding of the mechanisms of nociception and pain across all levels of investigation, from molecular and cellular analyses to preclinical or clinical studies.

This forum will provide an informal platform to promote and share our research and insights, from ECRs (including students) and senior colleagues.

Session 7: Spinal cord involvement in diabetic neuropathy

Summary

This session will explore changes in the spinal cord in diabetic neuropathic pain and will include presentations from Dr Lydia Hardowar and A/Prof Richard Hulse, Nottingham Trent University, UK. The focus of Dr Hardowar will be on investigating vascular interactions of pericytes and astrocytes within the spinal cord microvasculature during sensory neuropathy in diabetes. Lydia's presentation will explore the role of the neurovascular unit at the level of the spinal cord in regulating blood flow and how sensory neuronal dysfunction during neuropathy development arises from alternate vascular interactions in hyperglycaemia. A/Prof Hulse's talk will be on exploring hypoxia-induced neuronal degeneration at the level of the spinal cord during neuropathy developed in diabetes. Richard will be discussing the impact of hypoxia on sensory neurons in the spinal cord and how this contributes to neuronal maladaptations during the development of sensory neuropathic pain.

The invited speakers:

Dr Lydia Hardowar is a 2nd-year postdoctoral research fellow at Nottingham Trent University. Having defended her PhD thesis titled 'Investigating the Neurovascular Unit in Diabetic Sensory Neuropathy' in June 2022, Lydia will be graduating this summer. She has continued her work exploring microvascular changes at the level of the spinal cord from her PhD into her postdoctoral role. Lydia focuses on investigating the dorsal horn pericyte and astrocytic activation influencing blood flow change in hyperglycemic conditions. Through in vivo behavioural studies in dietary-induced hyperglycaemic animal models, intravital spinal cord blood volume imaging, confocal microscopy, and in vitro modelling Lydia has gained insight into causal effects on capillary deterioration preceding sensory neuronal maladaptations in neuropathic pain development.

Dr Richard Hulse is an Associate Professor in Sensory Neuroscience and theme lead for Integrative Neurophysiology in the Department of Biosciences at Nottingham Trent University. He was awarded his PhD in 2009 in the School of Physiology, Pharmacology and Neuroscience at the University of Bristol. He continued in Bristol for his postdoctoral research exploring how differing markers of neuronal injury, principally Vascular Endothelial Growth Factor-A, influences sensory primary afferent function and transition to chronic pain states. In 2013 he moved to the University of Nottingham to explore how modulation of the vascular network and microenvironmental adaptation within the dorsal horn are implicated in the onset of chronic pain, in particular diabetic and chemotherapy-induced neuropathic pain. His current work continues this focus, exploring vascular remodelling and its role in nociception, as well as investigating the dorsal horn neuronal maladaptation to local hypoxia and HIF1a dependence to underpin the development of diabetic neuropathic pain.

All are welcome to attend, including postgraduate students.

We look forward to seeing you there, please RSVP here.

Cardiogenic control of affective behavioural state

Hsueh, B., Chen, R., Jo, Y. et al. Cardiogenic control of affective behavioural state. Nature 615, 292–299 (2023).

DOI: https://doi.org/10.1038/s41586-023-05748-8

Reviewer: Karin Aubrey, Group Leader, Pain Management Research Laboratories, Kolling Institute, Royal North Shore Hospital and Faculty of Medicine and Health, University of Sydney

Review of article

Study group

This preclinical study used 8–12-week-old wild-type laboratory standard mice (C57BL6/J) of both sexes.

Aims of study

We know that emotional states influence body physiology in a top-down process. For example, when we feel anxious, our heart rate goes up. However, it is unclear if a higher heart rate alone can drive anxiety responses.

This study aims to control cardiac rhythms precisely and non-invasively and assess anxiety levels when the heart rate is selectively increased (in the absence of other stressors).

In addition, this paper investigates the neural correlates that link cardiac function to emotional (affective) states.

Brief methodology

This study has two major parts, both exploiting recent technologies.

The **first part** of this study involves the development of a new method to control heart rate in awake and freely behaving mice. This was achieved by selectively expressing a special type of channelrhodopsin called "CHRmine" in heart cardiomyocytes. The advantage of CHRmine is that it is activated by very low levels (0.1 mW mm-2) of amber light. Selective expression of CHRmine in the heart was achieved by systemically administering an AAV-vector encoding CHRmine under the control of a cardiomyocyte-specific promotor (mTNT promotor). Importantly, this means that CHRmine was expressed in cardiomyocytes but not expressed in other cardiac cells or other organs.

Next, light was delivered directly onto the intact skin of the mouse's chest non-invasively, the researchers designed a small mouse-vest, with an inbuilt amber LED-light that can be switched on and off at will. Using this system, the normal cardiac rhythm of mice could be increased from 600 to 900 beats per minute simply by switching on the vest-light and activating CHRmine in the heart. Normal sinus rhythms were restored once the light was switched off.

The **second** part of this study investigates the functional links between heart rate and anxiety states, first using animal behavioural models of anxiety and then investigating the brain regions involved. An intermittent ventricular tachycardia was induced with the vest-light. Then, anxiety-like behaviours were evaluated in a variety of tests. Next, researchers carried out a whole brain screen to identify potential regions involved, and then their activity was directly assessed during light-vest-induced tachycardia. Finally, two brain regions identified on the screen, with known involvement in anxiety (the insula and prefrontal cortex), were inhibited to investigate their role in tachycardia-induced anxiety-like behaviours.

Brief summary of the results

An increase in anxiety-like and apprehension behaviours were observed in response to light-vest-induced intermittent ventricular tachycardia. In contrast, mouse locomotor and pain responses were unchanged.

Light-vest-induced tachycardia correlated with significant changes in neuronal activity in several areas associated with central autonomic control. Notably, the activity of the insula and prefrontal cortex was time-locked to the tachycardia stimulations. However, only inhibition of the insula normalises tachycardia-induced anxiety.

Conclusions

The authors demonstrate that inducing tachycardia increases anxiety-like behaviours

and that inhibiting the activity of the insula cortex prevents this change.

Reviewer's critique & take home message from the article

This paper from the Diesseroth Laboratory at Stanford University elegantly uses advanced neuroscience techniques to demonstrate, for the first time, that non-invasively increasing heart rate can drive an anxiety-like state in mice, and identifies part of the neuronal circuit mediating this effect.

While there are a few experimental curiosities - broadly addressed in the discussion - this paper provides convincing data that supports psychological theories that heart rate CAUSALLY influence emotional states.

It is a demonstration of one way in which cool new neuroscience techniques are being used to interrogate brain circuits and their function in unprecedented detail, facilitating the next level of knowledge about how our brains are organised and work.

For APS clinical researchers, this paper provides mechanistic insights into the use of controlled breathing to reduce heart rate and as a result anxiety in chronic pain patients.

The article was also highlighted in April's issues of Nature in the News & Views, and the Research Highlights section of Nature Cardiovascular Research.

Declaration

Reviewer declares no conflict of interest.

Divergent modulation of pain and anxiety by GABAergic neurons in the ventrolateral periaqueductal grey and dorsal raphe

Xie, L., Wu, H., Chen, Q. et al. Divergent modulation of pain and anxiety by GABAergic neurons in the ventrolateral periaqueductal gray and dorsal raphe. Neuropsychopharmacol. (2022).

DOI: https://doi.org/10.1038/s41386-022-01520-0

Reviewer: Caitlin Fenech, PhD Candidate, Faculty of Medicine and Health, University of Sydney and Pain Management Research Institute, Kolling Institute, Royal North Shore Hospital

Review of article

Study group

This preclinical study used adult transgenic male mice; whereby gamma-aminobutyric acid (GABA) neurons are labelled with a Cre enzyme (GAD2-ires-Cre).

Aims of study

It is well known that the midbrain regions, the ventrolateral periaqueductal grey (vlPAG) and the dorsal raphe (DR), regulate antinociception and anxiety. However, the specific contributions of GABAergic neurons in these neighbouring regions are poorly understood. In addition, vlPAG^{GABA+} neurons play a significant role in endogenous opioid-induced analgesia, however the role of DR^{GABA+} in opioid-induced analgesia is unclear.

Therefore, this study aimed to:
(1) Evaluate the effect of activating and inhibiting vlPAG^{GABA+} and DR^{GABA+} neurons collectively and individually on nociception and anxiety-like behaviours and (2) understand the role of DR^{GABA+} neurons in opioid-induced analgesia.

Brief methodology

This study used cell-type specific chemogenetic and optogenetic manipulations to specifically activate and inhibit GABAergic neurons in the vlPAG and DR and observe the outcome in a nociception and anxiolytic behavioural assay.

Briefly, the animals were injected with either an excitatory (hM3Dq) or inhibitory (hM4Di) chemogenetic viral vector into the vlPAG, DR, or the vlPAG and DR region collectively. After three weeks, the animals underwent nociception tests to measure mechanical and thermal sensitivity, as well as tests measuring anxiety-like behaviours. Following this, an inflammatory pain model was induced via injection of an inflammatory agent into the hindpaw and the behavioural paradigm was repeated. This was to determine if activation or inhibition of these neuronal populations could be therapeutic in a persistent pain state.

To understand the role of DR^{GABA+} neurons in opioid induced analgesia, the study used an optogenetic approach, whereby the animals were injected with an optogenetic inhibitory vector (eNpHR3.0) and their mechanical nociceptive sensitivity was measured following systemic morphine administration combined with photoinhibition.

Brief summary of the results

Co-activation of vlPAG-DR^{GABA+} neurons increased mechanical sensitivity and increased anxiety-like behaviours. However, inhibition had no effect in naïve animals but did relieve hypersensitivity and anxiety-like behaviours following inflammatory pain induction. Interestingly, selective activation of vlPAG^{GABA+} neurons similarly promoted mechanical sensitivity but had no effect on anxiety-like behaviours. Surprisingly, manipulation of DR^{GABA+} neurons had the opposite effect, as inhibition (and chemical ablation) increased mechanical sensitivity. Although activation of DR^{GABA+} neurons had no effect in naïve animals, it did attenuate nociceptive hypersensitivity in inflammatory pain.

Lastly, the study used optogenetics to determine the effect of inhibiting DR^{GABA+} neurons following systemic morphine administration. Consistent with their chemogenetic results, inhibition of DR^{GABA+} neurons resulted in increased mechanical sensitivity, and interestingly, this was reversed by intraperitoneal injection of morphine.

Conclusions

This study was able to dissect the function of GABAergic neurons in the vlPAG and DR using modern neuroscience technologies. They demonstrated that chemogenetic co-activation bidirectionally modulates nociception and anxiety-like behaviours, but individual manipulation of these regions, in relation to

mechanical nociceptive sensitivity in both naïve and inflammatory pain states, revealed they have unique contributions.

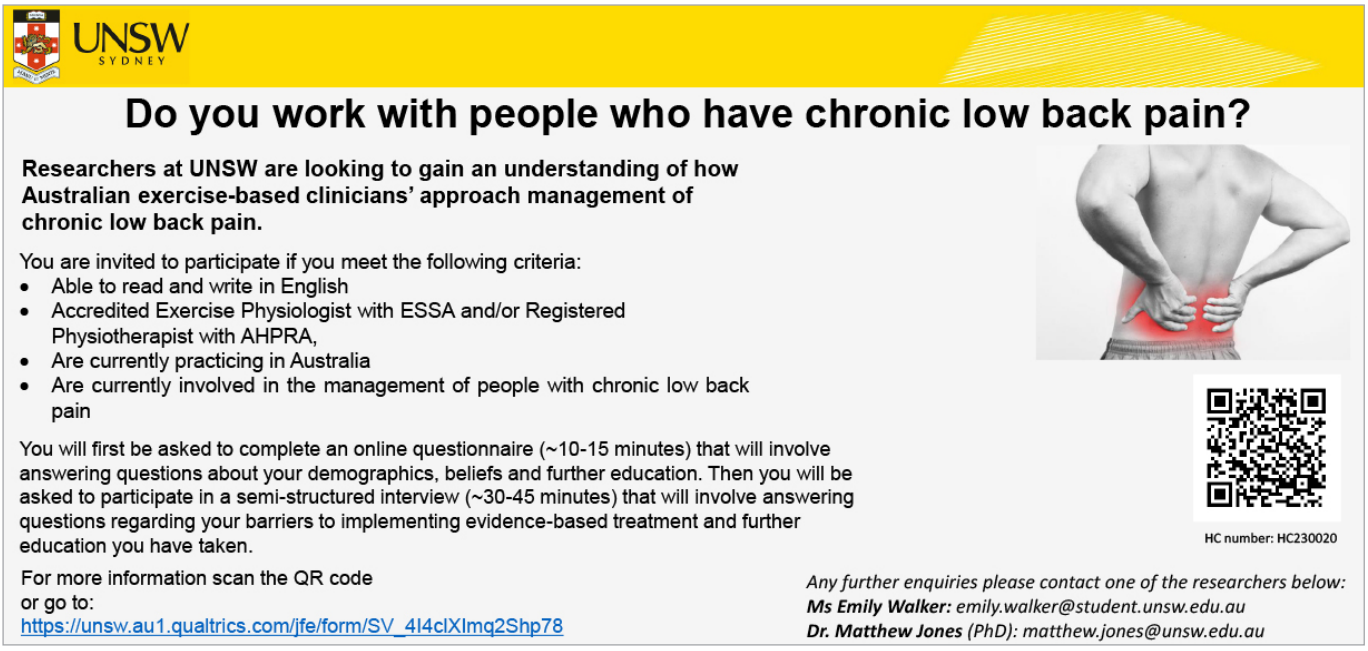
Reviewer's critique & take-home message from the article

Although mostly consistent with previous literature, this study does emphasise the importance of selective cell-type manipulations and precise targeting of brain regions. Through a careful systematic approach, they were able to determine the role of brain regions and synthesise the literature. However, it should be noted that although the study highlights the importance of precise neuronal targeting, the included representative coronal sections of virus infection suggest that the virus spread outside the target region/s. In addition, the sample size between treatment groups is inconsistent and the paper disregarded to include a power analysis.

Overall, the study illustrates how modern neuroscience technologies can be used to dissect the role of specific neuronal sub-populations and increase the understanding of neuronal circuits. In doing this, pain circuitry can be better understood and thus improve the likeliness of developing more effective therapeutics for pain sufferers.

Declaration

Reviewer declares no conflict of interest.



Remote local photoactivation of morphine produces analgesia without opioid-related adverse effects

López-Cano, M., Font, J., Aso, E., Sahlholm, K., Cabré, G., Giraldo, J., De Koninck, Y., Hernando, J., Llebaria, A., Fernández-Dueñas, V., & Ciruela, F. British Journal of Pharmacology, 2023, 180(7), 958–974.

DOI: https://doi.org/10.1111/bph.15645

Reviewer: Yo Otsu, Senior hospital scientist, Pain Management Research Institute, Kolling Institute

Review of article

Study group - who was studied

Adult male and female CD-1 mice (20-25g).

Aims of study

Major opioids are the most effective drugs for pain relief. However, their use is limited due to significant and severe side effects such as respiratory depression, dependence, and tolerance to their analgesic effects. To minimise these undesirable effects, a photosensitive morphine derivative was synthesized and characterised, allowing for the controlled release of morphine in response to light at specific locations.

Brief methodology

Photocaged-morphine (pc-Mor) was synthesized by chemically binding morphine to a photoremovable coumarin compound. The uncaged morphine could be released by exposing pc-Mor to 405nm light irradiation. Cell-based assays to detect the uncaged morphine were conducted using calcium imaging and patch-clamp recordings on cultured cell lines and neurons from mouse dorsal root ganglion. In order to assess pain sensation and various side effects (tolerance, constipation, dependence, and withdrawal syndrome), a formalin-induced animal model of pain was prepared by injecting formalin into the hind paw of mice. Subsequently, the mice were administered drugs (vehicle, morphine, or pc-Mor) via intraperitoneal injection, followed by either peripheral or central light irradiation. Peripheral light irradiation involved direct LED-mediated irradiation of the hind paw, while central light irradiation utilised a flexible fiber-optic implanted in the spinal cord. To evaluate tolerance, chronic drug administration was performed by administering drugs twice a day for five days, with each administration occurring before peripheral irradiation. Antinociception was measured and compared between acute and chronic treatment. Constipation was assessed by measuring the migration distance of intragastrically administered vegetable charcoal after peripheral irradiation. The development of dependence was studied using a conditioned place preference (CPP) paradigm, a standard behavioural test for examining the rewarding and aversive effects of drugs. Withdrawal syndrome characterised by the presence of several somatic signs (wet dog shakes, paw tremor, jumps, ptosis, decreased locomotor activity, and diarrhea) was monitored by administering naloxone to mice receiving daily drug injections. The antinociceptive effects of different treatments were evaluated by comparing licking/biting time in vehicle-treated animals to those treated with morphine or pc-Mor.

Brief summary of the results

In the cell-based assay, pc-Mor showed comparable potency to morphine when exposed to light. In the formalin animal model of pain, pc-Mor effectively provided antinociception through both peripheral and central light irradiation. Importantly, pc-Mor did not produce antinociceptive effects when the contralateral hind paw, which was not injected with formalin, was irradiated. Notably, the release of morphine from pc-Mor did not result in tolerance or affect gastrointestinal function. Furthermore, pc-Mor did not exhibit rewarding effects or induce a withdrawal syndrome, suggesting that the locally released morphine by light did not affect the central mechanisms responsible for opioid dependence.

Conclusions

pc-Mor, the first caged derivative of morphine, exhibits light-dependent antinociception

without inducing several side effects when activated peripherally. These results suggest locally releasing morphine through light activation may provide an effective approach to pain relief while minimising the risk of systemic side effects and opioid dependence.

Reviewer's critique & take-home message from the article

This study highlights the advantages of photopharmacology in achieving precise spatiotemporal control of pc-Mor's action, minimising systemic off-target effects associated with traditional morphine administration. Further preclinical investigations are suggested, including optimising the pc-Mor dose for light-induced morphine release, exploring neuropathic pain models, and monitoring additional side effects like respiratory depression and emotional aspects. Improvements in caged compound design are also proposed, such as increasing light sensitivity and enabling deeper tissue penetration without invasive optic fiber implants. Overall, further advancements in design and preclinical investigations hold the potential to enhance the therapeutic applications of photopharmacology in the future.

Declaration

Reviewer declares no conflict of interest.

EXPRESSIONS OF INTEREST ONLINE:
www.dcconferences.com.au/aps2024
Registrations Open 21 November 2023

IMPORTANT DEADLINES

Topical Sessions	10 October 2023
Rising Star Award	10 October 2023
Free Papers & Posters	23 October 2023
Early Bird Registration	27 February 2024

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INTERNATIONAL KEYNOTE SPEAKERS

Professor Christine Chambers, Dalhouse University, Canada

Dr Christine Chambers is the Canada Research Chair (Tier 1) in Children's Pain, a Professor of Psychology & Neuroscience and Pediatrics at Dalhousie University in Halifax, Nova Scotia, and a clinical psychologist. She also serves as the Scientific Director of the Canadian Institutes of Health Research's Institute of Human Development, Child and Youth Health.

She is also the Scientific Director of Solutions for Kids in Pain - a national knowledge mobilisation network whose mission is to improve children's pain management.

Professor Cheryl L. Stucky, Medical College of Wisconsin, USA

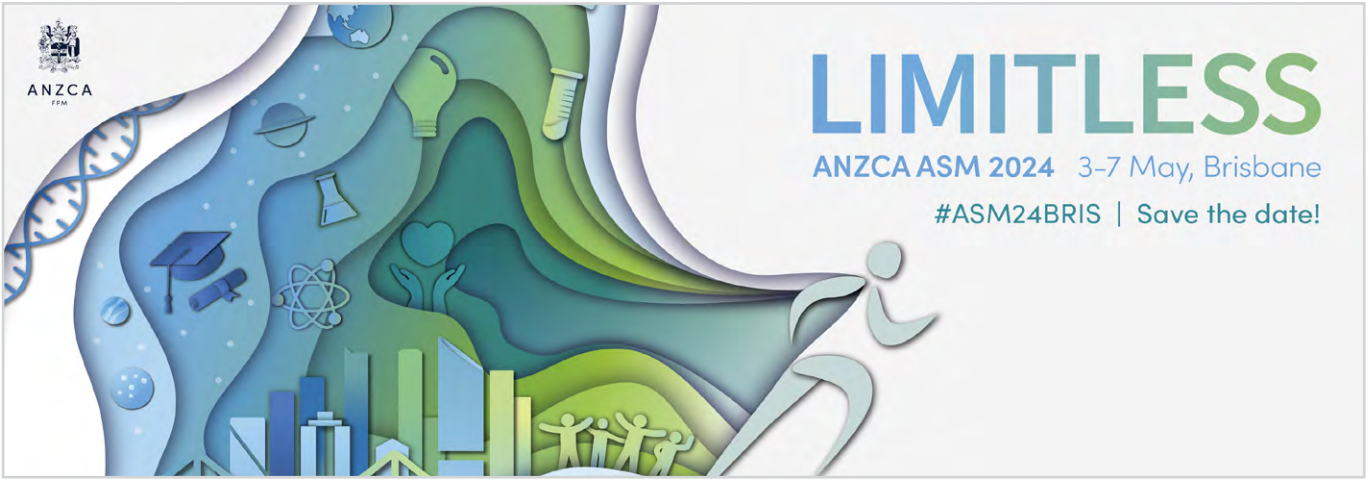
Cheryl Stucky is the Marvin Wagner Endowed Chair at the Medical College of Wisconsin where she is also Director of the Pain Division of the Neuroscience Research Center.

Dr Stucky's lab studies the molecular, cellular and physiological mechanisms of sensation, particularly how we sense touch and pain. The central theme of Dr Stucky's lab is to study the molecular and physiological mechanisms that underlie somatosensory mechanotransduction in the normal, healthy state and in conditions of tissue injury or disease.


25 YEARS
FACULTY OF PAIN MEDICINE
ANZCA
Save the date!
2023 FPM SPRING MEETING
Let's celebrate! From silver lining to silver anniversary
6-8 October 2023,
Pullman, Adelaide
Kaurna Country
#painSM23


NATIONAL TRAUMA SYMPOSIUM
NTS23
TOWARDS EXCELLENCE
14 NOVEMBER 2023
Te Papa Tongarewa, Wellington, New Zealand
Te Hononga Whētuki ā-Motu
National Trauma Network
www.traumasymposium.nz


21–24 March
The Dunedin Centre, Dunedin
www.nzps2024.nz
NZPS 2024
Empowering Pain Management in New Zealand
New Zealand pain society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ANZCA ASM 2024 3-7 May, Brisbane
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NEW!

- **National Pain Week, an initiative of Chronic Pain Australia, 24-30JUL23:** https://chronicpainaustralia.org.au/events/
  - **APS President, Joyce McSwan will participate in "The State of Pain" panel discussion, a Facebook live event, at 11am AEST on Monday 24JUL23.**
    - **National Pain Survey 2023 results will be shared.**

Other items of interest for our members:

- **Latest opioid data from the Australian Bureau of Statistics**: Opioid induced deaths in Australia. https://www.abs.gov.au/articles/opioid-induced-deaths-australia
- **Australia's annual overdose report 2019 from the Pennington institute**: http://www.penington.org.au/australias-annual-overdose-report-2019/
- **The Third Australian Atlas of Healthcare Variation: This series explores how healthcare use in Australia varies depending on where people live. It investigates reasons for variation that may be unwarranted, and provides specific achievable actions to reduce unwarranted variation.** https://www.safetyandquality.gov.au/atlas
- **Painaustralia eNewsletter latest issue, available online at** http://www.painaustralia.org.au/media/enews
- **ePPOC: electronic Persistent Pain Outcomes Collaboration: The electronic Persistent Pain Outcomes Collaboration (ePPOC) is an Australasian initiative that aims to improve the quality of care and outcomes for people who experience chronic pain**. For more information about ePPOC, refer to the website: http://ahsri.uow.edu.au/eppoc/index.html
- **PainHEALTH website: painHEALTH's aim is to help health consumers with musculoskeletal pain access reliable, evidence-based information and tips to assist in the co-management of musculoskeletal pain. painHEALTH is an initiative of the Department of Health, Western Australia**. http://painhealth.csse.uwa.edu.au/
- **Stanford University**: CHOIR Collaborative Health Outcomes Information Registry https://choir.stanford.edu/
- **Opioid Podcasts for GPs**: These podcasts are produced by David Outridge GP, and FAChAM Trainee as a project under the auspices of Dr Steven Kelly Staff Specialist in Addiction Medicine, Kullaroo Clinic Gosford. A 20 week series from the Hunter Postgraduate Medical Institute (University of Newcastle) : http://www.gptraining.com.au/recent-podcasts
- **Airing Pain**: Pain resources via an online radio show produced by Pain Concern, a UK registered Charity: http://painconcern.org.uk/airing-pain/
- **Indigenous Resources**: New webpage on the APS website aggregating Indigenous resources: https://www.apsoc.org.au/Indigenous-Resources
- Opioids: Communications videos: https://www.nps.org.au/opioids-communication-videos

TGA

- Codeine information hub: https://www.tga.gov.au/news/news/codeine-information-hub

NSW Agency for Clinical Innovation resources:

- Brainman and Pain Tool Kit translations, SEP15: http://www.aci.health.nsw.gov.au/chronic-pain/translated-resources
- Pain Management Resources: https://aci.health.nsw.gov.au/networks/pain-management/resources
- Quicksteps to Manage Chronic Pain in Primary Care: http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care
- Built into Quicksteps: "How to de-prescribe and wean opioids in general practice": http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care/how_to_de-prescribe_and_wean_opioids_in_general_practice
- A list of helpful apps for consumers and clinicians now available at: http://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/management-of-chronic-pain
- Chronic Pain in the ED: https://www.aci.health.nsw.gov.au/networks/eci/clinical/clinical-resources/clinical-tools/pain-management/chronic-pain-in-the-ed

Calendar of Events

11 August 2023

Neuromodulation Society of Australia and New Zealand (NSANZ)
NSZANZ Pre-Conference Cadaver Workshop 2023

Sofitel Brisbane Central, Brisbane, QLD

https://www.dcconferences.com.au/nsanz2023/Cadaver_Workshop

11-13 August 2023

Neuromodulation Society of Australia and New Zealand (NSANZ)
NSANZ 2023 16th Annual Scientific Meeting - Neuromodulation: From Niche Practice to Mainstream Medicine

Sofitel Brisbane Central, Brisbane, QLD

http://www.dcconferences.com.au/nsanz2023

31 August-2 September 2023

Interational Neuromodulation Society (INS)
3rd Joint Congress of the INS European Chapters - Addressing Tomorrow's Challenges Together!

Congress Centre Hamburg, Germany

https://e-ins.org/

7-9 September 2023

International Association for the Study of Pain (IASP)
NeuPSIG 2023 International Congress on Neurpathic Pain

The Lisbon Congress Centre, Lisbon, Portugal

https://neupsig.joyn-us.app/

10-13 September 2023

Rehabilitation Medicine Society of Australia & New Zealand (RMSANZ)
RMSANZ 2023 6th Annual Scientific Meeting - Diversity and Leadership

Hotel Grand Chancellor, Hobart, TAS

https://www.dcconferences.com.au/rmsanz2023/home

20-22 September 2023

European Pain Federation (EFIC)
EFIC 13th Congress - Personalised Pain Management: The future is now

HUNGEXPO Exhibition Centre, Budapest, Hungary

https://europeanpainfederation.eu/efic2023/

1-4 October 2023

International Association for the Study of Pain (IASP)
The International Symposium on Pediatric Pain 2023 (ISPP 2023)

Halifax Convention Centre, Halifax, Canada

https://ispp.joyn-us.app/

6-8 October 2023

Faculty of Pain Medicine (FPM)
2023 FPM Spring Meeting

Pullman Adelaide, Adelaide, SA

https://www.anzca.edu.au/events-courses/events/anzca-and-fpm-annual-events/fpm-annual-events/2023-fpm-spring-meeting

24-25 October 2023

Australia & New Zealand Musculoskeletal Clinical Trials Network (ANZMUSC)
Australia & New Zealand Musculoskeletal Clinical Trials Network (ANZMUSC)

Coogee Surf Club, Sydney NSW, Australia

https://anzmusc.org/annual-meetings/2023-annual-scientific-meeting/

14 November 2023

National Trauma Network
NTS23 "Towards Excellence"

Te Papa Tongarewa, Wellington, NZ

https://www.traumasymposium.nz/

23-25 November 2023

Australia New Zealand Society of Palliative Medicine (ANZSPM)
ANZSPM 2023 Medical & Surgical Update Meeting

Novotel Melbourne on Collins, Melbourne, VIC, Australia

https://willorganise.eventsair.com/2023-anzspm-update-meeting/

21-24 March 2024

New Zealand Pain Society (NZPS)
NZPS 2024 - Empowering Pain Management in New Zealand

The Dunedin Centre, Dunedin, NZ

https://www.nzps2024.nz/

21-24 April 2024

Australian Pain Society (APS)
2024 Australian Pain Society 44th Annual Scientific Meeting

Darwin Convention Centre, NT

https://www.dcconferences.com.au/aps2024/

3-7 May 2024

Australian and New Zealand College of Anaesthetists (ANZCA)
ANZCA 2024 Annual Scientific Meeting - Limitless

Brisbane Convention & Exhibition Centre, Brisbane, QLD

https://www.anzca.edu.au/events-courses/events/major-events/2024-anzca-asm

Vision, Purpose & Priorities

Vision:

All people will have optimal pain management throughout life.

Purpose:

The Australian Pain Society is a multidisciplinary association whose purpose is to advance pain management through education, research, and advocacy for transformational improvements in clinical care.

Priorities:

In order to achieve our purpose, the Australian Pain Society will provide:

- Membership
- Research
- Education
- Services and resources
- Good governance and operations
- Advocacy

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