Volume 43, Issue 4, June 2023

Australian Pain Society
Newsletter

BLOG WEB

THE
AUSTRALIAN
PAIN SOCIETY

Contents

Editor's Note

Dr Lincoln Tracy

After a brief break to recover from the amazing Annual Scientific Meeting (ASM) in Canberra earlier this year, the eNewsletter is back! This month's edition is packed to the brim with lots of great content, including a report from our new President Joyce McSwan, about her recent trip to Bangkok for the Association of Southeast Asian Pain Societies Congress (ASEAPS).

I am very pleased that the eNewsletter will again feature reflections from our ASM travel grant recipients about their experiences, with the first cabs off the rank included in this edition. Like last year, the submissions we have received to date are of an exceptional quality. Keep an eye out for more reports as we move into the second half of the year!

On a more serious note, I have seen two instances over the last few months where Cochrane reviews have attracted some "interesting" responses.

The first review, which was published in January, assessed the effectiveness of physical interventions to reduce the spread of respiratory diseases such as COVID-19. This review attracted a lot of attention, especially online, as the results suggested that "wearing masks in the community probably makes little or no difference to the outcome of laboratory-confirmed influenza/SARS-CoV-2 compared to not wearing masks." I'll let the experts talk about what the review found and why you should still wear a mask despite its findings.

The second review, published in March, assessed the benefits and harms of spinal cord stimulation (SCS) for people with chronic low back pain. This review was authored by individuals who are well-known to the society. In brief, the review found the data they examined "do not support the use of SCS to manage low back pain outside a clinical trial" and that the procedure "probably does not have sustained clinical benefits that would outweigh the costs and risks of this surgical intervention."

The spinal cord stimulation review attracted a response from a reader that challenged the approach and findings of the review, and the authors of the original review have now had the opportunity to respond.

The conversation surrounding these reviews, including a recent opinion piece questioning whether we should trust Cochrane reviews, has taught and/or reminded me of a few things:

1. Anyone can post a comment in response to a Cochrane review. They even have a prize for the best response that critically appraises reviews published by Cochrane.
2. We should encourage public discussion regarding accepted or published papers on a more regular basis.
3. The importance of keeping discussions where you may disagree with someone or something civil, even if you aren't standing directly in front of them and saying it to their face.

Take care,
Lincoln

President's Report from the AGM

Joyce McSwan

Hi APS Family!

Welcome to my first President's report.

It was truly a delight to see so many of you at our recent Annual Scientific Meeting (ASM) in Canberra in April. Thank you so much to those who came up and introduced themselves to me, and for your encouraging and kind words of support!

The energy level was palpable at this year's ASM, and it was fabulous to see so many first timers joining us in Canberra. One of the repeated comments I received was the true "MDT" (multidisciplinary) culture of the Australian Pain Society (APS) and how delegates appreciated the diversity and inclusivity of the conference. Certainly, one of the highly valued benefits of the APS ASM and ongoing membership is the generous sharing of information between the various networks well beyond the conference!

Thanks to ALL of you for making it the success that it was! Healthcare partners need to support and validate each other now more than ever, and there is no better way than to be part of an inclusive pain community such as the APS!

Thanks again to Alex Robertson from DCC&A, the local Organising Committee led by Dr Andrew Watson, and the Scientific Program Committee under the leadership of Prof Kevin Keay for yet another epic and meaningful program. The recordings of the presentations are now available for purchase via Evertechnology.

Congratulations to Dr Michelle Harris for presenting this year's IASP Global Named Lecture titled: *"The Person not the Pain: Integrative Pain Care in the Acute Setting"*, who spoke with such inspiring creativity! And a hearty salute to our international keynote speakers Professor Ted Price from Texas, USA and Associate Professor Melanie Noel from Calgary, Canada. The passion of their work gave so much hope to the new frontiers in pain management and they both gave us great perspectives, insights, and knowledge on how we can impact generations to come with the work which we all do.

This conference also saw the first meet up of our painSTAR participants since the interactive pain school in November 2022, and planning is underway for the next one in November 2024!

I recently had the great pleasure in attending the 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress in Bangkok. The APS has supported the ASEAPS Congress since 2013 by offering the APS ASEAPS Award, and I certainly enjoyed meeting our ASEAPS partners and participating in judging and awarding this prize.

On a global front, the International Association of the Study of Pain (IASP) is celebrating their 50th Anniversary in 2024. Throughout 2023 and 2024 the IASP will celebrate this milestone with 50th Anniversary initiatives, culminating at the 20th World Congress on Pain next August in Amsterdam. We are so proud that our very own Professor Michelle Sterling is Chair of the 2024 Scientific Program Committee.

Planning is underway for our next APS conference in Darwin in 2024. Get in early and arrange your leave for April 21-24 and join us at the Darwin Convention Centre. Keynote speakers include Dr Christine Chambers from Dalhousie University, Canada and Dr Cheryl Stucky from the Medical College of Wisconsin, USA who will be joining us there! Expressions of Interest are open for those keen to present, attend, exhibit, and sponsor! Don't forget June is an important month as this is when the portals open for topical session submissions, free papers & poster submisions and Rising Star Award applications.

Exciting times are ahead, and I truly look forward to working with the incredible board members and Scientific Program Committee. Not only are they talented contributors to the APS but they are supportive, compassionate, and thoughtful souls! We truly are so lucky to have such generous hearts in this APS family!

As I sign off, I'll leave you with the inspiring words of Henry Ford:

"Coming together is a beginning, staying together is progress and working together is success!!" - Henry Ford

Keep doing the amazing work that you all do!

With gratitude,
Joyce McSwan

Post Conference Review of the Australian Pain Society 43rd Annual Scientific Meeting

By Andrew Watson, Local Organising Committee Convenor, Scientific Program Committee Member and ACT Director

Exhibition Hall & Poster Display

With over 500 delegates in attendance, there was a real buzz at the Australian Pain Society (APS) Annual Scientific Meeting (ASM) in the nation's capital this year. The sheer joy of meeting face-to-face again, facilitated by a well-constructed social program, was a big part of this. The mainstay, the scientific program, was simply magnificent.

The IASP Global Year theme was *Integrative Pain Care* and our meeting explored this in style. We kicked off with a range of fabulous pre-conference workshops. What followed showed even further the real strength of the APS: the passion and diversity of its membership. The broad range of sessions, generated by excellent basic science researchers, clinical researchers, and practitioners in every field is the real point of difference to this meeting.

Dr Melanie Noel

Our international speakers had extraordinary knowledge and ability to communicate as well as genuine enthusiasm to contribute to the wider program. Dr Melanie Noel delivered a masterclass with her plenaries, sharing research and programs from her domain of excellence in child psychology in an inspiring way and delivering a string of gems to incorporate into the management of the adults I see in my practice.

Professor Ted Price

Professor Ted Price from the University of Texas was similarly inspirational. His background is as a basic science researcher and in forming companies to bring these findings into the clinical domain. His research, expanding our basic research on nociceptive pathways into humans is transformative, and it was exciting to see how he identifies key targets for new and different therapeutic agents. Both speakers contributed so much more than expected in terms of energising the meeting.

Our national speakers were equally as impressive, with Dr Michelle Harris speaking on an integrative whole person approach to pain on the acute pain round. Dr Joshua Pate delivered an engaging presentation on how we could educate kids about pain in school, and Rising

Dr Aidan Cashin, Rising Star Award Recipient

Star Award winner Dr Aidan Cashin explored the mechanisms for intervention and translating this into clinical practice. The Bonica Lecture, delivered by Professor Denise Harrison, both reviewed the use of sweet solutions for treating pain in infants and asked a provoking question: When is there enough evidence that a question is answered?

Professor Richelle Mychasiuk examined the key relationship between sleep and pain and how research is changing our understanding of this, while later in the day Professor JP Caneiro delivered another great plenary “from fear to safety” about managing musculoskeletal pain. Professor Ian Harris challenged some “sacred cows” by demonstrating the critical need for us to perform placebo-controlled trials for many of our current interventions and surgeries in a provoking analysis of orthopaedic publications. Dr Sarah Wallwork, Cops for Kids grant recipient, finished the session with a great summary of her work using picture books to transform conversations about pain- I found it interesting to discover that while digital products would be viewed once, these books were generally read several times.

Our national speakers were impressive and highlighted the high quality of work done in Australia. This extended beyond the plenaries to the 18 topical sessions which succeeded in covering a diverse range of subject (in-depth with great subject matter expertise), in a way that enabled experts to delve deeper into their specialist field, as well as sampling something completely different.

As well as the pre-conference workshops and concurrent topicals, there were a range of engaging initiatives from One Thing, Rapid Communication Sessions, and the Trainee Session *“Pick the Brain of a Pain Researcher”*. A real standout session was the panel on pain in the media, titled *Navigating ‘pain in the media’ from the perspectives of a journo, a researcher, and a social media guru*. For this session we were joined by renowned journalist Liam Mannix (The Age, Sydney Morning Herald), Professor Giandomenico Iannetti (University College London), and Dr Edel O’Hagan (University of Sydney, Westmead Applied Research Centre). Associate Professor Tasha Stanton did an excellent job pulling this session together and the panel discussion gave the audience an opportunity to participate in such an interesting and necessary conversation.

Congratulations to our three abstract prize winners, everyone did such a fantastic job and the poster sessions at lunch time were really buzzing! Always exciting to see new research being presented. Our prize winners were:

L to R: Tasha Stanton, Fernando Tinoco Mendoza

Free Paper

Fernando Tinoco Mendoza: Altered regional blood flow associated with spinal cord injury and the neural changes driving chronic pain


L to R: Tasha Stanton, Amelia Mardon

Poster

Amelia Mardon: What pain science concepts are important to females with persistent pelvic pain? A reflexive thematic analysis

Rapid Communication

Hannah Kennedy: Towards better educational interventions for chronic pain: An exploration of the 'Proctectometer' tool in young people and adults

Intertwined with the scientific program was a social program that gave delegates the opportunity to connect and create new relationships in a more casual environment. Thank you to those who joined me for a morning run in the brisk, Canberran air. Delegates enjoyed a social drink at *Our Place on London* on the Monday evening and the opportunity to show off some great dance moves at the Gala Dinner the following night.

Thank you to the Scientific Program Committee and its Chair Professor Kevin Keay, the Local Organising Committee, and Alex Robertson and all the staff from DCC&A for their extremely hard work and dedication in making the APS ASM once again exceed all expectations, and for providing us with a most enjoyable learning experience.

I would love to also extend a huge thank you to all who came for sharing your insights and creating such a great community. Pain is both a challenging and rewarding field to work in, both intellectually and emotionally. I find the opportunities to connect and refresh, in between the sessions, invaluable. Our field is dynamic, it is rapidly evolving with new approaches in every domain. I found the meeting inspirational, stimulating and fun and I can't wait to see you all in Darwin next year.


Mrs Joyce McSwan, APS President


L to R: Mrs Joyce McSwan (Current APS President), Ms Fiona Hodson (Past President 2017-2018), A/Prof Carolyn Arnold (Past President 2003-2005), Dr Tim Semple (Past President 2011-2012), Ms Trudy Maunsell (Immediate Past President 2021-2022), Dr Geoffrey Speldewinde (Past President 2015-2016), A/Prof Anne Burke (Past President 2019-2020)

21-24 APRIL
APS2024

2024 AUSTRALIAN PAIN SOCIETY
44TH ANNUAL SCIENTIFIC MEETING
DARWIN CONVENTION CENTRE, NT

It's time to save the date for next year's conference in Darwin from 21-24 April 2024, which will bring another exciting and inspiring program. Looking forward to seeing you all there!

APS2023

2023 AUSTRALIAN PAIN SOCIETY
43RD ANNUAL SCIENTIFIC MEETING

In the IASP Global Year for Integrative Pain Care

2 - 5 April 2023 • National Convention Centre Canberra, ACT

Thank you for attending APS 2023!

Thank you to those who joined us at the 2023 Australian Pain Society 43rd Annual Scientific Meeting held in Canberra, just before Easter.

APS 2023 Photos

The conference photographs are now available to view and can be downloaded below

DOWNLOAD PHOTOS

APS Conference Recordings are Now Available

We've got you covered if you missed out on the conference or want to review and refresh on your favourite sessions!

EverTechnology recorded 37 sessions at APS 2023.
These are now available in in MP3 Audio and MP4 Video format.

Check out the various packages below:

MP3

This recording is optimised for listening on portable audio players.

Whether you listen in the car or on your portable player, the voice will be clear and present.

MP4

Features crystal clear audio with the added benefit of seeing a full-screen presentation of the speakers' slides presentation.

PURCHASE RECORDINGS HERE

APS2023

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21-24 APRIL
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Get Ready for APS 2024!

We'll be holding our 44th Annual Scientific Meeting
on Larrakia country (Darwin) in the Northern Territory from
21-24 April 2024.

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

Further information on APS 2024 will be sent out in the coming months.

Express your Interest

Please click below to register your interest in APS 2024. You will be notified of important milestones – such as when abstract portals or registrations open.

I AM INTERESTED

We look forward to seeing you in Darwin!

Should you have queries, please contact the [Conference Secretariat]()

Sagan, Spin-outs, and a Slovenian Basketballer: A Chat with Professor Ted Price

Professor Theodore (Ted) Price is the Director of the Center for Advanced Pain Studies in the Department of Neuroscience at University of Texas at Dallas. The Center is interested in the molecular mechanisms driving the transition to chronic pain and focuses on developing novel drug therapies for chronic pain. In addition to his research work, Price has experience in 'spinning out' companies from his lab, including CerSci Therapeutics and Doloromics. Price was an international keynote speaker at the 43rd Annual Scientific Meeting (ASM) of the Australian Pain Society, held in Canberra from April 2-5, 2023. In the lead-up to the ASM, Price spoke with Lincoln Tracy, a researcher and writer from Melbourne, Australia, discussing how Carl Sagan's 'Cosmos' was an unlikely start to a career in pain research, his experiences as Editor-in-Chief for Pain Research Forum, and his love of the Dallas Mavericks. Below is an edited transcript of their conversation.

What was your path to pain research?

It was very indirect. I started in science – physics, specifically, as I wanted to be an astrophysicist – but eventually realised I wasn't quite good enough at the connection between the math and the physics to make a career of it. At the time I had a really great supervisor who suggested I try neuroscience, and I absolutely loved that. After I was drawn into neuroscience, I had every intention of working on the underlying mechanisms of depression and how we could develop new antidepressants and went off to grad school to work specifically in that area. During the interview process I happened to meet Chris Flores, who would eventually become my PhD supervisor. He was such a nice guy, and their lab had a fantastic environment – so I ended up staying there for my PhD.

But even while I was doing my PhD, I wasn't fully committed to staying in the pain field. It took me until I was doing my postdoc at McGill University to realise that pain was really for me. I think it was a combination of working with people like Fernando Cervero, Catherine Bushnell, and Jeffrey Mogil, who were all giants of the pain field and had collectively built this amazing centre. Those experiences helped me to decide that this was what I wanted to do, at least for the first part of my professional life.

What sparked your initial interest in astrophysics? Was it growing up at a time when space exploration was still quite common?

Seeing people going to space helped build that interest, but it really originated with Carl Sagan's Cosmos, which came out when I was a little kid. I was a pretty little kid, but I remember watching it live on PBS with my parents and was completely blown away by it. I was hooked. It was an amazing series because it was built for everybody on the planet and everybody connected with it, which is hard for a TV show to do. But it had a giant impact on me.

What are some of the major projects you and your colleagues at the Center for Advancing Pain Studies are working on most intensely at the moment?

Our big focus is trying to obtain a detailed understanding of human peripheral pain-sensing neurons and the connections they make in the spinal cord before eventually taking this into the brain. The brain imaging people have done an amazing job, but we still don't have a lot of details at the molecular level about the neurons that make up these pathways and circuits. We, and several other groups, have collectively developed technologies that have led to big advances in how we understand the peripheral nervous system.

The other big focus is trying to develop non-opioid therapeutics. Although there are a lot of different ways to think about treating pain, most of the group here have a neuroscience or pharmacology background – we're more drug focused people – and so there's a big effort to try and do better on that front. This is a big motivator for me personally, as I lived with neuropathy for a decent part of my life. I'm much better now than I have been for a long time but that personal experience motivates me.

One of the amazing things at McGill was how they integrated basic science and clinical care. This allowed me to learn how pain impacts peoples lives on a very personal level, which had a significant influence on me. I think a lot of people don't know the impact that pain has on people's lives because people often live with chronic pain quite silently. They don't necessarily tell people that they have the problem. It also often drives people to decrease their social lives a lot, and that makes it so less people know about the experiences that many people have with chronic pain. I consider myself really lucky to have been trained in an environment that gave me such a strong appreciation for that. That's another big motivator for me.

You previously served as the Editor-in-Chief for the Pain Research Forum – how did you get involved with the Editorial board, and what was your time as Editor-in-Chief like?

This is another situation where I was really lucky to have been at McGill – we got to meet all these amazing people who were involved in basically every aspect of pain and neuroscience. I can't remember who I met that was on the editorial board initially, I think it was Catherine Bushnell, and she suggested I join the board basically from the outset of Pain Research Forum. I became quite involved with all of it pretty quickly, because I like a lot of the outreach activities PRF was doing, and became really good friends with Neil Andrews, who was the Executive Editor of PRF for nearly a decade. Neil was such a joy to work with. I'm proud of the time we had there together and how we were able to build PRF into what it is today.

You have co-founded or been involved with several companies such as Doloromics, what drives your involvement in this space?

I think that if you want to see the work that you do make it to the clinic, you really have to start commercial ventures as that's the only way you can raise the money to turn your ideas into therapeutics. That's been my experience in the United States, at least, and I think it's a similar situation in Australia. As much as I love the discovery side of research, as I have moved on in my career, I've been motivated to try to create therapeutics that are going to help people – and I don't see any other way to do it.

It was a steep learning curve to get involved in the commercial side of things, because we don't train people for that in academia. I had some negative experiences initially. But I learned a lot from them, and I feel like I know my way around things and can defend myself adequately, if need be. It also helps that we have built one successful company because people can recognise our success and that we can do it. Now I really enjoy getting to work in both academic and commercial spaces. They're very different, and the things that motivate people in each of them are different, but there's brilliant people in both spaces.

If you had an unlimited bucket of money, what would you do as your dream research project?

I would essentially keep doing what we are already doing at Doloromics. At this point in my life, I firmly believe that personalised medicine for pain is a doable thing. And I don't mean individual-by-individual. Rather, I'm talking about large yet focused patient groups. I think we can identify mechanistic biomarkers within those populations and target therapeutics to interrupt the way those biomarkers work. That's exactly what we're doing at Doloromics. While we don't have an unlimited pot of money just yet, we do have a wonderful group of investors and we're building a really great team. Eventually we're going to have a chance to start building what we all believe is possible; we just need to keep committed to that idea and keep pushing the science forward as fast as we can.

It's an incredible time to be doing that because the technologies, especially for the cellular profiling, are just amazing. It's super exciting. Sequencing is going to get way less expensive. Proteomics are improving dramatically, and we're moving towards single cell, or at least groups of cell proteomic technologies and all sorts of other -omics are coming behind that. There are so many huge opportunities on the horizon – none of this stuff even existed when I was a graduate student.

If you could give your younger self one piece of advice, what would it be?

I definitely should have learned to code [laughs]. As we become more and more focused on being very data-centric in the way we do our basic research, I don't have the appropriate statistical or analytical tools to deal with a lot of what I'd like to do. So, I feel that was a mistake – not committing more to learning how to code when I was younger and more capable of learning new things.

Anyone who follows your Twitter feed can see you're a big sports fan. Would you rather see the Dallas Mavericks win the NBA Finals, or the Dallas Cowboys win the Super Bowl?

Mavericks, for sure! I love the Cowboys, but basketball is my true love in terms of sports. I always wanted to be a better basketball player than what I was, and if you gave me the choice to do anything, it would always be to play basketball. The same goes for if you gave me the choice to watch anything – it would be the NBA. I had the pleasure of living in San Antonio when the Spurs were on top of the league, and that was great, but it's been fun to be back in Dallas with the Mavericks playing as well as they have. It's going to be super interesting to see what happens with Luka [Dončić] and Kyrie [Irving], now the Mavericks have just traded for Kyrie.

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.

Pain as the Signature of Humanity: A Chat with Associate Professor Melanie Noel

Associate Professor Melanie Noel is a paediatric pain scientist and psychologist at the University of Calgary, Canada. Noel is also the team lead of the Pain Education, Advocacy, Knowledge (PEAK) Research Lab, a dynamic and interdisciplinary group housed between the University of Calgary and the Vi Riddell Pain Program at the Alberta Children's Hospital. She is passionate about partnering with people with lived experience to transform how we understand and treat people with pain, advocating for the use of evidence-based and developmentally tailored interventions. Noel was an international keynote speaker at the 43rd Annual Scientific Meeting (ASM) of the Australian Pain Society, held in Canberra from April 2-5, 2023. In the lead-up to the ASM, Noel spoke with Lincoln Tracy, a researcher and writer from Melbourne, Australia, discussing how she became a paediatric pain scientist and psychologist after starting as a business student, how the way she thinks about pain and research has changed over time, and more. Below is an edited transcript of their conversation.

What was your path to becoming a paediatric pain scientist and psychologist?

I always say that I fell into the field of pain – if you'll pardon the pun. I was an undergrad who didn't really know who I was or what I wanted to do. I ended up studying business initially because that's what my dad did. Along the way I took a psychology unit and ended up having a not even quarter life crisis – I was only 20 at the time – and realised I would much rather do psychology than feed the capitalistic machine.

It was really one professor, Carole Peterson, who played such a pivotal role in this change. She was passionate, quirky, and had such big ideas… she really helped me fall in love with developmental psychology. Carole was looking for research assistants to sit in an emergency department one summer and wait for parents to bring in their injured children. She was interested in whether children could be reliable eyewitnesses and used following them up over time after painful injuries as a model to test that. I still remember the moment when I was working with a particular child – going to their home, interviewing and engaging with them – I knew I was hooked. I knew I had to work with children.

After that I pursued a master's in developmental psychology, mostly focusing on language. It was around this time I knew I wanted to understand how to combine science and working therapeutically with kids. This led me to apply for clinical psychology programs and found Christine Chambers. As I'm sure a lot of people know, Christine is a guru in the paediatric pain field, but I was drawn to her because she merges paediatric pain with developmental psychology. I was really lucky – I certainly wasn't the top applicant – but Christine saw my potential and hired me as a research coordinator. Eventually I got a spot in the clinical psychology program.

What was it like working with Christine as a graduate student?

I knew she was a mum in academia when I saw she had pictures of the junior scientist – her child – on her website. Christine was doing this incredible, clinically informed work on pain in the children's hospital that was also developmentally relevant, so it seemed like a great fit. And she's one of those brilliant supervisors who doesn't get graduate students to simply propel her own agenda. I remember her asking me what I wanted to do from a research perspective and not really knowing – I wasn't expecting her to give me the option! It was daunting at the time. But I went away and thought about my earlier experiences back in Newfoundland as an undergraduate, and ultimately decided on memory for pain. Christine loved that idea, helped me shape it, and things went from there.

What are you working on most intensely at the moment?

I always want this to be a simple answer, but it's hard [laughs]. If I had to explain the main buckets, it would be memory, narrative and story, trauma and mental health, and intergenerational transmission. I can't nail it down to just one thing, but language and narrative tie it all together to try and understand what are the external forces that influence the experience of pain and what happens inside the brain and the body.

So as one example, we have projects focusing on memory, both in terms of the interplay between the memory regions of the brain and our language and memories in the transition from acute to chronic pain. We're looking at this transition in concussion and surgical populations – amongst others – about the narratives of pain. What are the cultural or societal narratives? Or the narratives between clinicians? And what are the stories we tell? How do we reminisce and talk about things that happened in the past? We have developed interventions to teach parents and clinicians how to talk to children who have experienced pain in simple ways to reframe how they remember and reminisce about the pain. And these interventions can improve pain experiences, as well as helping to shape empathy for pain in the future.

This relates to another line of work I have about the intergenerational transmission of pain. We're interested in if and how the pain or trauma of your parents or grandparents can influence the likelihood that you will develop or have issues with pain. We work with developmental neuroscientists in Australia – namely Professor Richelle Mychasiuk from Monash – on the neurobiological and epigenetic mechanisms that underlie the intergenerational transmission of pain and trauma. In addition, we have amazing collaborations with other researchers who have large birth cohorts where they followed pregnant mothers and their children, who are now 13 or 14, to explore how the pain and trauma reported by mothers affects the risk of pain and mental health conditions in their children. I'm really passionate about the merging of pain and mental health fields. There's such a strong bidirectional relationship between the two – pain needs to be on the mental health agenda.

Lastly, I'm fascinated about the social and clinical interactions people with pain have. For example, we are studying diagnostic uncertainty, and why people believe something serious is causing their pain and the doctors simply haven't found it? What role does the validation – or invalidation – of pain play here? This ties in with an interest about how pain is portrayed in popular media, like cartoons, on Netflix, and in Hollywood movies. We're doing some rigorous coding of pain instances in these shows and movies, which means taking an intersectional lens and looking at how the sufferers are being responded to, whether people are empathic, and whether that differs based on your race, ethnicity, gender, and sexuality. The broader systems and systemic influences play such an important role.

In a 2018 interview you said that your most pressing research question was why acute pain becomes chronic in some children. Is this still the case?

That's a great question. Prevention is still very important, but the way I think about prevention and has changed. At that time, I was thinking about the brain, and what's happening at the individual level in terms of the child and their parent at the clinic. Now, I think more about how we can inform prevention before a child is born – how can we understand how to address or prevent pain from a cultural or societal levels? That is, thinking about systemic structural issues, influences, and oppressors, and how they influence and drive ideas and policies around pain.

I'm still thinking about what happens in the brain – but as I mentioned before, we need to focus more on those broader influences. And we need to be actively recruiting sociologists, political scientists, anthropologists, and a suite of other people who think about these broader systems. I feel that if we don't understand the influence institutional, societal, and cultural factors have on pain, there's only so much you can do to change how someone thinks and feels about pain, or how someone talks to them about pain, if they're going straight back into communities that aren't set up to validate and support them.

What have you learned about yourself as you have progressed through your career from being an emerging researcher to leading the Pain Education, Advocacy, Knowledge Research Lab?

I've learned that we need to evolve as people as our field of research – and society more broadly – evolves. A lot has happened in the eight years since I first became a Principal Investigator (PI). Who I was when I started my faculty position is not who I am today. But those roots from the early days are so important. But I do feel the way I approach being a PI has drastically changed from when I started. There is great power in community and taking a communal approach to academia, which is traditionally very individualistic.

And I think that change has been a great superpower for me – collaborating with great colleagues and having great students who become great friends. I've learned that I'm at my happiest when I'm being less individualistic and more communal. And the landscape is really changing to help support this. There's no longer a one size fits all approach to how we should do things or what we need to do to be successful. I love the sense of building community, and carrying on what I learned from my mentors by devoting more of my career to fuel the inspirations and strengths of others. That's what fuels me at the moment.

Speaking of change, what impact do you feel COVID has had on the way you and others work?

While I can't speak for all of Canada, the impact of COVID depends on who you were and your approach. But I feel it's given us a lot more freedom, made us more nimble, flexible, and creative. The last few years have also removed barriers for people. I say that from my experience as a single mother of triplets, but also from seeing what some of my trainees who have relationships abroad or who have disabilities have experienced. It's made it easier for them to engage and to be a part of this community – and that's fabulous. I'm also on sabbatical this year, and that's been amazing in terms of the freedom it allows. I was in South Africa recently teaching workshops, and someone said "pain is the signature of humanity". And that's so right – it's the great unifier. People think pain is such a niche area, but it shows up everywhere.

But the last few years have also changed how we, myself included, think about equity, diversity, and inclusion. It's accelerated and caused discomfort in a good way, that we are more accountable for the things we do and don't do. The way I conceptualise research and the questions that I ask are completely different – I'm more structural and systemic than I ever was. Even being a PI has changed as a result of the last few years, my lab is so much more diverse now than it was in the before times. But I don't know if I would have gotten to this point if things such as the pandemic and [the murder] of George Floyd really shone a spotlight on how our field is not as inclusive as it needs to be, despite pain being the signature of humanity. We need to be better at recognising that we've all dealt with a collective – but not uniform – stressor and trauma.

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

Expect the unexpected – and hope for it. Some of the best ideas have come from things that were unexpected, and some of the best directions or changes in my life were because unexpected things happened, even if it was a difficult journey to get there. I think you need to learn and grow outside of academia. I feel I'm a much better pain researcher because I spend time taking in the arts, learning about things that I think have nothing to do with pain because eventually you find yourself drawing amazing connections from understanding other things beyond what your dissertation is about. It's important to keep evolving and learning about things, rather than just staying in our own lanes, and doing things the same way. But don't do it with the mindset of trying to relate things to pain. Fuel your passions and your interests. One of the cool things about pain is that it touches everything. The connections will appear eventually – you don't have to force them.

What are you looking forward to the most about coming to Australia for the ASM?

The people! I have incredible Australian colleagues – there's a different energy that I love about the Australian pain community. You are global leaders in this area and there's a real rigor about what you do, yet you're so fun and quirky. There's an authenticity about Australian pain researchers, which really speaks to me. Your country is like Canada, but more fun and with better weather! I'm excited about engaging and connecting with the people and community when I'm over there for the ASM. I can't wait to see how you come together to solve problems and have fun at the same time – I'm looking forward to being part of that energy and coming up with new ideas.

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

Making a Career from a Childhood Job: A Chat with Professor Denise Harrison

Professor Denise Harrison is a registered nurse, midwife, and professor in the Department of Nursing at the University of Melbourne. Harrison has worked both in Australia and Canada and was the inaugural Research Chair in Nursing Care of Children, Youth and Families at the University of Ottawa and Children's Hospital of Eastern Ontario in Canada. She leads the interdisciplinary Be Sweet to Babies research team which, together with parents and clinicians, aims to improve pain management in neonates, infants, and young children. Harrison was a national keynote speaker and delivered the Bonica Lecture at the 43rd Annual Scientific Meeting (ASM) of the Australian Pain Society, held in Canberra from April 2-5, 2023. In the lead-up to the ASM, Harrison spoke with Lincoln Tracy, a researcher and writer from Melbourne, Australia, about her path to becoming a paediatric intensive care nurse, the similarities and differences between Canada and Australia, and her love of running. Below is an edited transcript of their conversation.

Denise, you were a neonatal intensive care nurse when you first jumped into the world of pain research. What first drew you to nursing, and then how did you progress to working in the NICU?

I used to love looking after little babies, even when I was a little kid. When I was six or seven, my parents had friends with a couple of children around my age, but they also had a young baby. I absolutely loved the baby and spent a lot of time looking after her – back then people were obviously more comfortable leaving little kids alone with babies. I remember I would spend a whole hour sticking a dummy in the little pot of sweet glycerine that the mother had provided 'for emergencies' putting it the baby's mouth, back in the pot, back in the mouth, as a way to calm her. It's kind of ironic that my whole research career would end up revolving around sweet solutions for pain management in babies. I cared for a range of different families, and from 13, I was basically a full-time nanny in the school holidays.

So, when I was at school and I was trying to decide what I wanted to do as a career, I originally considered mothercraft nursing – similar to what you would call an enrolled nurse today. The careers counsellor told me those roles were being phased out, and she was exactly right. I pursued nursing instead and figured that would lead me to working with babies somehow. I loved almost every rotation I did – except for being a recovery nurse, I hated that with every bone in my body – but I still really enjoyed being on the paediatric ward.

Eventually, I saw the Royal Children's Hospital in Melbourne were advertising for non-experienced neonatal nurses. That was my in. I had no idea what working with really sick babies would be like, but I absolutely loved it there, working in several different roles, including studying paediatric intensive care, midwifery, then completing graduate research studies. Even when I left the neonatal unit for my studies, I always returned back to the neonatal unit.

You've worked both in Australia and in Canada – are there a lot of similarities or differences between the two countries?

Australia and Canada – or wherever I went in Westernised countries – were pretty similar from a clinical perspective when you think about the neonatal intensive care unit. I felt like I could walk in, take my jewellery off, roll up my sleeves, and it would be no different. But at the time, I was offered the great opportunity to undertake postdoctoral studies with Professor Bonnie Stevens, a neonatal pain research guru. During my postdoctoral fellowship in Toronto and then my time at the Children's Hospital of Eastern Ontario, there were excellent grant opportunities for knowledge synthesis or translation, so I was able to expand my program of funded research.

There were also more opportunities to support undergraduate nursing students to do research, which I felt really privileged to be involved in. I got to mentor around 30 undergraduate nurses in research. However, times have changed too. I moved back to Australia just prior to the COVID-19 pandemic, so it's possible I was there when more opportunities were available; before much research pivoted and changed because of the pandemic.

Otherwise, the biggest difference is that The University of Ottawa is officially a bilingual university, so I had to learn French. I was lucky that I didn't have to teach in French – my contract was to teach in English – but I did have to be able to understand and read the language. So, that was a big change [laughs].

What are you and the Be Sweet to Babies team working on most intensely now?

We're currently surveying nurses, midwives, and phlebotomists who work in Australia about how they use pain management during routine painful procedures in both babies in neonatal intensive care all the way through to healthy, full-term babies. We have about 500 responses to date, and the survey will be open for another month. We're doing this because the last lot of data collection about pain management in newborns in Australia was done well over a decade ago. Getting an up-to-date baseline understanding is important because it's challenging to propose an intervention to improve pain management if you don't have a solid understanding of what is already happening. We have previously surveyed parents on their perspectives of how things can improve; this second survey will be an important and complimentary piece of work.

We are interested in learning about whether nurses and midwives are encouraging and supporting mothers to breastfeed, or all parents and carers to hold the baby skin-to-skin during the heel prick test every baby gets in the first day or two after being born. And we're actively trying to help clinical staff to support parents – we've made an ergonomics video with a multidisciplinary team to show nurses and phlebotomists how to best position themselves so they can successfully do the heel prick test while a baby is being breastfed or having skin-to-skin contact.

We want to focus on supporting parents on how to help calm their baby during the rest of their development, such as when they receive all their vaccinations during childhood. Because developing a fear of needles is a real thing, and helping parents implement effective strategies from the really early stages could have significant benefits for years to come.

You were recently part of a study exploring elevated sound levels in the NICU – why is this an important area of research?

Neonatal intensive care units are incredibly busy. There are so many sick babies and alarms – it's really non-stop. Because of this, a lot of units would try to have a period of quiet time where there were no painful procedures performed or rounds undertaken for an hour or two just to give everybody – the babies, the staff, and the parents – a chance to get some quiet. But over time, one particular unit in Ottawa where I was working stopped having quiet time. And there's a number of reasons for that, such as it being an older style unit with between four and eight babies in very large rooms. It makes it hard to minimise the noise.

Eventually, Kelli Mayhew, one of the clinical staff who would go on to become my master's student, became aware of how loud the unit was and realised somehow the quiet time had just disappeared.

So, we bought Kelli a sound meter and after collecting thousands upon thousands of data points, she showed that the sound levels were consistently above the noise levels recommended by the American Academy of Pediatrics – in a lot of cases it was almost double the recommended level. But a lot of the noise was nurses and doctors talking, with more of noise attributed to the nurses because we're there all the time. Then the question becomes, 'short of building a whole new hospital, what can we change about the culture to reduce the sound?' And we can look at strategies such as modifying our own voices or resetting the alarms so they're loud enough for us to hear, but not so loud that they set everyone off.

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

In all the work I've done over the years, we still haven't managed to truly partner parents and staff together to care for their baby and put all the known and evidence-based pain management strategies into place. This has been a slow process, as traditionally it has been seen that doctors and nurses look after the babies, while parents are just visitors. For example, I was looking at one study where parents were really supported to be engaged in their baby's care, but they were still asked to leave the room when the baby needed a blood test. So, there's this huge gap.

And although pain management is just one aspect of a baby's care, it brings the broader idea of developmentally supportive care into play – how can we best support that baby throughout their whole hospital stay, but how can we also empower parents? They can often find themselves in a very stressful, anxiety-ridden place. Many paediatric and maternity hospitals are working towards this as the next step: bringing both parties together to look after the baby as one team. And a key part of this is having both parents and nurses on our research teams – working together to determine what research questions we have, how we're going to measure it, and how we're going to change practice.

I can see from your social media that you're quite the avid runner; how did this interest come about?

I was never a runner until a decade ago when I was in Canada. I had recently been through a period of illness. One day I was walking down some stairs and had to stop, because I felt I wouldn't be able to get back up the stairs. That moment really hit me in terms of how much conditioning and fitness I'd lost because of the illness. A friend of mine suggested I join the Running Room, which is a great business in Canada where they sell all the cool running gear, but they also do run clubs, where you can just show up and run.

Although I'd always been fit before my illness, I'd never been a runner. I was reluctant to join initially, but the idea just stuck in my head. I went along eventually and started with one of the 'learn to run' clinics they offered, before progressing to a five-kilometre run, a ten-kilometre run, and then a half-marathon. It was such a supportive group environment and a useful set of clinics – Ottawa is -30° in the winter and 35° plus in the summer – so you really needed to learn to run safely in these extreme temperatures.

Then when I moved back to Melbourne I was looking for something similar, and another friend told me about parkrun. I now run and volunteer at Parkville parkrun, my local. It's only five kilometres, which is nice, short, and isn't too hot by the 8am start time in summer. It's great to volunteer and get to know people, which you don't necessarily get when you are just running.

Finally, if you could have dinner with anyone in the world, dead or alive, who would it be?

As a nurse with a love of portraying and visualising data in a way that changes peoples minds and informs them, it has to be Florence Nightingale. She was a nurse who empowered teams around her to bring about change, but she was also a statistician who showed data in a clearly understandable way that bought about change. She clearly showed that most soldiers didn't die from their wounds. Rather, they died from infection and communicable diseases, which resulted in significant changes in terms of sanitation and overcrowding.

People think of her as this romantic vision – the lady with the lamp – but she was so much more than that. She was educated, and rebelled against her family's wishes by becoming a nurse, which wasn't seen as a suitable profession for a lady at the time. She had incredible impact on military hospitals initially, but then medicine more broadly beyond that. I'd love to learn more about how she used data to tell stories, which is what we are trying to do now with our research translation efforts. She did this way before we all thought it was a useful thing!

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.

Additional Resources

Reducing pain in newborns

Reducing pain in infants during vaccination

Pain in the Media: The Good, the Bad, and the Ugly

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. This session explored all things 'pain in the media', from the opportunities and challenges in how the media represents pain science through to how we can use social media as an innovative way to research pain conditions. Read on for a summary of the plenary panel.

Public knowledge of pain is lagging

Liam Mannix, a multi award-winning journalist from The Age and the Sydney Morning Herald, began his presentation by sharing an anecdote of an in-depth explainer piece he had written about pain. After speaking with Lorimer Moseley and Tasha Stanton and crafting an interesting article about many modern pain concepts, including how there might not be a 'pain signal', his editor came to him in disbelief.

"She came up to my desk and said, 'Liam, I'm sorry, but this article cannot be right. Everyone knows that there are pain signals. When I bang my toe, the signal travels from my toe up to my brain, and that's how I have pain'," Mannix recalled.

So, Mannix went back to Moseley and Stanton to review the article he had written and check whether he correctly understood and presented the concepts they had spoken about. He returned to his editor, who still refused to believe what he had written.

The article was never published and has been relegated to the virtual filing cabinet for the foreseeable future.

But why is the public perception of pain – including those who work in the media – so far from the reality? For Mannix, the answer is how many people think about pain in a mechanical (biomedical) sense.

"I think we live in a very mechanical society, where technology represents the solution to every problem. Every day we're interfacing with devices like our phones that run on wires, and it's very easy to think of the body in the same way. You find the bit that's broken, take it out, and replace it," Mannix postulated.

To counter this, Mannix encouraged delegates to engage with the public and push the translation of modern pain science to help people in the community better understand how pain works. Speaking with your university or hospital media and communications team are some good first steps.

Mannix acknowledged the common fear many researchers, clinicians, and scientists have about their words being misinterpreted when speaking to the media but provided assurance that journalists were there to help disseminate your work.

"Mine is a field that attracts a lot of criticism. I've heard plenty of that today, and I think it's reasonable. We do oversimplify and we do get it wrong. But I think there is one misperception about journalists, which is that we're deliberately bad actors, [that] we're trying to stitch you up or that we're trying to do the wrong thing."

"I don't think I know any journalists who didn't get into journalism for the right reasons. We want to help. We want to tell the truth. We want to take the truth to our communities, and we really don't want to be wrong."

Mannix ended on a quick note of hope, pointing to books from Paul Biegler and Rachel Zoffness as examples of modern pain science filtering out in the real world, and announced his own book on "the new science of pain" will be released in September.

What to expect when your research findings are misinterpreted

Professor Giandomenico Iannetti, a neuroscientist from University College London and the Italian Institute of Technology, joined via video link to share his experiences in dealing with the media in response to his research being implicated in the legal battle to overturn abortion access in the United States.

Iannetti was initially unaware that his work had been used as evidence to support the revocation of Roe vs Wade and was shocked when he heard the news from colleagues. The Mississippi lawyers who sought to ban abortions claimed that a foetus can feel pain.

"For many years I have used functional MRI (fMRI) to understand the meaning of the brain response you get when you deliver a stimulus that is perceived as painful. And until a few years ago, there was this misconception that the blobs you get on the fMRI scans when someone feels pain were reflecting the neural basis for pain," Iannetti explained.

"[But] what I and others have done in the past is shown that you get the same pattern of brain activation when you deliver intense, surprising, and unexpected – but not painful – stimuli, like a bright flash of light, or a sudden loud noise."

These findings were initially misinterpreted by other researchers, who went on to claim that the cerebral cortex is not necessary to feel pain. The lawyers fighting against abortion rights based their argument around the incorrect interpretation of Iannetti's results.

Iannetti felt the fellow researchers – and by extension, the lawyers – had "changed the question" his research was designed to ask. He and other scientists wrote an amicus brief to the US Supreme Court to highlight the misinterpretation and improper use of the research findings, but this was ignored.

Roe vs Wade was overturned, stripping millions of American women of their access to abortions.

The amicus brief was inevitably picked up by the media, which resulted in Iannetti receiving a significant amount of attention from journalists. Iannetti would describe his experiences with the media as a mixed bag.

"As Liam said, I could really feel and perceive [some] journalists trying to get it right and to understand what happened. For example, there was a very nice piece that came out in *The Observer* (the Sunday edition of *The Guardian* in the UK). However, there was massive variability in the types of questions I was getting from different media outlets."

Iannetti used his experiences – which included being asked about his personal views on abortion – as an example of how to highlight how to deal with potentially tricky questions that go beyond simply talking about science.

"It doesn't mean that you cannot [answer these questions]. But if you do, I think it's very important to acknowledge that you are stepping into a different field which goes beyond your scientific knowledge," he concluded.

Improving communication with patients and the public using social media

To conclude the panel, Dr Edel O'Hagan (Westmead Applied Research Centre and the University of Sydney) spoke about how we can reach, understand, and support people using social media.

O'Hagan started by discussing evidence from qualitative research studies suggesting patients aren't always satisfied with their clinical consultations. Patients need time to feel they can safely share their thoughts and concerns with healthcare professionals, which causes challenges for shared decision-making if patients don't feel comfortable communicating their expectations for management.

What's interesting is that people are more willing to speak to a computer than a real person. Pointing to evidence from a 2014 study, O'Hagan discussed how people participating in a mock mental health screening for a job interview were less concerned and more open about discussing their emotions with a virtual human on a computer screen compared to when they were told there was a real person listening to them on the other end.

"This suggests that perhaps we aren't getting the full picture in clinical encounters, that perhaps we're not creating a space where people are willing to disclose some elements of their clinical history," O'Hagan said.

It turns out O'Hagan was right about there being something missing from clinical encounters that was preventing patients from sharing important information – validation. As part of a 2021 study, O'Hagan and colleagues used data scraping tools to identify over 700 social media posts about low back pain. Half of the posts were patients seeking validation for their pain, with one in three responses containing sympathetic messages.

But social media can be used for more than just studying public posts, O'Hagan explained. Social media allows individuals and organisations to reach literally billions of people at the fraction of the cost compared to older advertising methods, such as television or radio campaigns.

For example, the "Don't Take Back Pain Lying Down" campaign, which ran in Victoria in the late 1990's and encouraged people with back pain to stay active and avoid extended periods of inactivity, was highly effective at reaching significant proportions of their target population and improving people's beliefs about back pain over time.

Yet attempts to replicate this campaign in other countries, such as Norway, Scotland, Ireland, and Canada were unsuccessful – largely due to the substantial budget used in the original Victorian campaign.

"The budget at the time was seven and a half million, which is at least 15 million these days. I don't think most research groups have that kind of budget," O'Hagan said.

In contrast, using social media to reach people and nudge their behaviour is a far cheaper yet equally effective approach. O'Hagan used an American study from 2021 to demonstrate the effects of large-scale social media advertising on human behaviour.

"It was a social media campaign run on Facebook in December 2020, at the height of the COVID lockdowns, and the aim of the campaign was to encourage people to stay home for the Thanksgiving and Christmas holidays," O'Hagan told delegates.

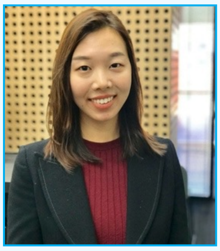
The geo-targeted campaign, which featured doctors and nurses in 20-second videos encouraging stay-at-home behaviours, reached 12 million people. The states that were shown the videos in the lead up to each holiday had fewer people travelling for the holidays, which resulted in a decrease in the number of COVID infections in the subsequent days.

"It seems like there is some value in social media nudging at behaviours, or as an intervention that supplements other interventions," O'Hagan concluded.

The session ended with an engaging question and answer component for the three speakers, covering topics such as the slow (yet welcome) decline in clickbait and how to communicate uncertainty when speaking with journalists.

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: Shania Liu

Author biography: *Shania is a PhD candidate from the University of Sydney involved in research to improve the safe use of opioid analgesics among patients receiving hip or knee replacement surgery. Shania is also a clinical pharmacist working at the Prince of Wales Hospital in New South Wales.*

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Report

I presented a poster at the Australian Pain Society Annual Scientific Meeting (ASM) on the prevalence and predictors of persistent postoperative opioid use among patients undergoing orthopaedic surgery at five hospitals in New South Wales. The main outcome of my poster presentation was the dissemination of my research findings to academics and clinicians from across Australia, as well as the opportunity to learn about others' work in this field across the nation.

The Travel Grant enabled me to travel from Sydney to Canberra to present my research at the ASM. As a result, I was able to connect with other academics and clinicians involved in pain management research, and to learn about the newest research in this space.

I have previously attended other conferences in Australia and internationally, but I was impressed by the high quality of work presented at the Australian Pain Society ASM, with presenters publishing in journals such as JAMA and the BMJ delivering insightful new research. I had the opportunity to meet colleagues as well as potential new collaborators in my area of research. Thus, I was able to strengthen and expand my professional network by attending this meeting.

I particularly enjoyed the workshop on the recently released Opioid Stewardship in Acute Pain Clinical Care Standards where I was able to meet other clinicians involved in opioid safety and discuss their local practices in this space. I was also intrigued by a presentation by Professor Ian Harris outlining surprising lack of randomised clinical trial evidence to inform the efficacy of orthopaedic surgical interventions for treating pain.

I am looking forward to attending the 2024 Australian Pain Society ASM in Darwin to learn about the latest pain management and opioid safety research, engage with current and future colleagues, and to share my own work with this community.

Declaration: Shania Liu has received funding from the NHMRC for a Postgraduate Scholarship and the Prince of Wales Hospital Foundation for research grants.

APS 2023 - Travel Grant Recipients

Watch out for the Travel Grant recipients' reports in this and following editions of the eNewsletter.

PhD Travel Grants

Ms Meredith Smith, Physiotherapy, SA
Ms Rebecca Robertson, Science Research, NSW
Ms Nell Norman-Nott, Psychology, NSW
Ms Asta Fung, Science Research, NSW
Ms Nicole Rickerby, Psychology, QLD
Mr Fernando Tinoco Mendoza, Science Research, NSW
Ms Ria Hopkins, Epidemiology, NSW
Ms Mirjana Valdes, Anaesthesia, NSW
Ms Ingrid Bindicsova, Psychology, QLD
Ms Shania Liu, Pharmacology, NSW
Ms Lydia Bastas, Anaesthesia, NSW
Ms Samantha Millard, Science Research, NSW

PinC SIG Travel Grant

Ms Nicole Pope, Nursing, VIC

BPR SIG Travel Grant

Mr Jayden O'Brien, Science Research, NSW

Annual Scientific Meeting Travel Grant Recipient Report

Author name: Asta Fung

Author biography: *Asta Fung is a PhD candidate at the University of Newcastle. Her research focuses on a telehealth-based group breathing intervention for people living with chronic pain. Asta has over 20 years clinical experience as a speech pathologist and is a graduate of the Rural Research Capacity Building Program with the Health Education and Training Institution (HETI).*

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Telehealth breathing intervention group for people with chronic pain

The APS conference is the first I have been to where the organiser or association has provided a travel grant. It made the conference experience sweeter; as a PhD candidate I felt encouraged and supported. Having been offered the opportunities to present my research in the poster and rapid communication sessions were great but also a little daunting, so having the travel grant gave me a bit more incentive to overcome any presentation nervousness.

Arriving at the APS conference, I was immediately welcomed by a buzzing vibe and a palpable sense of community and congeniality. In a sea of blue lanyard bearers, I was given an orange lanyard, which I soon learned was for the first time conference attendees. I thought to myself "How wonderful to see so many return attendees, it must be the place to be for pain people." Admittedly, I am new to the pain community as a speech pathologist, but curiously I felt included. I was overjoyed when I could finally embrace Dr Hema Rajappa from Hunter New England from the HETI Rural Research Capacity Building Program whom I have collaborated with for the last three years but have never met in person.

I presented a poster on my study, *Telehealth breathing intervention group for people with chronic pain: A mixed methods pilot study*. I learned from my participants that they viewed an online breathing training group to be acceptable and valuable for people with chronic pain as it has benefited them, has a low treatment burden, and they liked the online group delivery. I diligently followed my supervisors' advice and engaged with those who looked at my poster with interest. I managed to "capture" Dr Ali Gholamrezaei (Research Fellow at the University of Sydney), I heard about his fascinating research on breathing and gut health just the week before the conference. It was a highlight for me to have had a stimulating chat about our mutual research interest in breathing. This has since developed into delightful collaboration opportunities. The rapid communication presentation was my first experience in this format. I was intrigued by how creative other presenters were in communicating their research in 90 seconds. Being new to research, these opportunities to learn and practice communicating our research in different formats and to a range of audiences are invaluable.

During this conference, I had a delicious Japanese dinner with the Sydney Local Health District Pain Team headed by Dr Timothy Brake and the Orange Health Service Pain Team headed by Dr Claire Sui. Networking over a meal undoubtedly is as fun and fruitful as ever. From the dinner, I was invited by Dr Brake to present my research and to give a breathing practical at the post-APS conference day with his team. Out of all the informative presentations, I found Dr Aidan Cashin's talk thought-provoking. As a clinician, I often wonder why some interventions would have better results than others even when they seemed similar. What are the secret ingredients to consider when developing and delivering our interventions? There are a few points from Dr Cashin's talk that I will continue to ponder and look into, especially for my upcoming randomised controlled trial on the effects of an online breathing training group for people with chronic pain.

Next year, not only I am looking forward to progressing to the blue lanyard status, but I am also anticipating meeting familiar and new faces, and learning more about what has been happening in the pain community.

Declaration: Asta Fung has nothing to declare.

A Reflection on ASEAPS 2023

Joyce McSwan, APS President

The energy was palpable as Presidents from the Southeast Asian region gathered for the 9th Association of Southeast Asian Pain Societies (ASEAPS) Congress from the 3rd to 6th May 2023. Held in Bangkok and organised by the vibrant Thailand Association of the Study of Pain (TASP) under the leadership of TASP President, Dr Sasikaan Nimmaanrat and Chair of the ASEAP Congress, Dr Chuthamanee Suthisisang, the conference was colourful, ceremonious, and spirited by warmth and camaraderie. It was a buzzing affair of clockwork precision and making new connections. This was complemented by the high quality of the scientific program featuring contributions from world leaders in pain management such as IASP President Dr Catherine Bushnell, Dr Lars Arendt-Nielsen, Dr Mary Cardosa and our own Professors Fiona Blyth AM and Michael Nicholas, just to name a few.

Dr Suratsawadee Wangnamthip

I was incredibly proud to chair the ASEAP Presidents Panel discussion with IASP President Elect Professor Andrew Rice as well as representing the Australian Pain Society in presenting Dr Suratsawadee Wangnamthip (Siriraj Hospital, Thailand) with the Best Poster Award, which the APS proudly sponsored. Dr Wangnamthip's poster explored the incidence, characteristics, impact, and risk factors of post-COVID chronic pain in Thailand.

Dr Yogen Deo

This was also the first year the APS sponsored a Pain Camp participant, Dr Yogen Deo from Fiji. The initiative, which involves an intensive pain education boot camp, has ran for more than a decade. The generosity of such prestigious awards contributed by the APS is well appreciated and regarded by our friends in ASEAPS. Past APS President Dr Tim Semple started this legacy; I am so pleased that Tim had this vision and grateful we continue this wonderful initiative today. It is important that we remain inclusive of our neighbouring countries and do what we can to support the progression of research and education in these regions. These efforts enable other brilliant colleagues to continue to impact their local communities towards better access of multimodal pain management beyond Australia!

The ASEAPS Pain Camp has been very useful in developing the introductory Pain Education program, Essential Pain Management (EPM), developed by another past APS President Dr Roger Goucke and promoted by him and Dr Mary Cardosa from Malaysia in SE Asia and the pacific over the last 10 years.

Keep your eyes peeled for the next ASEAPS Conference in 2025 in Singapore!! A conference not to be missed!

Left to right: Dr Roger Goucke, Dr Mingota Herculano, Dr Mary Cardosa, Dr Michelle Masta and Dr Yogen Deo

Meet a Member

Sinan Tejani, NSW Director

Sinan Tejani works as a physiotherapist in Launceston, Tasmania primarily with patients experiencing persistent pain. Sinan believes in the need for advocacy to improve standards of pain care which is why he is a member of the APS and its board.

How did you get into working in pain?

I came to Australia in 2015 to pursue a Masters in Sports Physiotherapy from Curtin University, WA. Having enjoyed my time working with patients during my placements, I decided to stay in Australia to consolidate my skills as a physiotherapist. I moved to Burnie, Tasmania to start working in a private practise in early 2016 and very quickly realised the challenges of working in a regional community. Most of the patients I was seeing had complex, persistent pain in the context of multiple comorbidities and mental health issues. In order to adapt to this caseload, I set upon a journey of self-learning to better help the patients in my community.

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

My clinical focus is mainly working with patients who experience persistent pain. This caseload is often a mix of motor vehicular accidents and injuries, workers compensation, and private patients. I like working with patients on workers compensation because it allows me to use my skills as a psychologically informed physiotherapist in helping people return to work. I am interested in social determinants of health and health inequities and in my experience of working in the compensation setting, these factors are often significant contributors to pain and recovery.

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

I think there will more of a focus on inequities in pain care and more focus on social determinants of health and their impact on pain.

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

Follow what you are passionate about but make sure you take the time to enjoy the journey!

How and why did you join the APS Board?

I am a strong believer in the need for advocacy for better pain care and management. The APS has a history of doing some amazing work in this space and as an organisation it is truly multi-disciplinary, and evidence based. It was a no-brainer for me when I was given the opportunity to contribute to this work!

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

If not in the pain science field, I would have been a professional soccer player in Europe! While I love the sport and I am passionate armchair critic, I have no real skills, so I would've probably ended up a journalist!

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.

Public Listing of Members

Among the several benefits of membership is the ability for members to opt in to the **Public Listing of Members** on the APS website.

This feature is available to all members and allows basic location and contact details for individuals and their organisations/practices to be accessible to the general public via the open access area of our website.

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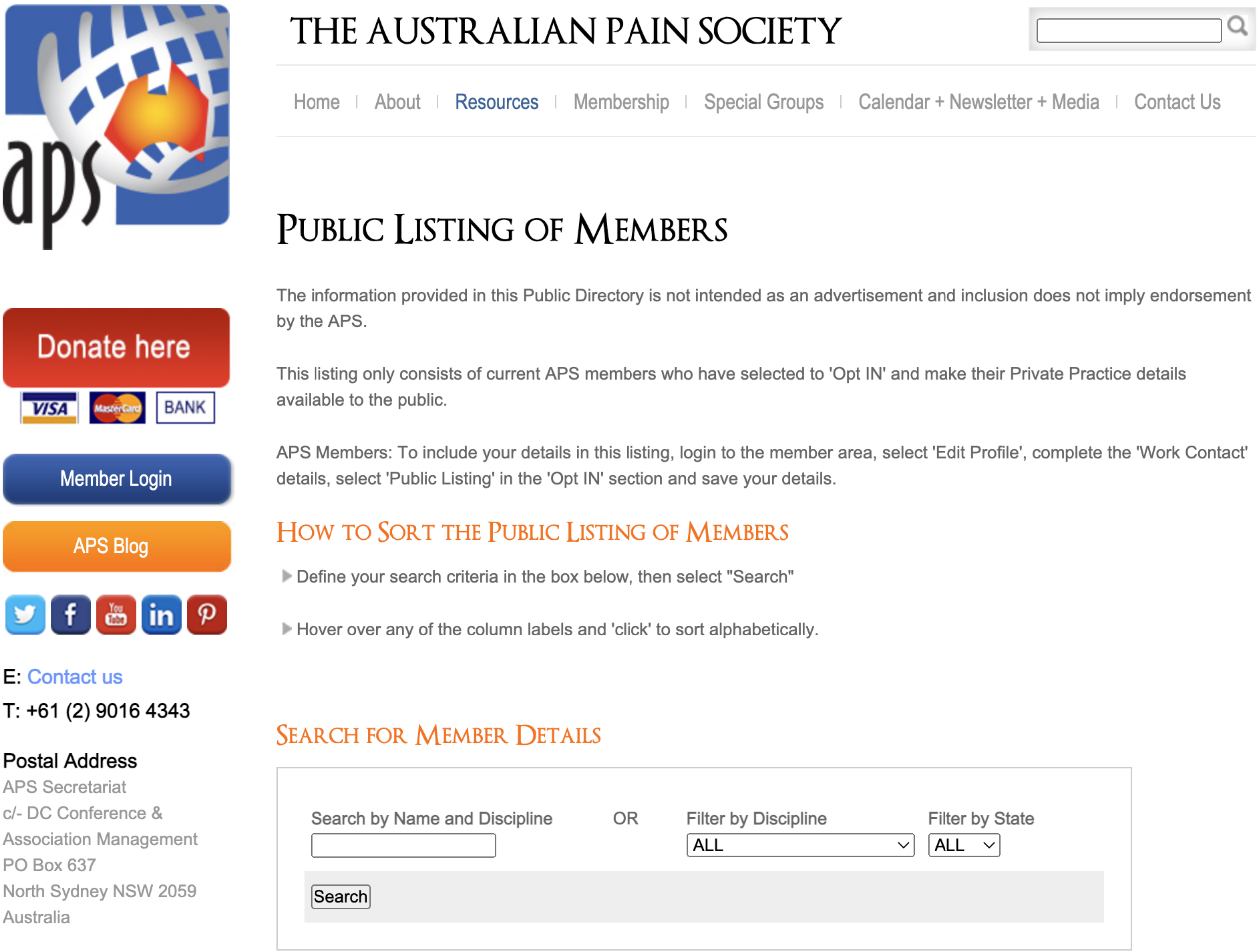

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Translating evidence: pain treatment in newborns, infants, and toddlers during needle-related procedures

Thank you to APS member Denise Harrison and colleague Mariana Bueno (SickKids, Toronto, Canada) for sharing the following recent publication.

Article first published online: 21 February 2023

Journal Reference: Harrison D, Bueno M. Translating evidence: Pain treatment in newborns, infants and toddlers during needle-related procedures. PAIN Reports. 2023; 8(2), 1-8.

DOI: https://doi.org/10.1097/PR9.0000000000001064

Abstract

Introduction

Treatment of pain in preterm, sick, and healthy newborns and infants and toddlers (up to two years of age) is consistently reported to be inadequate, and effective strategies are poorly implemented.

Objectives

To present existing evidence of effective pain treatment strategies during needle-related procedures and to highlight initiatives focused on translating evidence into practice.

Methods

This Clinical Update focuses on the 2022 International Association for the Study of Pain Global Year for Translating Pain Knowledge to Practice in the specific population of newborns, infants, and toddlers. Best evidence is reviewed, and existing knowledge translation strategies and programs available to implement evidence into practice are presented.

Results

Effective strategies for newborn and young infants during frequently occurring needle procedures include small volumes of sweet solutions, breastfeeding, or skin-to-skin care when feasible and culturally acceptable. In addition, strategies such as nonnutritive sucking, positioning, swaddling, gentle touch, facilitated tucking, and secure holding can be used. For toddlers, the evidence is less robust, and discerning between pain and distress is challenging. However, strategies recommended for needle related procedures include upright secure comfort holding by parents/caregivers, age-appropriate distraction, and topical anesthetics. Translation of effective pain management needs to involve the family, who need to be supported and empowered to comfort their child during painful procedures. Organisational, nationwide, and global initiatives aimed at improving implementation of effective pain treatments exist.

Conclusions

There is evidence of effective pain management strategies for newborns, infants, and toddlers, and a great deal of effort is being made to translate knowledge into action.

Discussion

This invited paper was part of the task force work for the Global Year for Translating Pain Knowledge to Practice (2022). These Pain Clinical Updates specifically target clinicians and focus on clinical topics; in this case, pain in newborns, infants, and toddlers.

Key Points

1. Carefully monitor the need for bloodwork and other invasive procedures.
2. Effective and safe pain treatment strategies during procedures for sick and healthy newborns and infants include breastfeeding, skin-to-skin care, and sweet solutions.
3. For toddlers during needle procedures, consistent use of (1) upright secure comfort holding by parents/caregivers; (2) age-appropriate distraction; and (3) topical anesthetics are recommended. Sweet solutions may also help to reduce pain and distress in this age group.
4. Involving and empowering parents/caregivers during painful procedures is crucial.

Declaration

Denise Harrison and Mariana Bueno have nothing to declare.

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.

Clinical utility of a mHealth assisted intervention for activity modulation in chronic pain: The pilot implementation of pain ROADMAP

Thank you to APS members Nicole Andrews and Michael Deen and their colleagues David Ireland and Marlien Varnfield for sharing the following recent publication.

Article first published online: 10 March 2023

Journal Reference: Andrews, N. E., Ireland, D., Deen, M., and Varnfield, M. (2023). Clinical Utility of a mHealth Assisted Intervention for Activity Modulation in Chronic Pain: The Pilot Implementation of Pain ROADMAP. European Journal of Pain. https://doi.org/10.1002/ejp.2104

DOI: https://doi.org/10.1002/ejp.2104

Abstract

Background

According to the World Health Organization, mobile health (mHealth) technologies can transform the face of health care service delivery across the globe. The evaluation of mHealth interventions for pain management is an emerging field that has been identified as a research priority. The aim of current study was to explore the clinical utility of a mobile health platform (Pain ROADMAP) for assisting with the delivery of a tailored activity modulation intervention through remote monitoring and the identification of activities that cause severe pain exacerbations (i.e., overactivity periods).

Design Pilot implementation.

Setting

Outpatient clinic at a multidisciplinary pain centre located in a large tertiary public hospital in Australia.

Subjects Twenty adults with chronic pain.

Methods

The twenty adult participants undertook a one-week Pain ROADMAP monitoring intervals in their own homes which involved wearing an Actigraph activity monitor and entering pain, opioid use, and activities carried out throughout the day into a custom-made phone app. The Pain ROADMAP online portal integrated and analysed the data to detect activities that caused a severe pain exacerbation (i.e., a pain flare up) and provided information about progress overtime through summary statistics pertaining the data collected. As part of a 15-week treatment protocol, participants received feedback from three dispersed Pain ROADMAP monitoring periods. Treatment focused on adapting pain-provoking activities, gradually increasing goal-related activity, and optimising routine.

Results

1. For the most part, participants were able to tolerate and adhere to the monitoring procedures.
2. All participants who filled in the evaluation questionnaire at the end of the study indicated that Pain ROADMAP feedback was valuable and that it was worth undergoing the monitoring to receive the feedback that was provided by the clinician.
3. Participants who completed the 15-week treatment protocol had a significant reduction in activity related pain flare ups and experienced a stabilisation in their pain levels.
4. Clinically meaningful decreases in opioid use, depression, and activity avoidance along with increases in productivity were also observed.
5. A few participants commented that the Actigraph activity monitor was bulky and that the ability to wear the monitor on other parts of the body would improve Pain ROADMAP monitoring.
6. Participants recommended a number of minor changes to the app such as customisable notification tones and the ability to edit data once it has been entered.
7. Two participants under the age of 25 dropped out of the study early. Hence, strategies may be needed to ensure mHealth assisted treatments are engaging for young people such as the use of gamification to increase motivation.

Conclusions

This is the first study to demonstrate how mHealth innovations that utilise ecological momentary assessment can be successfully integrated with wearable technologies to provide a tailored activity modulation intervention that is both highly valued by people with chronic pain and assists individuals to make constructive behavioural changes. Overall, the results of the pilot implementation provide evidence for the clinical utility of mHealth assisted activity modulation interventions within the pain field. Adaptions such as low costs sensors, increased app customisability and gamification may be important for enhanced uptake, adherence, and scalability.

Declaration

This work was supported by a Metro North Hospital and Health Service LINK project grant and the Motor Accident Insurance Commission (MAIC), Australia. Dr Andrews was supported by a Patricia Dukes Fellowship administered by the Royal Brisbane and Women's Hospital Foundation.

Call to focus on digital health technologies in hospitalised children's pain care: clinician experts' qualitative insights on optimising electronic medical records to improve care

Thank you to APS members Nicole Pope, Denise Harrison, and Greta Palmer and their colleagues Mike South and Ligyana Korki de Candido for sharing the following recent publication.

Article first published online: 5 January 2023

Journal Reference: Pope N, Korki de Candido L, Crellin D, Palmer G, South M, Harrison D. A call to focus on digital health technologies in hospitalized children's pain care: clinician experts' qualitative insights on optimizing electronic medical records to improve care. PAIN [Internet]. 2023.

DOI: http://dx.doi.org/10.1097/j.pain.0000000000002863

Abstract

Background

Most hospitalised children experience pain that is often inadequately assessed and undertreated. Exposure to undertreated childhood pain is associated with negative short-term and long-term outcomes and can detrimentally affect families, health services, and communities. Adopting electronic medical records (EMRs) in paediatric hospitals is a promising mechanism to transform care. As part of a larger program of research, this study examined the perspectives of paediatric clinical pain experts about how to capitalise on EMR designs to drive optimal family-centred pain care.

Methods

A qualitative exploratory design was used to illustrate the perspectives of paediatric clinical pain experts about EMR designs that support optimal pain care for hospitalised children and families. A purposive sample of participants were recruited via email invitation. Reflexive content analysis was conducted in parallel with ongoing recruitment to evaluate sample size requirements in relation to the principles of information power. Data were managed in Nvivo. This research was approved by the University of Melbourne Human Research Ethics Committee (protocol number 2021-22171-23430-6).

Results

Fourteen nursing (n=9) and medical (n=5) experts from 10 paediatric hospitals across five countries (United States, Canada, United Kingdom, Australia, and Qatar) were interviewed online using Zoom for Healthcare. The researchers developed four broad categories during qualitative content analysis. They were labelled as follows: (1) capturing the pain story, (2) working with user-friendly systems, (3) patient and family engagement and shared decision making, and (4) augmenting pain knowledge and awareness.

Conclusions

User-centred, evidence and theory-informed EMR designs are critical to improving pain care for hospitalised children. Participants with a range of EMR experience called for a greater focus on optimising hospital EMRs to drive clinicians beyond searching for objective measures of pain and pharmacological interventions toward including psychological, social, and developmentally targeted assessments and treatments. Intuitive, customised EMR interfaces draw clinicians to the most pertinent data and safeguard high-risk practices without overwhelming them. Findings demonstrate that no single action will ensure that EMRs guide clinicians toward evidence-based practices. Pain education and institutional approaches that support quality improvement remain pillars of effective pain care. Electronic medical record use in children's pain management is an evolving practice. We must leverage their potential to highlight pain as a priority. Further research should study the use of patient-controlled interactive technology integrated with the EMR and their potential to support and promote shared decision making.

Declaration

Nicole Pope is a PhD candidate and has received funding from the Melbourne Research Scholarship and the Be Sweet to Babies studentship to support her doctoral studies. She is also the recipient of the Vera Scantlebury Brown Child Welfare Memorial Trust Scholarship and the Australian Nurses Memorial Centre Prince Henry's Affiliates Scholarship facilitating her PhD nursing studies.

Patterns of pain over time among children with juvenile idiopathic arthritis

Rashid, A., Cordingley, L., Carrasco, R., Foster, H. E., Baildam, E. M., Chieng, A., Davidson, J. E., Wedderburn, L. R., Ioannou, Y., McErlane, F., Verstappen, S. M. M., Hyrich, K. L., & Thomson, W. (2018). Patterns of pain over time among children with juvenile idiopathic arthritis. *Archives of disease in childhood*, 103(5), 437–443.

DOI: https://doi.org/10.1136/archdischild-2017-313337

Reviewer: Lilian Squire, Physiotherapy Student & Meg Pounder, Senior Physiotherapist, Complex Pain Team, The Children's Hospital at Westmead, Sydney, NSW

Review of article

Study group

Eight hundred and fifty-one participants, all diagnosed with new onset Juvenile Idiopathic Arthritis (JIA), aged one to 16 years, 66% female.

Aims of study

To identify predictors of experiencing ongoing pain for children with JIA and describe the patterns of pain over time, considering that pain cannot be entirely explained by disease severity.

Brief methodology

Participants were recruited via the Childhood Arthritis Prospective Study following diagnoses of JIA. The study utilised the visual analogue scale (VAS), Active Joint Count (AJC), Physician's Global Assessment (PGA), Patient/Proxy General Evaluation, Child Health Assessment Questionnaire (a measure of functional disability), and the Moods and Feelings Questionnaire. Additionally, medication taken in the first year after diagnosis was recorded, as was the physician-assigned International League Against Rheumatism subtype of JIA. Data collection occurred at baseline, six-months, one-year, and then annually for up to five years. Data were extracted through questionnaires and medical records. The primary outcome measure used was the VAS.

Brief summary of the results

A three-group model of pain was used: consistently low pain over five years (around 1.8/10 VAS, 50% of participants), consistently high pain (around 4.9/10, 17%), and improved pain (starting at 5.5/10 followed by dramatic improvement in first year, 32%).

JIA subtypes appear to have a correlation with pain trajectory. Whilst approximately 42% of the study population had oligoarthritis, over half the consistently low pain group did. Conversely, whilst only 17% of the study population was in the 'consistently high pain' group, approximately a quarter of those with extended oligoarthritis, polyarthritis with positive rheumatoid factor, and psoriatic arthritis, and over 30% of those with enthesitis-related arthritis, were in the consistently high pain group.

Pain severity at presentation was the strongest predictor of consistently high pain. Children with consistently high pain were more likely to be prescribed disease-modifying antirheumatic drugs and biologics compared with those in the other pain groups. Age of onset of pain also appears to have a relationship with pain trajectory. Participants with consistently low pain were on average younger, those with improved pain were more commonly in the middle of childhood at onset of pain and those with consistently high pain were on average approaching early adolescence. Poor function and longer disease duration at baseline were also associated with consistently high pain. Baseline measures of disease activity such as the AJC and PGA, did not predict children's membership of a pain trajectory and neither did depression.

Conclusions

Children with higher pain severity, age, disease duration, and functional disability at diagnosis, as well as those with certain subtypes of JIA, appear to be at greater risk of consistently high pain over time. It is important for children with JIA to have integrated non-pharmacological pain management in addition to pharmacological management, especially for those at higher risk of consistently high pain. Multi-modal pain management should commence as early as possible to improve long-term outcomes in pain and function.

Reviewer's critique & take-home message

The only outcome measure reported beyond baseline is pain rated on the VAS. It would be helpful to report the child's level of function over time as this reflects their meaningful participation in life. For example, a child with lower pain rated on a VAS may have very poor functional participation. Another variable not explored is the non-pharmacological pain management children may have engaged with over the study period. In the paediatric pain clinic of the reviewers it is not uncommon for children with JIA to be referred when pain is persisting and affecting function, even in the absence of active disease in the painful area(s). Families often report past pain was due to active disease and present with confusion and anxiety around what is causing the current pain. The current pain is better explained by sensitisation of the nervous system from recurrent pain from arthritis in the context of their past and current lives. They are used to pharmacological management of pain and often physiotherapy/physical activity. However, many have never considered the psychosocial contributors to or 'mind-based' strategies for pain. If education and training in age-appropriate non-pharmacological pain management strategies is introduced at the time of diagnosis and developed as the child grows, future pain and disability (in the presence or absence of arthritis) can be reduced. Undue reliance on medical practitioners could be minimised with children becoming confident in appropriate self-management into adulthood.

Declaration

The reviewers declare no competing or conflicting interests in reviewing this article.

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APPLY

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Application Deadline: 14 August 2023

APPLY

Recurrent abdominal pain in children: Summary evidence from 3 systematic reviews of treatment effectiveness

Abbott, R.A; Martin, A.E; Newlove-Delgado, T.V; Bethel, A; Whear, R.S; Thompson Coon, J, & Logan, S. (2018). Recurrent abdominal pain in children: Summary evidence from 3 systematic reviews of treatment effectiveness. Journal of Pediatric Gastroenterology and Nutrition. 67(1): 23-33.

DOI: 10.1097MPG.0000000000001922

Reviewer: Natasha Haynes, Nurse Practitioner, The Children's Hospital at Westmead Sydney, NSW

Review of article

Study group

3572 children aged five to 18 years.

Aims of study

The authors felt there was inconsistency in treatment for recurrent abdominal pain in paediatrics. The aim of this paper is to bring together the current evidence to underpin treatment decisions in young people with recurrent abdominal pain (RAP).

Brief methodology

Utilising the Cochrane principles for systematic reviews and meta-analyses, 55 randomised controlled trials (RCTs) and one randomised cross-over study of children with RAP or an abdominal pain-related functional gastrointestinal disorder as per Rome III criteria were analysed. The study was interested in dietary, pharmacological, or psychosocial interventions versus placebo, pain (intensity, frequency, duration), medium to long term follow-up, as well as school, social or psychological functioning, quality of life, and adverse events.

Brief summary of the results

Dietary intervention: Probiotics were found to improve pain in the short-term (limited long-term data were available). However, the strain of probiotics was not consistent, therefore there is insufficient evidence to guide clinical practice.

Four trials (299 children) with fibre-based interventions did not improve pain intensity ($p = 0.27$), but these trials only included irritable bowel syndrome (IBS) patients and long-term data.

A reduction in pain intensity and frequency with Low FODMAP diet was found in one small study. There was insufficient evidence for dietary interventions including fibre-based diets, FODMAP, or fructose-restricted diets. There was low quality evidence for probiotics, however recommendations need to be with caution due to unknown strain recommendations.

Pharmacology: A variety of pharmaceutical products, including antispasmodics – peppermint oil, Drotaverine and Mebeverine (four studies, 277 children), tricyclic antidepressants - amitriptyline (two studies, 213 children), antibiotics – rifaximin cotrimoxazole (two studies, 112 children) and other smaller studies looking at trimebutine, tegaserod, cyproheptadine, pizotifen, citalopram, melatonin, domperidone, and famotidine were included. All studies found insufficient evidence leading to the conclusion of extremely weak evidence for any pharmacological agents.

Psychosocial interventions: Cognitive-Behavioural Therapy (CBT; 11 studies, 687 children) found to improve pain immediately post intervention of 4 trials with number needed to treat (NNT) of four. Long term data suggests this benefit was not maintained.

Hypnotherapy (four studies, 152 children) found a NNT of three; with five-year data in one study finding significantly lower pain intensity and frequency. In conclusion, CBT and hypnotherapy had low-quality evidence for efficacy and a recommendation of treatment, however, the format of CBT or hypnotherapy was unable to be recommended due to inconsistency in studies reviewed.

In addition, three studies (involving 127 children) exploring yoga found no significant effect compared to usual care. Therefore, the authors concluded there was insufficient evidence to support its recommendation.

Reviewer's critique & take home message

This article is a good summary of RCTs within the paediatric RAP population, with specific recommendations and quality of evidence presented. It acknowledges that most studies included were carried out prior to the Rome IV classification of RAP which includes functional dyspepsia, irritable bowel syndrome, abdominal migraine and functional abdominal pain, however none of the results provide any classification of what diagnostic category they fit into. While an aim of the study was to assess quality of life and psychosocial impact it unfortunately does not evaluate this within the included studies.

Providing an overall summary and recommendation of 55 RCTs is promising evidence for treatment of children with RAP. This article highlights the need for a biopsychosocial model of care for children presenting with RAP with multidisciplinary input. While gut psychotherapies are specific, with limited expertise in this area and little to no psychological support within gastroenterology teams within Australia, many of these children either fall through the gaps or present in pain clinics. In an ideal world gastroenterology teams would be armed with services to provide for these children, as they are in some clinics in the USA. In the meantime, primary care providers and/or pain clinics can fill some of the specific recommendations.

I would like to draw attention to the [2021 ACG Clinical Guideline for the Management of Irritable Bowel Syndrome](), which is not paediatric specific but provides specific guidelines on dosages and therapeutic recommendations. Additional statements and information regarding diagnostic strategies, specific drugs, doses, and duration of therapy can be found in the guideline.

Declaration

The review has no conflicts of interest to declare.

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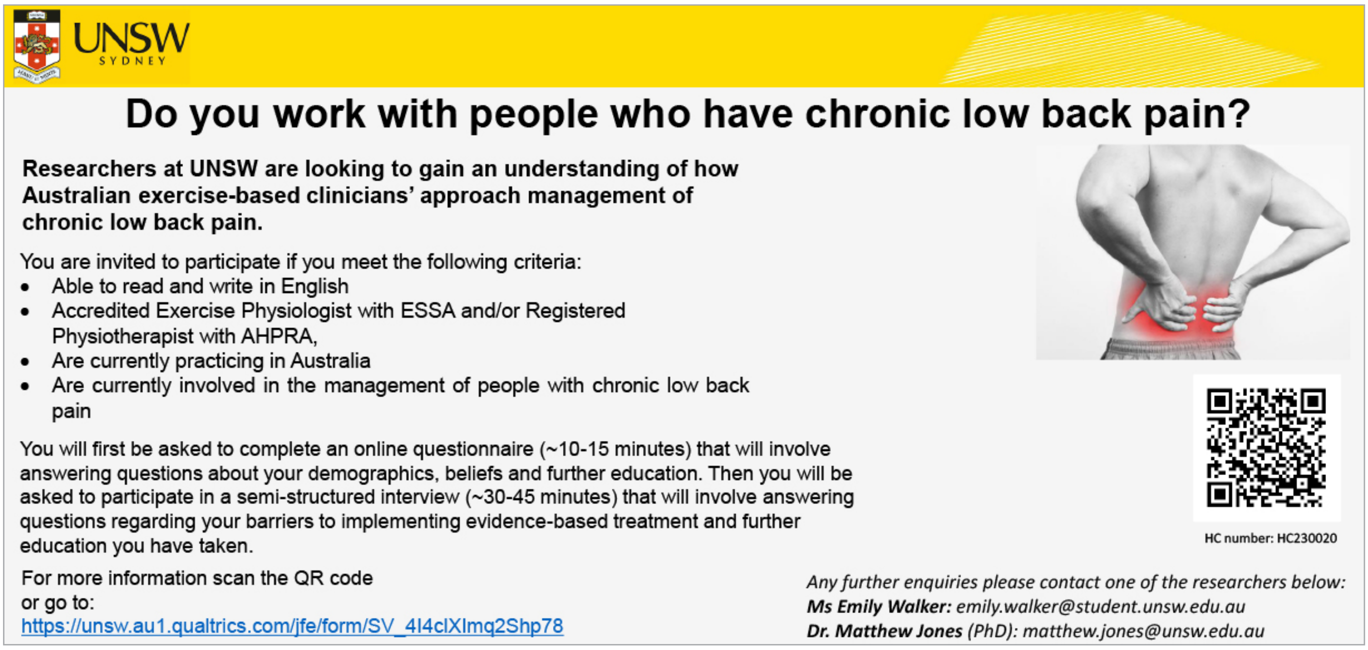

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Ms Emily Walker: *emily.walker@student.unsw.edu.au*
Dr. Matthew Jones *(PhD): matthew.jones@unsw.edu.au*

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NEW!

We have two new paediatric themed items this month:

- **young painHEALTH - A new web-based resource co-created with and for 16-24 year olds experiencing chronic primary and secondary musculoskeletal pain** https://youngpainhealth.com.au/
- **Canadian Paediatric Pain Management Standard now available FOC via the following link** https://store.healthstandards.org/products/pediatric-pain-management-can-hso-13200-2023-e

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

New Members

New Members as at 25 May 2023:

Mrs Leone Bennett	Physiotherapy
Ms Brittany Cattanach	Psychology
Miss Victoria Dale	Nursing
Dr David Gleadhill	Musculoskeletal Medicine
Mrs Yiru Guo	Science Research
Mr James Hill	Physiotherapy
Ms Adamina Jowett	Pharmacy
Dr Joanne Kara	Pain Medicine Physician
Mr Wilfred Lax	Psychology
Dr Mikhaila Lazanyi	Gynaecology
Dr Katleho Limakatso	Physiotherapy
Mr Andre Mare	Pharmacology
Mrs Georgina Palmer	Physiotherapy
Dr Reuben Slater	Anaesthesia
Dr Amanda Wisely	Pain Medicine Physician

Calendar of Events

21-23 June 2023

Occupational Therapy Australia (OTA)
OTAUS2023 - 30th National Conference & Exhibition
Cairns Convention Centre, Cairns, QLD
https://www.otausevents.com.au/otaus2023/

22-24 June 2023

MASCC/JASCC/ISOO
2023 NARA
Nara Prefectural Convention Centre, Nara, Japan
https://mascc.org/annualmeeting2023/

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/

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/

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/

Vision, Purpose & Priorities

THE
AUSTRALIAN
PAIN SOCIETY

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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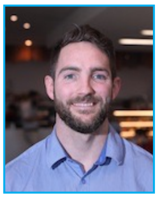

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