



Editor's Note

Welcome to the June edition of the Australian Pain Society newsletter. In this edition you will find a teasing article from the erudite Professor Duggan, a final report on the successful annual scientific meeting on the Gold Coast, a report from Amal Helou and Mike Jennings on the Conference on Happiness and its Causes, and a report on increased funding for treatment of persistent pain in Queensland (how jealous I am!). As always thanks to our contributors for taking the trouble to keep us informed about various happenings relevant to the Australian Pain Society, and thank you to the staff at DC Conferences, especially Tracy Hallen for their assistance with producing the newsletter.

Happy reading,

Will Howard

Newsletter Editor

Budget Boost for Sufferers of Persistent Pain in Queensland

TUESDAY, JUNE 08, 2010

The Queensland Government today announced an unprecedented investment to help sufferers of persistent pain in the 2010-11 State Health Budget.

Treasurer Andrew Fraser said the State Government would invest \$39.1 million in operational funds over four years for the staged implementation of a hub and spoke persistent pain service network across Queensland.

Queensland Health has been working in close consultation with a committee of stakeholders with expertise and experience in pain medicine to examine models of care for a consistent state-wide approach to persistent pain services.

Building on the existing service at the RBWH dedicated persistent pain treatment pilot sites will be rolled out across the State.

"This investment will reduce the waiting list for Queensland's only dedicated persistent pain treatment service at the RBWH, extend access to specialist interventions across the State and provide sufferers of persistent pain with the best opportunity to live a fulfilling life," Mr Fraser said.

The implementation of a hub and spoke service network throughout Queensland will deliver more than 6,000 occasions of service per year, per hub.

Deputy Premier and Minister for Health Paul Lucas said around 576,000 Queenslanders suffer from debilitating persistent pain, with the number expected to increase as the population ages and grows.

"An MBF Foundation report conducted by Access Economics has estimated that chronic pain costs the Australian economy \$34 billion per annum," Mr Lucas said.

One in five Australians will suffer persistent pain in their lifetime, with the predominant causes musculoskeletal and connective tissue problems.

Associate Professor Leigh Atkinson AO, National and Queensland Board Member of the Faculty of Pain Medicine in the Australian and New Zealand College of Anaesthetists, said more than 30 per cent of cancer

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patients survive their disease, but suffer from chronic pain which prohibits them from returning to home or work.

“This investment into persistent pain services across the State will be a major improvement to these people’s lives.”

Living with persistent pain can be debilitating and have an enormous impact on people’s daily life, working life and education.

Most persistent pain can be managed with medication, education and support in the primary care setting by GPs, private allied health providers, nurses and complementary/alternate therapists.

However for complex cases, treatment is ideally provided in a hospital setting to improve access to a broad range of specialist clinicians.

Secretary for the Australian Pain Management Association Inc. Elizabeth Carrigan said the Bligh Government’s investment in a state-wide persistent pain service network will allow rural and regional persistent pain sufferers far greater access to services currently only available in South East Queensland.

“It will also provide GPs in these areas with much needed support in the treatment of their patients that suffer from persistent pain.

“Chronic pain tends to lead to underemployment, unemployment and impoverishment. “Access to specialist pain treatment and management services will help people back to health and productive life in their communities,” Ms Carrigan said.

Mr Lucas said understanding the condition would come when we stop talking about it as a symptom and recognise it as a condition in its own right.

“This \$39 million investment will have the dual benefit of better management for Queenslanders who live with persistent pain, as well as assistance with returning to work.

“The Queensland Government is committed to expanding health services across the State and helping Queenslanders who suffer from persistent pain achieve a better quality of life,” Mr Lucas said.

REMINDER:

Topical Session Submissions for the 2011 Conference in Darwin due **1 OCTOBER 2010** via the APS website.

Please start planning your sessions now. These usually involve a chair and three presenters.

| The Dose of Morphine – Quotations from the literature from 1822 to 1991

In the publication, *Acute Pain Management: Scientific Evidence*, put out by the Faculty of Pain Management of the Australian and New Zealand College of Anaesthetists it is stated that IM morphine 10mg, is effective in the management of moderate to severe postoperative pain. Subsequent oral doses of 20mg, 4 hourly, appear to be satisfactory for acute pain control. Continued morphine administration for severe chronic pain is a different situation since repeated administration theoretically should induce tolerance and hence doses used for acute administration become largely irrelevant. In this brief essay I shall briefly discuss two descriptions of long term opiate usage, one from the point of view of the ingestor and other from the viewpoint of the prescriber.

To a pharmacologist tolerance is best considered as a shift to the right in the dose response plot of an agonist. It looks like the change produced by a competitive antagonist. Both experimentally and clinically, tolerance can be seen in two ways.

- (1) A declining effect of a drug despite a presumed fixed concentration in the vicinity of the relevant receptors. Clinically this may be seen as a shortening of the drug’s effect and hence a request for the drug before it is due.
- (2) The need to give progressively larger doses to attain a given effect.

The molecular basis of tolerance is still not fully understood but over the years most hypotheses have fallen into two categories.

- (1) Continued exposure to opiates evokes an active response, which functionally opposes the opiate action. Abrupt withdrawal of the opiate allows this active response to act unopposed and it manifests itself as the withdrawal syndrome (cold turkey). This active response could either be organised solely within the cells bearing the opiate receptors but equally could be a systems response involving many cells
- (2) Continues exposure to opiates causes the relevant receptors to desensitise. This has the problem that abrupt withdrawal should have no functional effect and the system should gradually return to normal.

Of course it is possible that both types of mechanism underlie tolerance and dependence.

I am not going to delve into addiction. As an aside however, you may be interested that the Latin verb *addico* literally means “I speak to” but this verb could be used when assigning a slave from one master to another. Indeed, the slave - master analogy seems rather appropriate when considering drug addiction.

An Ingestor

The Confessions of an English Opium Eater by Thomas De Quincey was first published in 1822 although it had appeared in serial parts in the London Magazine of 1821. There is a sentence in it, which is well known to students of opiate pharmacology and therapeutics:

“Thou hast the keys to paradise, O just subtle and mighty opium”.

My copy of De Quincey is the Everyman’s Library edition printed in 1907 which I purchased from an antique bookshop near Wells cathedral in Somerset. De Quincey was in no way a scientist but his observations on the effects of opium made in an era when there was no social opprobrium attached to taking a freely obtainable preparation are a delight to read and I think have some scientific merit.

De Quincey took laudanum which is an alcoholic extract of opium (a tincture). The Latin verb *laudo* means “I praise” and I have always regarded this as the origin of the word laudanum. The Oxford English Dictionary however suggests a link to laudanum a resin

derived from rock. The name is usually attributed to Paracelsus the Swiss alchemist who is given credit by some for the beginnings of modern pharmacology although others regard him as a fraud.

The Dose

De Quincey at his peak ingestion period was taking 8000 drops of laudanum each day. He estimates 25 drops of laudanum as equal to 1 grain of opium. As there are 65mg to the grain, De Quincey was taking 20,800mg of opium per day. The Merck Index states that good quality opium contains 9 to 14% morphine and on this basis we can estimate that he was ingesting between 1872 and 2912 mg of morphine a day. Of course it is highly probable that the potency of 19th century opium varied greatly between suppliers and hence these figures are not to be taken literally although I have little doubt that De Quincey was taking a large amount of morphine. If we assume that a starting dose of oral morphine today is 20mg and it is repeated 3 times in a day then De Quincey was ingesting approximately 250 to 350 times a therapeutic total daily dose of morphine used for acute pain. This is indeed tolerance but those of you with experience in treating patients dying with severe cancer pain will know that doses of this order are not extraordinary. De Quincey appeared not to be in chronic pain and hence a more valid comparison would be with modern day recreational uses of morphine. I do not know what amounts are consumed in this way.

The Effect

How did he feel? Firstly it needs to be stated that although it is sometimes stated that De Quincey initially took opium for toothache, this may not be correct. His account of his first ingestion follows (the punctuation is as written) -

“From an early age I had been accustomed to wash my face in cold water at least once a day; being suddenly seized with toothache, I attributed it so some relaxation caused by some casual intermission of that practice; jumped out of bed, plunged my head into a basin of cold water, and with hair thus wetted went to sleep. The next morning as I need hardly say, I awoke with excruciating rheumatic pains of the head and face, from which I had hardly any respite for about twenty days.

By accident I met a college acquaintance who recommended opium.”

On taking his first dose he describes the effect thus

“In an hour, O heavens what a revulsion! What a resurrection, from its lowest depths of the inner spirit! What an apocalypse of the world within me. That my pains had vanished was now a trifle in my eyes; this negative effect was swallowed up in the immensity of those positive effects which had opened up before me, in the abyss of divine enjoyment thus suddenly revealed. Here was a panacea, here was the secret of happiness, about philosophers had disputed for so many ages, at once discovered.”

He was not impressed by the medical profession’s views on the bodily effects of opium. “To professors of medicine writing ex cathedra I have but one emphatic criticism to pronounce – Nonsense.”

De Quincey was not aware of respiratory depression with opiates but he was aware of supposed diminished mental alacrity (he uses the word torpor) with chronic opiate use. He was quite a racist as he states “Turkish opium-eaters, it seems are absurd enough to sit like so many equestrian statues on logs of wood as stupid as themselves.” De Quincey reserved his opium binges for the nights when Grassini sang at the King’s Theatre opera house. To quote him again. “The choruses were divine to hear; and, when Grassini appeared in some interlude as she often did, and poured forth her passionate soul as Andromache at the tomb of Hector, I question whether Turk, of all that have entered the paradise of opium eaters can have had half the pleasure I had.”

De Quincey was reluctant to ascribe any significant drawbacks to continued opium use but he does admit that when he reduced his daily dose by some 80% that a state of depression appeared to lift. He also describes the mental state of the opium eater as follows “his intellectual apprehension of what is possible infinitely outruns his power, not only of execution but even of proposing or willing”. *The Confessions of an English Opium Eater* is a great read but take it with a grain of salt.

A Prescriber

As a contrast to De Quincey I have chosen a review by Kathleen Foley of the Pain Service, Memorial Sloan-Kettering Cancer Service in New York. The title is Clinical Tolerance to Opioids and is in the book *Towards a New Pharmacotherapy of Pain* Eds A.Basbaum and

J-M Besson 1991 John Wiley. The book reports the proceedings of a Dahlem Symposium held in Berlin in the same week that the Berlin wall came down in 1989. Although this review is now 19 years old I think it is still a valid summary of long term use of opioids in a medical setting. Kathleen Foley is giving the John D. Loeser Distinguished Lecture at the 13th World Congress on Pain at Montreal this year. Her lecture is entitled “Advancing Pain and Palliative Care Globally. Challenges and Opportunities”

The author has had extensive experience in treating patients with terminal cancer pain using opiates. She describes three patterns of drug use:

- (1) Rapidly escalating doses of opioids associated with escalating pain and/or anxiety
- (2) Stable doses of opioids for long periods of time (weeks to months) without dose escalation and/or reduction
- (3) Discontinuance of opioid drugs following effective relief of pain by anti cancer therapies or anesthetic or neurosurgical procedures.

This indicates a complex situation but importantly there appears not always to be a progressively increasing degree of tolerance as the dose of opioids is increased. Foley emphasises increasing levels of pain and not pharmacological tolerance as the dominant factor underlying a need to increase doses. I am somewhat surprised by this but that is what she says. The doses could be high. Although 34% were in the 5-99mg IM morphine per 24 hours, 10% received 2000-5000mg and 3 had 7992-35,165mg per day. That clearly beats De Quincey!

Foley discusses tolerance to various opioid effects developing at different rates but tolerance to respiratory depression seemed to parallel tolerance to analgesia. As a pharmacologist I would expect the latter, as mu opioid receptors predominantly underly both effects. Clinical dependence on opioids has been shown in many studies but the withdrawal syndrome in cancer patients appears not to be a problem as shown by pattern 3 listed above in which opioids could be reduced or withdrawn and no mention is made of a disturbing withdrawal syndrome. I assume this was done gradually, as cold turkey from abrupt withdrawal of street opiates is very common. As the pharmacokinetics of heroin result in rapid blood

rises and rapid falls I suspect that with abrupt heroin withdrawal cold turkey is near inevitable.

Cross tolerance is a tricky question but clinically it appears to be variable, as Foley draws attention to studies in which a diminution in the analgesic effect of one opioid could sometimes be overcome by substituting or adding another opioid. The only explanation I can offer for this is that differing opioids have differing affinities for the three major opiate receptors, mu, delta and kappa. The mu and delta receptors are both linked to analgesia. Kappa receptors are also linked to analgesia but some opiates with kappa affinity unfortunately can be mu antagonists. Tolerance by an action at one receptor may not be accompanied by tolerance to an action at another opiate receptor but this is pure conjecture.

As recently as 20 years ago it was not uncommon to see papers decrying the underuse of opioids in patients with chronic pain. Things seem to be different now and one is seeing papers dealing with inappropriate use of opioids and the occasional serious mishap including accidental overdose leading to death. The journal *Pain* recently had editorials dealing with this question. One considered the use of opioids for chronic non-cancer pain in the USA. Despite the WHO analgesic ladder being a recommendation for pain management in the USA, one report found that many patients were receiving opiates for arthritis and headaches. Another study found that patients with a history of substance abuse were 4 times more likely to be prescribed opiates for chronic non cancer pain than those with no such history. That is not to say that the former substance abusers had persistent tolerance to opiates although this has been proposed. Rather, other investigators have suggested that these subjects have a low tolerance to painful stimuli. This is all rather strange to me but it seems that, although we have not returned to the era of De Quincey, prescription opiate usage is changing and does need intermittent review.

Arthur Duggan
Wellington Point
March 2010

| Annual Scientific Meeting of the Australian Pain Society and the New Zealand Pain Society (Combined)

GOLD COAST, QUEENSLAND
28 TO 31 MARCH 2010

After two years of planning and much anticipation, the Combined Annual Scientific Meeting of the Australian Pain Society and the New Zealand Pain Society was held on Australia's Gold Coast 28 to 31 March 2010.

Over 700 delegates were in attendance to enjoy the sun, the surf and the sand whilst also learning about the latest advances in clinical and basic pain research from both local and international clinicians and researchers.

We were honoured to have our international speakers, Professors Troels Jensen, Irene Tracey and Francis Keefe, overcome the tyranny of distance to travel Down Under and impart their vast experience and expertise to our local audience. The conference also highlighted the high quality pain-related research currently being undertaken in Australia and New Zealand as well as the steadfast commitment of health professionals in our respective countries to improve the management of acute pain, cancer pain and non-malignant chronic pain. The success of the event reinforces our focus on working together locally, nationally and to an increasing extent internationally to address pain and its management.

We would like to thank all those who presented papers and posters during the ASM and the conference delegates and to congratulate the trans-Tasman Local Organising Committee, the Scientific Programming Committee and the conference Secretariat for an enjoyable, educative and overall, very successful Combined Annual Scientific Meeting of our Societies.

Judy Leader and Michael Deen
Co-Convenors



ASM2010
Co-Convenors:
Michael Deen (APS),
Judy Leader
(NZPS President)
and
Stephen Gibson
(APS President)



Stephen Gibson with
Roger Goucke and
his "Distinguished
Member Award"

Aboriginal Dancers



Report from Happiness and its Causes conference

4 – 7 MAY 2010
DARLING HARBOUR, SYDNEY NSW

by Amal Helou

This conference was an initiative of the Vajrayana Institute. There were over 1500 registrants, The APS endorsed this meeting along with over 42 other organisations. There were pre- and post-conference workshops. Among the eminent speakers presenting were: Naomi Wolf, author of *The Beauty Myth*; Prof Barbara Fredrickson, *Pioneering Positive Emotions Research*; Dr Edward de Bono, leading creative thinker and author of *The Use of Lateral Thinking*; Prof George Vaillan, professor of psychiatry at Harvard Medical School; psychologist, social researcher and author Hugh MacKay.

Each of the speakers also had a book to promote and these were on sale along with book signing. I enjoyed the conference as it provided me with innovative ways of communicating concepts that I have wanted to share with my patients. I would go again if there were similar excellent speakers.

Six thinking Hats

Edward de Bono designed the Six Thinking Hats as a tool to assist in the decision-making process. He believes that when the thinker has to deal with a wide range of information and perspectives at once the thinker loses focus and thinking becomes muddled.

To help separate information and perspectives de Bono created a tool called the Six Thinking Hats with each hat being a different color. The Aim? By separating and focusing upon parts of the problem the thinker will be able to make clear choices.

When a group is using the hats all participants must wear the same hat at the same time. For example, all are wearing white and must focus on facts; when wearing the red hat, all must give their emotional response; no one can say "pass".

- **White Hat**
 - The Facts, seeking information
- **Blue Hat**
 - Metacognition, for planning, monitoring & thinking about thinking

- **Yellow Hat**
 - Positives, looking for the advantages
- **Black Hat**
 - Negatives, looking for the disadvantages
- **Green Hat**
 - Creativity, generating alternative ideas or solutions
- **Red Hat**
 - Feelings, identifying and expressing feelings

It is designed to assist you to solve problems and make decisions based upon factual information, clear perspectives and logical thinking.

Hugh MacKay said sadness is what defines what happiness is. To be fully human we must acknowledge that sadness is appropriate and helps us appreciate the delightful times of joy and the fleeting moments of bliss. Sadness, disappointment and grief are part of the human state and, if we learn from them, are instrumental in helping us get to the joy of living. He said we learn more from failure than success and should not fear these states or moods of melancholy.

He encouraged the audience not to seek the pursuit of happiness but to seek a virtuous whole life that is well lived and to have moral courage. The quality of our personal relationships are central to living a fully human life based in love and only through loving others are we made whole.

We can grow as we allow emotions to come to the surface and deal with them, rather than use a happy pill or to try and squash them. This allows others and ourselves to learn through failures. Think realistically rather than being artificially positive.

Naomi Woolf started with the concept we should not be preoccupied with how we look as men and women but rather how we should be. There were several factors shaping our world view directed at us from the "cosmetic industry", advertisers with their agenda, all the way to the "surgical augmentation industry". Happiness is what she defined as inner freedom; we should not be enslaved to social standards, which are based on the agenda of what others think we should look like and be, and which can be restrictive and harmful.

She then talked about good successful leaders were the ones who learned from their mistakes and were able to find others around them who supported them in what they wanted to achieve and moved on step by step.

If you fail try again, no need to be perfect just willing to try. Live your life each day in the moment; utilize your dream muscles; use a critical mind to evaluate the impact of your dream.

Prof Barbara Fredrickson (University of North Carolina) provided research from the work her team did on the effects of positive emotions. Positive emotions transform us into better people and when people are experiencing positive emotions they take in a bigger global picture of their world. She presented many studies that backed up the following about happiness.

A large empirical literature shows that people who are happier achieve better life outcomes, including financial success, supportive relationships, mental health, effective coping, and even physical health and longevity. Moreover, prospective and longitudinal studies show that happiness often precedes and predicts these positive outcomes rather than simply resulting from them.

(Emotion COHN, FREDRICKSON, BROWN, MIKELS, AND CONWAY © 2009 American Psychological Association 2009, Vol. 9, No. 3, 361–368 1528-3542/09/\$12.00 DOI: 10.1037/a0015952)

She also presented work on the 3:1 ratio which she said had scientific validity, that for every negative emotion you need 3 positive emotions to counteract this and allow the person to flourish.

Studies to back this up are on <http://www.unc.edu/peplab/publications.html>.

We do not need toxic insincerity of a superficial “smile and be happy” but creating the mindset of positivists, which is, be open, appreciative, curious, kind and real.

A BRIEF REPORT FROM MICHAEL JENNINGS ON THE HAPPINESS CONFERENCE

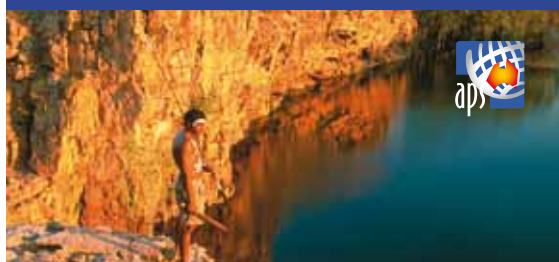
I was mainly interested in George Vaillant, who has published in psychiatry since the 60s. He, like a number of speakers, used a couple of chapters from his recent book, “*Spiritual Evolution*”, as the basis for a presentation and workshop.

He put spirituality in an historical context, including the development of the limbic system in mammals, with the capacity for bonding and empathy, the growing dominance of verbal ‘rational’ left brain stuff submerging the non-verbal etc., in especially Western culture. He also summarised recent neuroanatomical and other research giving more significance to positive emotions, love and interpersonal connections, than psychology and psychiatry have done. This connects with his Harvard study of over 50 years, following adults from their undergraduate years to their 80s. His message: love and good relationships are what make a satisfying life in the long run. In the workshop he lived his message, being open, inclusive, empathetic, interactive and enjoying himself. Your correspondent enjoyed it too.

The **FRONTIERS** of Pain



Australian Pain Society 31st Annual Scientific Meeting | 12 - 16 June 2011 | Darwin Convention Centre, Northern Territory, Australia



DEADLINES

Topical Session Submissions | **1 October 2010**

Free Paper & Poster Submissions | **11 February 2011**

Early Bird Registration | **15 April 2011**

Draft program available online www.dconferences.com.au/aps2011

For sponsorship & exhibition opportunities contact the Secretariat - details overleaf

Calendar of Events

BIENNIAL SCIENTIFIC MEETING OF THE PAIN ASSOCIATION OF SINGAPORE (IASP CHAPTER)

Expressions of Pain
23-25 July 2010
Holiday Inn Atrium, Singapore
www.pasbsm2010.com

PROSTATE CANCER FOUNDATION AUSTRALIA

Advancing Quality of Life
6-8 August 2010
Gold Coast Convention and Exhibition Centre, QLD
www.prostate.org.au

OFFICIAL SATELLITE SYMPOSIUM OF THE 13TH WORLD CONGRESS ON PAIN

Moving the pain education agenda forward: Innovative models
26-27 August 2010
Toronto, Ontario, Canada
www.bloomberg.nursing.utoronto.ca/PainSymposium

2ND INTERNATIONAL COURSE ON PAIN MEDICINE

27-29 August 2010
Montreal, Canada
www.ICPM.net

13TH WORLD CONGRESS ON PAIN

Current Concepts in Urogenital Pain
29 August - 2 September
Palais des congrès de Montréal, Montréal, Québec, Canada
www.iasp-pain.org/Montreal

INTERNATIONAL PAIN SUMMIT

3 September 2010
Palais des congrès de Montréal, Montréal, Québec, Canada
www.iasp-pain.org

AUSTRALIAN AND NEW ZEALAND SOCIETY OF PALLIATIVE MEDICINE (ANZSPM) CONFERENCE

15-17 September 2010
Ars moriendi – Palliative Medicine in the 21st Century
Hyatt Regency, Adelaide, SA
www.anzspm.org.au

THE BEST OF BOTH WORLDS

Rehabilitation 2010: Mind and Body
6 - 8 October 2010
Hilton on the Park Hotel, Melbourne
www.dconferences.com.au/rehab2010

FACULTY OF PAIN MEDICINE (FPM) 2010 SPRING MEETING

Transitions in Pain
8-10 October 2010
City Hall, Newcastle NSW
www.anzca.edu.au/fpm

4TH ASIA PACIFIC CERVICAL SPINE SOCIETY CONFERENCE

3 - 6 November 2010
Hilton Hotel, Sydney, NSW
www.dconferences.com.au/apcss

MIND AND ITS POTENTIAL CONFERENCE

18-19 November 2010
Sydney Convention and Exhibition Centre, NSW
www.mindanditspotential.com.au

NEW ZEALAND PAIN SOCIETY 36TH ANNUAL SCIENTIFIC MEETING

Planning for Pain Management
17-20 March 2011
Hotel Grand Chancellor, Christchurch, New Zealand
www.nzps.org.nz

FACULTY OF PAIN MEDICINE (FPM) REFRESHER COURSE

Pain Management – Getting Closer to the Dragon Pearl
13 May 2011
Hong Kong Convention Centre, Hong Kong
www.anzca.edu.au

AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS ANNUAL SCIENTIFIC MEETING

Seeking the Dragon Pearl
14-17 May 2011
Hong Kong Convention Centre, Hong Kong
www.anzca.edu.au

AUSTRALIAN PAIN SOCIETY 31ST ANNUAL SCIENTIFIC MEETING

The Frontiers of Pain
12-16 June 2011
Darwin Convention Centre, Darwin, NT
www.dconferences.com.au/aps2011

New Members

Mr	Paul	Silk	Psychology
Ms	Laurea	Atkinson	Nursing
Ms	Khanh Jennifer	Lam	Physiotherapy
Mr	Sun-Hong	Bou	Physiotherapy
Mrs	Belinda	George	Nursing
Ms	Linda	Bruce	Psychology
Mr	Allan	Lotfizadeh	General Practice
Dr	George	Chalkiadis	Anaesthesia



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