

President's Report



The last few months have been busy for the Directors of the Australian Pain Society with many directors working on subcommittees as well as being involved with the IASP World Congress and associated satellite conferences.

The IASP World Congress presents a great opportunity for colleagues to learn more about pain and its management and will encourage "new" people to join in and be inspired to research and work in this challenging but interesting field.

The APS Directors will have their Annual 'Face to Face' meeting in Sydney during the World Congress and the Australian Pain Society Annual General Meeting will also be held during this time.

The Scientific Programming Committee has been working with the Local Organising Committee to prepare our 2006 Meeting for Melbourne. A new initiative will be the opportunity to submit workshops for this meeting. Put on your thinking caps and see what you can put together as this is a real chance to contribute to the meeting - make it multidisciplinary and reflect your interest to a larger audience. Stephen Gibson (Chair SPC) is also finalising negotiation with a journal for publication of Conference Abstracts.

Kathryn Nicholson-Perry, a clinical psychologist from the Pain Management Research Centre at Royal North Shore Hospital has been awarded the PhD scholarship commencing 2006. This scholarship was funded by Mundipharma. We congratulate Kathryn and look forward to hearing of her progress.

Roger Goucke and his committee have worked hard to complete the Guidelines for Pain Management in Residential Aged Care Facilities, which are now being piloted with the help of a Commonwealth grant. Information about this is available on the APS Website.

Others matters for discussion have included:

- ACHS rewriting Equip 3 seeking input - please feed back any clinical indicator ideas for pain clinics
- Correspondence with Ian Buttfeld in SA about the new International Association for Pain and Chemical Dependency (IAPCD), and a committee working on a local 'frequently asked questions' document on this topic
- Adoption of Directors' Liability Insurance

On a personal level I have had a demanding time steering my 7 year old son through a chronic illness which has been poorly understood by a large number of specialists and professors. The parallels of our experience and that of my patients in the chronic pain clinic have not been lost on me and have caused me to reflect deeply on patient experiences 'from the receiving end'. Perhaps I will share some of these insights in future. My perspective has certainly broadened.

I have appreciated the assistance of all directors who have shared some of my presidential duties and will continue, as I take leave this month. Looking forward to a year of great learning!

Carolyn Arnold

President's Report	1
Fibromyalgia Syndrome	2 - 4
Are children of chronic pain patients more likely to develop pain?	5 - 6
Tribute to Professor Arthur Duggan	7 - 8
Pain in the Elderly	8 - 9
APRA Update	9
Announcements, Quotes, Websites	10
IASP News	11 - 12
APS Website	12
IAPCD	12
Upcoming Meetings	13
New Members	13
APS Executive / Contacts	14

Fibromyalgia Syndrome

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The assertion that Fibromyalgia Syndrome (FMS) is one of the most common musculoskeletal chronic pain conditions diagnosed by Rheumatologists¹ with a prevalence of 2%-20%²⁻⁴ in western societies and a female preponderance, presupposes that clinicians have at their disposal, diagnostic tests of sufficient sensitivity and specificity, including positive predictive values and kappa scores, given the frequency of this diagnosis and the plethora of interventions advocated.

Yet the literature would suggest otherwise. Irrespective, certain investigators propagate the view that FMS can be accurately diagnosed clinically without special diagnostic tests.⁴ The presumed criterion standard is widespread tenderness and 11 of 18 tender points (TeP).

A syndrome [syn (together) + dromos (running)] is an aggregation of symptoms & signs associated with any morbid process and contributing together to the picture of the disease.⁵ The accuracy of test results is a function of specificity (how good is a test in detecting the disease in question) and sensitivity (or how good is the test in excluding the disease in question). Kappa scores reflect reliability or reproducibility. Based on Boolean algebra, the only statistic for Fibromyalgia is "11 of 18" tender points (TeP). One need not be too assiduous to ask the obvious. Secondly, to be pukka, the pundits would be unforgiving should you confuse TeP (Fibromyalgia) with active or latent TrP (Trigger points) of the myofascial variety.

In its evolutionary consternation, Smythe (1979) suggested 12 of 14 TeP. Yunus (1981) examined 40 but suggested a maximum of 5. Bennett (1981) opted for 10 of 25; Wolfe (1983) 7 of 14 and upon reflection Yunus (1988) recommended greater than 50% of the 18 examined.

At its official gestation in 1989, Wolfe⁶ described the cardinal features of Fibromyalgia. Whilst wide spread pain and widespread

tenderness were the 'core features' common accompaniments included Irritable Bowel Syndrome, Raynauds, headache, subjective swelling, paraesthesia, psychological abnormality and functional disability and sometimes back pain, neck pain, arthritis and tendonitis. Wolfe⁶ designated specific locations for the TeP and cautioned that widespread tenderness was NOT equivalent to tenderness everywhere.

Definitive statements were pronounced by the American College of Rheumatology in 1990.⁷ Based on a case-controlled study of 558 participants, the multicentre criteria committee advised

against dolorimetry, abandoned the concept of primary and secondary Fibromyalgia and declared a sensitivity of 88% and specificity of 81% for the 11 of 18 TeP dictum. The 47% that comprised the control group suffered from back pain, neck pain, tendonitis, trauma related pain syndromes, SLE, Rheumatoid, Osteoarthritis or combinations. There were no normal volunteers.

The adoption of Wolfe's original diagnostic criteria would invoke the concept of heterogeneity. Multivariate analysis may not ensure a homogenous differentiation and invariably Type 1 and Type 2 errors will predominate. To locate a TeP, it is essential to apply a force of at least 4kg. The means by which the inter- and intra-

examiner kappa scores for such a variable may be established is an added confounder. Hence, by applying the basic tenets of clinical epidemiology, a combination of tender points and widespread tenderness cannot legitimately constitute a "syndrome."

Two years later, even the experts were unable to reach an agreement. Four experts in Fibromyalgia and four experts in Myofascial pain failed to reach consensus when examining 23 patients for active TrP, Latent TrP, taut band and twitch.⁸ There was however at least a 75% agreement on tenderness. Yet semantically, the descriptor "Myofascial" is the reversed mirror image of "Fibromyalgia."

On the home front confusing terminology abounds - each most likely reflecting personal belief / disbelief and philosophies



Fibromyalgia Syndrome

amongst the protagonist, antagonists and self appointed gatekeepers. Labels such as fibrositis, myofacitis, repetitive strain injury (RSI), occupational overuse syndrome (OOS), cumulative trauma disorder (CTD), psychogenic rheumatism, soft-tissue rheumatism, non-articular rheumatism or psychogenic musculo-skeletal syndrome are commonplace and in certain jurisdictions, self-serving.⁹ In the medico-legal context the ingenious would naively invoke Pilowsky's¹⁰ odyssey of "abnormal illness behaviour" or Waddell's "inorganic signs"¹¹ without really understanding either their genesis or opinions offered to the contrary.¹² Others assert that RSI, OOS, CTD and Whiplash are a form of localised fibrositis syndrome; but in compensable patients, "it is psychosomatic."¹³

In the workplace, around 25% of people with FMS are in receipt of some form of disability or injury compensation.¹ Littlejohn¹⁴ refers to a link between the prevalence of FMS and the structure of various "safety net programmes," in particular those that involve illness compensation schemes. He further suggests that a change in legislative mechanisms could alter reporting rates of FMS within these compensatory settings. It would be reasonable to assume that a change in legislation involving almost any compensable condition could alter its rates of reporting.

From a rehabilitation perspective, many people who are in receipt of Worker's Compensation benefits already feel the effects of stigmatisation. Health care providers need to be sensitive and compassionate. To suggest that illness is contingent upon the availability of illness compensation schemes may be unethical, immoral and illegal.

Indeed, one of the concerns identified by FMS patients is not having their status confirmed as being an "ill person."¹⁵ Hadler¹⁶ on the other hand believes that if patients have to prove that they are ill, they can never get well.

In 1989 Wolfe⁶ ushered in a new era with the publication of his seminal treatise, "Fibromyalgia: The Clinical Syndrome" - a pronouncement legitimised by the Copenhagen Declaration of 1992. But in 1997 the same author wrote:

"Fibromyalgia is out of control: it is a clinical invention; disability awards on FM should be abolished! Stop the necessity for proving the presence of a certain number of tender points - a notoriously unreliable and manipulable exercise. The problems are psychosocial issues... inappropriate behaviour... and... somatization."¹

In the late seventies (but not limited to), hypertension, gastric ulceration and asthma were considered to be "psychosomatic" disorders and migraine sufferers were castigated as "Type A personalities." Unravelling the pathophysiology of all four conditions has generated treatment that is logical, rational and

biologically plausible. David Fishbain,¹⁷ Professor of Psychiatry at the University of Miami, reported that under certain circumstances, the DSM-III was unable to discriminate an organic from a psychiatric disorder. A significant number of patients referred to his clinic with a diagnosis of "psychogenic pain" actually suffered from an organic disorder and he cautioned that the diagnosis of "psychogenic pain is made far too freely." Is it possible that "abnormal treatment behaviour"¹⁸ is the primary progenitor to "abnormal illness behaviour?"

If the widespread tenderness of Fibromyalgia is essentially a form of mechanical allodynia,^{19,20} then the central nervous system would be implicated.

Central sensitisation, by way of neuronal plasticity is a plausible mechanism. Whiplash may be one type of peripheral catalyst^{21,22}

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Fibromyalgia Syndrome

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The children of chronic pain patients

Are the children of chronic pain patients more likely to develop pain?

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From time to time adult chronic pain patients express great concern over how their pain condition may be affecting their child. How does one respond? With assurances that children are resilient? With an acknowledgement that we just don't know? Or is it safest simply to change the topic? We owe it to these patients and their children, to give this question serious consideration.

It is important to consider both whether children of pain patients are more likely to have pain and, if there is such an association, then by what bio-psycho-social mechanisms this may be transmitted. Numerous studies have suggested an association between the incidence of childhood pain problems and having parents with chronic or recurrent pain conditions.¹⁻⁶ Amongst a paediatric rheumatology clinic sample (n = 100), more than 90% of children were found to have a parent reporting at least one chronic pain condition.² This figure is considerably higher than the general prevalence rates of chronic pain conditions reported in adult community samples - 17.1% for males & 20.0% for females.⁷ Adolescents with chronic pain have been found to be more likely than adolescents without chronic pain (matched for sex, age and educational level), to report pain in significant others and to have a higher number of significant others with pain.⁸ However, these pain 'models' were not necessarily their parent's.

Children of chronic headache sufferers have been found to be more somatically focussed than children of illness-free parents. Children of patients with chronic pain have also been found to have more frequent abdominal pain and to use more medication than children of parents without pain.⁹ Moreover, children of parents with chronic low back pain were more likely to complain about physical symptoms than children of diabetic parents or children of healthy controls.¹⁰ The latter finding suggests that the parental influence is likely to be more specific than simply due to having a parent with a chronic medical condition per se.

While many studies in this field are compromised by small samples and a reliance on retrospective parental reports,¹¹ a large-scale prospective, self-report study concurred with the above findings.⁴ With data obtained from 693 families (2202 participants) using a 1- week parent and child self-report pain diary, children whose parents reported more incidents of pain, more severe pain, and more disabling pain, were found to be at an increased risk of reporting pain and disability themselves.⁴

In contrast to the above-mentioned body of literature, a large epidemiological study (n = 1326) did not find the children of pain patients to be at greater risk of developing pain than children whose parents did not have a pain condition.¹² The rather paradoxical conclusions drawn by Jones et al. (2004) were that "Parental pain is not a risk for child pain. Pain behaviour is not learned. Rather, child pain is probably attributable to individual factors and the social environment." (p1152) These conclusions are problematic given that attributing children's pain behaviour to social but not parental factors ignores the fact that a child's social environment is closely shaped by a variety of parental factors, with these factors extending well beyond the mere presence or absence of parental pain. Nevertheless, the results of this well-conducted study stand in contrast to the bulk of the literature in this area.

Such discrepancies in the literature regarding a possible association between parent and child pain conditions may be partly attributable to overall trends being obscured by the presence of certain vulnerability factors within some families but not in others. While genetic factors may have a significant role in some pain conditions (eg familial hemiplegic migraine), twin studies suggest that environmental factors play a much greater role than genetics in accounting for differences in chronic widespread pain in children.¹³ Such environmental factors may take many guises, for example:

- 1 Pain behaviours may be learnt through observing others displaying pain behaviours⁸
- 2 Poor coping skills may be learnt from observing significant others, which may render an individual less able to deal with life's stressors and more vulnerable to problems with the expression, course or resolution of pain problems¹⁴
- 3 Shared lifestyle factors, such as poor nutrition⁴ and lack of exercise, may impact on pain
- 4 Shared social factors, such as marital or family tensions,^{15,16} or positive reinforcement contingencies for illness behaviours¹⁷ within the home, may also render some families more vulnerable to pain problems

The children of chronic pain patients

The majority of research in this field has been cross-sectional; longitudinal studies are needed to establish causal mechanisms. More research is needed to gain a clearer understanding of the relationship between parental and child pain problems and the possible influencing mechanisms. However, it should be acknowledged that the children of some parents with pain conditions seem to have heightened vulnerability to developing pain conditions themselves. Identifying and addressing vulnerability factors may prove a fruitful avenue for future work. In the meantime, coaching adult pain patients to use more effective coping skills,¹⁸ instructing patients and their families about the potential problems of unintentionally reinforcing pain and illness behaviours,^{17,19,20} and addressing any marital issues stemming from the pain problems,^{15,16} are likely to benefit not only patients, but also their children. Help for parents in coping with their own pain is likely to help prevent the development of at least some children's pain problems.

Acknowledgements

The author gratefully acknowledges input from Prof Carl von Baeyer, Assoc.Prof David Champion, Anna Cole and Marita McInerney.

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Tribute to Arthur Duggan



I had the privilege of meeting Arthur Duggan in 1985 at an Australian Pain Society Annual Meeting where he invited me to speak on the role of the nurse in Pain Management. He always impressed me as someone who could communicate complex research about pain to clinicians at

*all levels of scientific knowledge. As a nurse I was struggling to make sense of all the scientific information I was hearing, but when Arthur presented I could follow his talk, and came away with more understanding. He quickly became a favourite conference speaker among members of the society. At a recent retirement dinner honouring Professor Duggan, the following tribute was presented by **Professor Michael Cousins**. Arthur plans to play more golf, spend more time with his grandchildren, make some money and (I hope!), write for the APS newsletter*

Amal Helou

Arthur Duggan is undoubtedly one of Australia's most distinguished neuroscientists and an internationally recognised basic scientist in the field of pain research. His career as a scientist was catalysed by two significant events.

Firstly, in 1957 he undertook a Bachelor of Science degree in the midst of a medical course at the University of Queensland. His graduation with First Class Honours was a signal that he was destined for outstanding achievements and this proved to be correct. Following medical school, in 1960, he undertook medical practice for four years, including a fairly challenging appointment to a general practice in Julia Creek. He had, however, already determined that his future lay in medical research and in 1964 he was appointed as an NH&MRC research officer. In 1968 he moved to the Department of Physiology at the ANU working in the John Curtin School of Medical Research under the direction of Professor David Curtis, where he undertook his PhD studies. Curtis had an international reputation in neuroscience, a very well equipped laboratory and was pursuing leading edge research in the field of synaptic transmitters both inhibitory and excitatory and their interaction with drugs¹.

Following the award of his PhD in 1971, he obtained a prestigious NH&MRC C.J. Martin Travelling Fellowship to work in the Department of Physiology at the University of Bristol, returning as a Visiting Fellow in 1973, to the ANU, where he became progressively Fellow, and Senior Fellow over the eighteen years that he worked with David Curtis. In 1987 he was attracted to a Chair in Veterinary Pharmacology at the University of Edinburgh where he remained for ten years, also performing the role of Associate Dean for Research from 1995. He became Emeritus Professor of the University of Edinburgh in 1997 and in 1998 was appointed as Visiting Professor at the University of Sydney and Principal Hospital Scientist in the Pain Management Research Centre of Royal North Shore Hospital, Sydney. **Two of Arthur Duggan's career highlights are:**

1 The demonstration in 1976, that the administration of minute amounts of morphine into the area of the spinal cord known as the "substantia gelatinosa" powerfully blocks transmission to the brain of information related to pain. This finding played a significant part in stimulating clinicians to explore the use of opiate drugs at a spinal level, resulting in extensive application in the treatment of acute, chronic and cancer pain. This key paper was published in the prestigious journal "Nature." By 1976, five of Arthur Duggan's thirty six publications had already been accepted by "Nature", a feat that very few scientists ever equal.

2 The development of a new technique for detecting the release of neuropeptides in the brain and spinal cord. This involved the use of minute glass electrodes which were coated with antibodies on their outer surface. These electrodes were inserted into various regions of the brain and spinal cord to detect the release of neurotransmitters at the precise site of release. This technique was first described by Duggan and Hendry in *Neuroscience Letters* in 1986 and proved to be a very powerful tool over the succeeding ten years and indeed up to the present time. To limit a description of his research to the above two items would be quite inadequate. Over 150 publications spanning the years 1958 to 2002 have made major contributions to our understanding of:

- Inhibitory mechanisms in the spinal cord, including Glycine, GABA, endogenous opioids, noradrenaline, serotonin, and dynorphin
- Excitatory mechanisms in the spinal cord, including excitatory amino acids, acetylcholine, substance P
- Disturbances in the firing of spinal neurones in the presence of inflammation, nerve & spinal cord injury
- Direct measurement of release of growth factors in spinal cord in the presence of nerve injury, including neuropeptide Y and brain-derived neurotrophic factor.
- Of interest to clinicians, he was first to demonstrate that direct electrical stimulation of the central nervous system results in the release of GABA which is likely to be the major mechanism involved in the analgesia produced by spinal cord stimulation. He continues to be actively involved in basic research, most recently demonstrating some exciting new findings in thalamic neuronal activity in the presence of spinal cord injury.

Major awards include:

- Elected Fellow of the Royal Society of Edinburgh, 1994
- Honorary Membership of the Australian Pain Society
- Royal Society of Medicine Professorship to lecture at the American Pain Society Scientific Meeting in 1989
- Burroughs Wellcome Professorship 1996
- Sunderland Lecturer, 1996 APS ASM
- Bonica Lecturer, 2002 APS ASM
- He was one of a small number of individuals who participated in the 1979 Inaugural Scientific Meeting of the Australian Pain Society, held at Surfers Paradise
- He organised the 1985 meeting of the APS in Canberra and served as President of this Society 1986-87.
- He has been a Council Member of the Australian Physiological and Pharmacological Society and has been a frequent invited speaker at major international Neuroscience and Physiological Society meetings.
- Throughout Arthur Duggan's career, he has maintained a strong interest in the application of his basic research to the treatment of patients - reflected in his ready acceptance of multiple invitations to speak at national and international scientific meetings of clinicians.
- Recent examples include his contribution to the Inaugural 1999 Scientific Meeting of the Faculty of Pain Medicine in Adelaide, and to the Australian Pain Society in 2002.

Professor Michael Cousins

More on pain in the elderly

Roger Goucke

Thank you to those members who sent in comments on the draft *Guidelines for Managing Pain in Residential Aged Care Facilities*. www.apsoc.org.au/pdfs/Draft1APSRACPMG.pdf

The second and hopefully final draft of this document will be available soon. As part of this project the Working Group approached the Department of Health and Aging in Canberra for financial support of a trial implementation of:

Section 1 • Identification &

Section 2 • Assessment of the Guidelines

(with particular emphasis for their use in residents with dementia)

The trial was conducted by Stephen Gibson at Royal Freemason's Homes in Melbourne. The report from the study is now available to view on the Australian Pain Society website.

www.apsoc.org.au

The study found that with the exception of the informant Brief Pain Inventory, the other tools (verbal modified BPI, PAINAD and Abbey Pain Scale) were useful, reliable and valid in this population.

Importantly the staff involved in the trial of implementation appreciated the need for a multi-dimensional assessment tool measuring the impact of pain on mood, activity, and quality of life, as being clinically relevant and useful. However a univariate pain assessment tool was seen as being necessary for more frequent use and for monitoring fluctuating pain. (From this recommendation, changes will be made to the Draft guideline).

Some further recommendations for modifying the precise words for the next version of the tools may be made following consultation with a group of like-minded users of the Brief Pain Inventory at Edith Cowan University in Perth. A further recommendation following the study was to incorporate a movement based protocol for pain assessment.

Those members of the Society with an interest in qualitative feedback will find pages 27 to 30 interesting, as they report the results using focus group methodology.

Pain in the elderly



APRA Update

Other recommendations include:

- Employing an actor to teach the use of the assessment tools, perhaps making a DVD (for more widespread distribution)
- The use of large print laminated prompt cards, remembering that aged care residents and their carers are not always fluent in English
- Having the tools in a range of languages other than English

The report concludes by stressing the need for a pain "champion" to steer the use of these tools into a facility, and the importance of having organisation-wide support, particularly from senior management at the facility.

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4TH INTERNATIONAL CONFERENCE ON OROFACIAL PAIN AND TEMPOROMANDIBULAR DISORDERS

27 - 28 August 2005

Sydney Convention & Exhibition Centre
Darling Harbour, Sydney NSW Australia

Contact DC Conferences: Phone 02 9954 4400
Email icot2005@dcconferences.com.au
Website www.dcconferences.com.au/icot2005

Maree Smith

Chair, APS / APRA PhD Scholarship Committee

I am delighted to update the APS membership on the progress of the Society's (now three) PhD scholars.

Our most recent scholarship awardee, **Ms Kathryn Nicholson Perry**, was selected to receive the inaugural Mundipharma sponsored APS / APRA PhD scholarship for the next 3 yrs: 2005 - 2007 incl. When informed of her application success just prior to Christmas 2004, Kathryn declared that she was "thrilled and extremely honoured". We in the Society congratulate Kathryn on her academic excellence and we look forward to regular updates as her research progresses. Kathryn's PhD thesis topic is

Cognitive behavioural pain management programmes in spinal cord Injury-related pain and her thesis supervisors are Assoc.Prof. Michael Nicholas (Pain Management & Research Centre, RNSH) and Dr James Middleton (University of Sydney Rehabilitation Studies Unit, Ryde).

Ms Anne Pitcher has now commenced her 2nd year as the CSL sponsored APS / APRA PhD scholar. Anne's project, entitled **Investigating the factors that influence nurses in assessment of pain in people with dementia** is progressing well. To date, she has completed data collection in three nursing homes, and preliminary analysis is underway. Anne is being supervised by Professor Rhonda Nay, Director, Gerontic Nursing Clinical School at Latrobe University.

Ms Debbie Tsui is the APS / APRA supported PhD scholar and she has recently commenced the 3rd year of her PhD program. Deb's research has involved the undertaking of both in vivo and in vitro studies targeting the alleviation of painful diabetic neuropathy (PDN). In the last 12 months, she has focussed on developing an in vitro model of PDN using culturing rat embryonic neurones. Deb's supervisory team comprises Dr Greg Monteith, Dr Peter Cabot and myself, all from the School of Pharmacy at The University of Queensland. She will present her recent results as a poster at the 11th World Congress on Pain to be held in Sydney in August this year.

Announcements

OPPORTUNITY TO RECYCLE BOOKS AND JOURNALS

WANTED: Textbooks not more than 10 years old
and recent journals for colleagues in Iraq

Post to: Dr Iannuzzi, 59 Cassilis St, Coonabarabran, NSW 2357

Quotable quotes

“ That an inward looking profession, obsessed with its own tribalism, collectively failed to make self-regulation work properly and so protect all patients from avoidable harm, is quietly ignored. ” Donald Irvine (Lancet 2004; 364:1479)

“ Happiness is beneficial for the body; but it is grief that develops the power of the mind. ” Marcel Proust

Interesting websites

www.ebandolier.com

An absolute must!

Affiliated with the Oxford University Pain Unit, the site publishes a number of reviews which are evidence-based. Free download.

Paediatric Pain Resources on Internet

List compiled by Tiina Piira (Websites current at 16 February 2005)

www.pediatric-pain.ca

Pediatric pain: Science helping children

Run by IWK Grace Health Centre & the Psychology Department,
Dalhousie University, Halifax, Nova Scotia, Canada

www.painsourcebook.ca

Pediatric Pain Sourcebook of Protocols, Policies and Pamphlets

www.painsourcebook.ca/docs/pps92.html

Faces Pain Scale - Revised (FPS-R):

Administration instructions and translations

www.painsourcebook.ca/docs/pps80.html

"Pain, Pain, Go Away: Helping Children with Pain"

Booklet for patients and families

www7.health.gov.au/nhmrc/publications/pdf/cp57.pdf

Acute Pain Management: Scientific Evidence

Chapter 6: Pain in Children

National Health & Medical Research Council

www.rcn.org.uk/publications/pdf/guidelines/cpg_contents.pdf

Clinical Practice Guidelines: The recognition and assessment of acute pain in children (UK document)

www.ampainsoc.org/advocacy/pediatric.htm

Pediatric Chronic Pain:

A position statement from the American Pain Society
Background, policy, and references on the multidisciplinary assessment & treatment of chronic pain in children & adolescents

www.aap.org/policy/9933.html

American Academy of Pediatrics:

Prevention and management of pain and stress in the neonate

www.thesufferingchild.net

"The Suffering Child"

A multidisciplinary journal on children's pain

www.vh.org/navigation/vh/topics/adult_patient_pain.html

Virtual Hospital: A digital library of health information,
including resources for paediatric patients and paediatric providers (website run by the University of Iowa)

www.sch.edu.au/departments/pain_research

Pain Research Unit, Sydney Children's Hospital, Randwick

www.sch.edu.au/health/factsheets/

Sydney Children's Hospital and Children's Hospital at Westmead
Joint Fact Sheets

www.rch.org.au/anaes/index.cfm?doc_id=778

Anaesthesia & Pain Management

at the Royal Children's Hospital, Melbourne

Links to information for kids, parents and health professionals

www.childcancerpain.org

Pain Management for Children with Cancer

Run by the Texas Cancer Council,

Texas Children's Hospital and Baylor College of Medicine

www.unhchr.ch/html/menu3/b/k2crc.htm

United Nations Convention on the Rights of the Child

www.unicef.org/programme/breastfeeding/baby.htm

UNICEF: Baby Friendly Hospital Initiative

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IASP News

Geoff Gourlay Reports...

In early January, I attended the INCON (International Conference Network) Roundtable Discussion held in Singapore. I was invited to participate as Chairman of the Local Arrangements Committee (LAC) of the Sydney World Pain Congress. In essence, INCON is a conference of Conference Organisers otherwise known as PCOs (Professional Conference Organisers). The PCO for the Sydney Pain Congress is TourHosts Pty Ltd and they were responsible for my invitation to Singapore. It was particularly interesting hearing the issues that other organisations who arrange major meetings encounter.

The legal perspective was provided by a senior partner from one of Australia's leading law firms, a representative of the professional organisation covering Europe's leading furniture removalists, a PCO representative that works exclusively for one of the UK based international pharmaceutical companies, and a representative from the organisation that works with the engineers that install and maintain the equipment that produces a vast array of pharmaceutical products in the developed and developing world (eg generic drug manufacturers).

We all have the same aim of creating a quality Congress or Conference for our constituents. The recurring algorithm for all of us to create a successful Congress was first and foremost, the quality of the program in terms of content, presenters and the opportunity for delegates to maximise the information exchange and secondly, the location of the Congress. This was succinctly explained to me by former IASP President John Loeser during planning stages of the Adelaide World Pain Congress, when he said, he was not aware of any evidence that showed that there was any less information exchange when a Congress was held in a highly desirable geographical location compared to an ordinary location PROVIDED that appropriate and detailed attention was given to the scientific program.

One hardly has to defend Sydney as it consistently rates amongst the most highly desirable MICE (Meetings, Incentive, Conference and Exhibition) destinations. It is interesting to note that statistical



data presented in Singapore indicates that Australia in general and Sydney in particular, rate extremely highly in booked MICE functions and activities and many Asian destinations are anxious to compete with us in the future.

The convention facilities in other Australian States also rate well although Sydney is the prime location.

The scientific program is the responsibility of the Scientific Program Committee (SPC) within the IASP, which is composed of many nationalities and like all other IASP committees, is multidisciplinary in nature. The Sydney World Pain Congress SPC is under the

Chairmanship of Professor Herta Flor from Heidelberg in Germany. The SPC met in Kaunas, Lithuania in May 2003 and is in regular electronic communication. The very interesting and high-quality plenary lectures, workshop topics (around 80 over the five-day meeting) and refresher courses can be viewed via the Congress section of the IASP website at www.iasp-pain.org Access via the 'Congress' link on the homepage, then open 'Scientific Program.' Included on the website are descriptions of each plenary lecture and refresher course.

As many of you will be aware, the free communications section in the form of Posters closed at the beginning of February. For the 2002 San Diego Pain

Congress, approx. 1700 posters were displayed and there will be just as many at the Sydney Pain Congress. (We had expected a 15% - 20% reduction in poster numbers relative to San Diego) This is an outstanding achievement and is the first dependable sign that we will have significant attendance from around the world.

I have monitored the receipt of posters over the last month and am impressed by the diverse nature of topics reported as well as the innovative study designs. They will undoubtedly be a highlight of the World Congress, and the source of much discussion both during and after. Scientists, clinicians and educators from 62 countries have submitted poster abstracts - the greatest volume from the USA, as expected, the next greatest from the UK and Australia came third, supplying approx. 8% of submitted abstracts.



Although few in number, it was particularly pleasing to see posters originate from such countries as Azerbaijan, Bangladesh, Bulgaria, Chile, China, Columbia, Egypt, Georgia, Ghana, Iran, Nepal, Nigeria, Qatar, Romania, Slovenia and the Ukraine.

The SPC has ensured that the formal section of the scientific program at the Sydney Congress will be first class whilst scientific, clinical and other material from researchers and clinicians of all IASP disciplines will be varied and stimulating. The location is one of the premier MICE destinations in the world and everybody should endeavour to attend the 11th World Congress of Pain as is surely not to be missed.

As I have indicated previously, it could be a couple of decades before this concentration of pain researchers, clinicians, scientists, educators and other practitioners will visit our shores again.

Geoff Gourlay

APS Website

A Call for Volunteers

The Australian Pain Society is calling for volunteers to form a sub-committee for the upgrade and renewal of the Australian Pain Society Website. A knowledge or interest of content management systems, website design and specifications is encouraged. To register your interest, please contact the

APS Secretariat • DC Conferences
Phone 02 9954 4400 • Email mail@dcconferences.com.au

I N V I T A T I O N

As a prelude to the
August 2005 IASP World Congress on Pain in Sydney,
The Clinical - Legal Issues in Pain - Special Interest Group
invites you to attend a two-day conference on

Occupational & Post-Traumatic Pain Syndromes
18 -19 August 2005

The Victoria University Conference Centre, Melbourne
Convenor • George Mendelson • Contact Conference Organiser at
PO Box 385 Malvern Victoria 3143
Phone +61 3 9509 7121 • Fax +61 3 9509 7151
Email info@conorg.com.au

The International Association for Pain and Chemical Dependency

The IAPCD is a newly founded association which aims to extend the work of the highly successful International Pain and Chemical Dependency Conferences which have been held in the USA over the last 8 years. The organisation is to be truly international as reflected in the membership and the Executive Board.

The immediate aims of the IAPCD are to:

- 1 Promote appropriate treatment for all patients with pain, including individuals with substance use problems
- 2 Support one another when undertaking the difficult and sometimes controversial work of appropriate prescribing of controlled substances such as opiod drugs for patients with acute or chronic non-cancer / cancer pain
- 3 Provide educational opportunities for all healthcare professionals working in this emerging discipline of medicine
- 4 Work with regulators, law enforcement, politicians, lawyers, pharmacists and the media to improve communication and education regarding the appropriate use of controlled substances while supporting their appropriate use in medical care
- 5 Promote strategies and practices that decrease misuse or diversion of controlled substances while supporting their appropriate use in medical care

A unique feature of IAPCD is the opportunity to participate in a closed email information exchange network called e-Bulletin.

The Australian representative of the Executive Board is Dr Ian Buttfield who acts as Chairman of the Association.

Contact Dr Ian Buttfield via email at:
buttfield@ozemail.com.au

Upcoming Meetings - Dates

Faculty of Pain Medicine Refresher Course: 'Pain & the Brain'

6 May 2005 • Aotea Centre, Auckland, New Zealand

Email painmed@anzca.edu.au

Website: www.fpm.anzca.edu.au

3rd Annual Comprehensive Pain Board Review Symposium

2 - 6 August 2005

Marriott Madison West Hotel, Middleton, Wisconsin, USA

Email for information to cj.kaltenberg@hosp.wisc.edu

Website www.orthorehab.wisc.edu/rehab

Expanding Vistas in Neuropathic Pain

An official satellite of the 11th World Congress on Pain

17 - 20 August 2005 • Ayers Rock Resort, Northern Territory, Australia

Contact DC Conferences • Phone 02 9954 4400

Email mail@dcconferences.com.au

Website www.dcconferences.com.au/npp2005

Partners in Pain: Patients, Clinicians and Pain Management

An official satellite of the 11th World Congress on Pain

18 - 19 August 2005 • Sydney Convention & Exhibition Centre

Darling Harbour • Sydney NSW Australia

Contact DC Conferences • Phone 02 9954 4400

Email pinp@dcconferences.com.au

Website www.dcconferences.com.au/pinp2005

CCSM • Chronic Condition Self Management Workshop In conjunction with the 2-Day Partners in Pain Conference

19 August 2005 • Sydney Convention & Exhibition Centre

Darling Harbour • Sydney NSW Australia

Contact DC Conferences • Phone 02 9954 4400

Email ccsm@dcconferences.com.au

Website www.dcconferences.com.au/pinp2005

IASP 2005 11th World Congress on Pain

21 - 26 August 2005 • Sydney NSW Australia

Contact Sarah Foda at TourHosts Pty Ltd • Phone 61 2 9248 0809

Email sfoda@tourhosts.com.au

Website www.iasp-pain.org

International Conference on Orofacial Pain and Temporomandibular Disorders • ICOT 2005

An official satellite of the 11th World Congress on Pain

27 - 28 August 2005 • 26 Aug - Pres's Reception & Registration

Sydney Convention & Exhibition Centre • Sydney, NSW, Australia

Contact DC Conferences • Phone 02 9954 4400

Email icot2005@dcconferences.com.au

Website www.dcconferences.com.au/icot2005

AACPDM Australasian Academy of Cerebral Palsy and Developmental Medicine: 'Completing the Picture'

10 - 12 March 2006 • Adelaide Hilton Hotel, SA, Australia

DEADLINE CALL FOR ABSTRACTS 15 AUGUST 2005

Contact DC Conferences • Phone 02 9954 4400

Email aacpdm@dcconferences.com.au

Website www.dcconferences.com.au/aacpdm

Australian Pain Society 26th Annual Scientific Meeting: 'Pain across the Lifespan'

9 - 13 April 2006 • Grand Hyatt Melbourne, VIC, Australia

DEADLINE CALL FOR WORKSHOPS 17 JUNE 2005

DEADLINE CALL FOR FREE PAPER & POSTER ABSTRACTS 1 NOV 05

Contact DC Conferences Pty Ltd for further details:

PO Box 637 North Sydney NSW 2059 Australia

Phone 61 2 9954 4400 • Fax 61 2 9954 0666

Email mail@dcconferences.com.au

APS Secretariat Website www.dcconferences.com.au

APS Website www.apsoc.org.au

New Members

The Society would like to welcome new members to the APS

Mr Mark Aspinall	VIC	Agency Business Manager	(Regular)
Ms Bonny Foye	NSW	Nursing	(Regular)
Ms Denise Harrison	VIC	Nursing	(Student)
Dr Shelley Joe	QLD	Osteopathic Medicine	(Regular)
Dr Richard Upton	SA	Medical Scientist	(Regular)
Dr Louise Welch	QLD	Palliative Care	(Regular)



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Caulfield Pain Management and Research Centre
260 Kooyong Rd, Caulfield VIC 3162
Tel 03 9276 6834 • Fax 03 9276 6675

Vice President: Ms Amal Helou

Royal Prince Alfred Hospital Pain Management Centre QE II
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Tel 02 9515 9739 • Fax 02 9515 9928

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Tel 08 9388 8289 • Fax 08 9386 5927

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Tel 02 4722 8100 • Fax 02 4722 8388

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