

The Australian Pain Society NEWSLETTER

Volume 38, Issue 4



► Editor's Note

Welcome to our June newsletter, which marks the halfway point not only in the calendar year, but also in the IASP Global Year for Excellence in Pain Education. And what better way to educate oneself than to attend a conference! A great scientific meeting was had by all, those of you that attended said it was the best conference ever. Should you not have been able to attend, if you are an APS member, you can access the plenary videos on the website. Tim Austin has written an excellent post conference report and synopsis of the ASM in Sydney. Hope to see you next year on the Gold Coast! Save the date for next year's meeting, 7-10th April 2019, in the IASP Global Year Against Pain in the most Vulnerable.

Continuing along the theme of excellence in education, A/Prof Julia Hush has published enlightening work in her paper "Embedding the IASP pain curriculum into a 3-year pre-licensure physical therapy program: redesigning pain education for future clinicians" to address major deficiencies in pain education of health professionals. It is a great step in the right direction and adds to the IASP endeavor. But there is something you can do to help improve education. Share your views and complete the survey conducted by Curtin University. The survey aims to improve a web based resource tool for consumers, health professionals and government and non-government organisations.

In this edition there are several publications worth a read, Stephanie Davis in her paper on interventional techniques "The place of interventional pain procedures" gives good insight into most techniques, whilst keeping a holistic approach in mind. Tim Austin recalls a meeting with a member of the Argentinian Pain Society and points us towards "Fact Sheets" that have been put together by IASP in the Global Year for Excellence in Pain Education. Readers working with children will also find three papers covering Pain in Childhood.

Have a great month.

Christin Bird
Assistant Editor



Post conference review of the combined Annual Scientific Meeting of the Australian and New Zealand Pain Societies, held in Sydney from April 8-11

By Tim Austin, Local Organising Committee Convenor and APS Treasurer

Well, what a tremendous Sydney Annual Scientific Meeting! The overwhelming vibe of the conference was positive. During the meeting, many people commented that this was the best ASM ever.

The scene was set on Sunday with what can only be described as lively pre-conference workshops, with a record number of participants. Pete Moore’s Pain Toolkit was a unique addition to the array of workshops, and his energy was certainly the spark that kick-started the conference. APS members are encouraged to keep abreast of the Pain Toolkit as it develops. Also, check out Pete’s videos from the conference [here](#).



After a stunning Welcome to Country, it was a true honour for the conference to be opened officially by Prof Fiona Blyth AM. Our International Speakers had so much to live up to, and they did not at all disappoint! Their talks throughout the conference were excellently prepared, and covered so much detail in the time allowed. Frank Huygen broke the most difficult topic of CRPS down into a meaningful current mechanistic understanding. On the back of jet-lag, and speaking in English, he also managed to say Isosorbidedinitrate 3 times in 20 seconds without stumbling once! Stephen McMahon presented two plenaries (including the Pat Wall lecture) on the challenge of understanding why certain individuals appear predisposed to developing pain. He covered genetics, epigenetics,

gender differences, environmental and immune factors and more, always attempting to give mechanistic answers to the many contributors.



Welcome to Country



Prof. Fiona Blyth AM



Prof. Frank Huygen

Liesbet Goubert and Tonya Palermo each presented two plenary lectures around their specialty areas. Liesbet delivered the Sunderland Lecture on the topic of resilience in pain management. Her second lecture on the interpersonal dynamics of pain outlined the theoretical basis for and therapeutic meaning of variables such as stigmatizing and solicitous behaviour. Tonya’s talks covered paediatric pain, firstly looking at the complexity of the numerous relationships involved in children with pain, and secondly, exploring the challenge of addressing sleep in an adolescent population (as if adolescents don’t have enough problems with sleep before you add chronic pain into the mix!).



Prof. Stephen McMahon

The local (Australian and New Zealand) plenary lectures covered an equally large variety of topics. Greta Palmer's plenary fitted so well with those of Tonya Palermo, as it discussed the challenges of accumulating data around the assessment and management of paediatric pain. In the Tess Cramond lecture, Damien Finniss gave a delightful synopsis of the current understandings of the placebo effect, covering Pavlovian theory, the opioid and cannabinoid systems, interpersonal dynamics, expectations and more. Listeners were challenged to consider to what degree their clinical practice might helpfully harness placebo effects. Simon Brookes debunked the myth that basic science lectures have to be boring! He discussed the differences between somatic and gut nociceptors, highlighting the need for a different research approach and clinical management.



Prof Liesbet Goubert



Dr Tonya Palermo



A/Prof Damien Finniss



Dr Leinani Aiono-le Tagaloo



Prof Rachele Buchbinder



Dr Flavia Di Pietro



Mr James Kang

Possibly the most riveting plenary of the week was provided by Leinani Aiono-le Tagaloo. Titled "The road less travelled", Leinani told her own story of growing up in Samoa and then moving to and studying in New Zealand, most extraordinarily tying in her experiences with those of the many chronic pain patients that we treat. She said that initially "being a doctor took away my soul", but then her journey into pain medicine allowed her to be a true physician once more. APS members can listen to all the plenary lectures from this conference via the Members Only area of our website; do not miss Leinani's talk!

Later in the conference, Tony Fernando from Auckland provided a frank assessment of the co-morbid challenge of sleep and pain. He implored clinicians to take active steps to encourage change in sleep in their patients. Rachele Buchbinder and Peter O'Sullivan provided beautifully polar views of musculoskeletal pain; Rachele describing a systems-based approach to collecting and disseminating research data, and Peter looking at the micro view of the patient and the practitioner engaging in treatment approaches that are more strongly evidence-based.

The scientific meeting also provide opportunity for the “next generation” of pain researchers to be involved. It was abundantly clear why Flavia Di Pietro won the 2018 Rising Star Award. Her brief plenary talk covered her current and proposed research interests in topics such as trans-hemispheric and other brain interactions, delightfully showing her skill in deriving research projects from clinical conundrums. Also included in the plenary programme, James Kang and Audrey Wang, completing and recently completed APS/APRA PhD scholars, gave updates on their work, both in brain mechanisms. Current PhD scholar, Sherelle Casey, updated us on her research into cannabis and neuropathic pain and we were delighted to hear from Dr Adrienne Harvey, our first Cops for Kids Clinical Research Grant awardee who shared her findings on the use of gabapentin for managing pain in children with dystonic cerebral palsy. A further innovation in this Sydney conference was a “Trainee” session, which enabled junior researchers to get together with more experienced colleagues, as a way of networking and mentoring. Now in their 10th year, the Rapid Communications are still a hit with the delegates, enabling selected poster presenters with 90 seconds to spruik their research.



Dr Adrienne Harvey



Ms Sherelle Casey

The scientific meetings also provide the opportunity to acknowledge the outstanding contributions of established members. Given his birthplace of New Zealand, and extensive clinical, research and education career in Australia, it was most felicitous that this year Professor Michael Nicholas was awarded the APS Distinguished Member award.



Dr Audrey Wang

The Topical Workshops and Free Paper sessions set a new benchmark in quality and delivery. They covered so many topics, synthesised the relevant research, and always had an eye on clinical outcomes. Even more than usual, delegates “complained” about the challenge of choosing which sessions they would attend, as there was usually more than one concurrent session that held attraction.



L to R: Ms Fiona Hodson, Prof Michael Nicholas and A/Prof Julia Hush

Special mention should be made of the prize winners from the conference; Joshua Pate for the best Free Paper (a child’s concept pain), Sin-Ki Ng for the best Rapid Communication (neural activity during emotional regulation in LBP), and Phil Austin for the best Poster (a self-report measure of central sensitisation).

The social programme at the ASM was innervating to say the least! The Welcome Reception set the scene for a most collegial conference, and enabled delegates and sponsor/ exhibitors to converse in a most convivial atmosphere. First time Welcome Sponsor, the TAC, is to be most heartedly thanked for facilitating this event, and delegates enjoyed wonderful food and some draughts and ales from local Sydney Inner West brewers. The welcome function also provided the opportunity for the APS to launch the much-awaited 2nd edition of the Pain in Residential Aged Care Facilities: Management Strategies book (have you purchased your copy yet?).

On Monday evening, the charming Shelbourne Hotel provided delegates with a chance to chat informally, but there did seem to be some serious networking going on as well! But the “pièce de résistance” of the ASM is always the Conference Dinner, this year at the nearby Doltone House. As usual, dessert (delicious as it looked) was bypassed, as delegates “hit the dance floor” while the band was still warming up! The mood of the night was epitomised by the score or so of dancers still strutting their stuff to the recorded music that was playing whilst the band packed up! Our delightful APS President, Fiona Hodson, revived the tambourine, and if that is not a metaphor, I don’t know what is! To bring the conference to an end, 17 delegates joined a cruise and tour to Cockatoo Island on Sydney Harbour. Our knowledgeable guide provided a most instructive tour of the Island, highlighting the convict heritage through to the more recent naval boat-building. There was also the opportunity to explore some of the Sydney Biennale installations in such a unique setting.



A/Prof Kevin Keay with Sin-Ki Ng



A/Prof Kevin Keay with Joshua Pate



Dr Phil Austin



Welcome Reception



Mr Tim Austin welcoming delegates and sponsors



Ms Tracy Hallen with Ms Fiona Hodson at book launch display wall

There are so many people to be acknowledged with regards to delivering such a special conference. Our sponsors and exhibitors are essential, and delegates are reminded to continue to interact with them. The scientific programming committee under the guidance of Kevin Keay thoughtfully brought together the speakers, sessions, timings and more. The local organising committee gave the conference a truly Sydney flavour. A special thanks goes to the staff of DC Conferences and Alex Robertson, who successfully organised and sustained the conference just days before the birth of her second child! And finally, YOU, the membership! You turned up, delivered workshops, and provided the energy for our collective learning. THANK YOU and see you all on the Gold Coast in 2019.



Gala Dinner packed dance floor



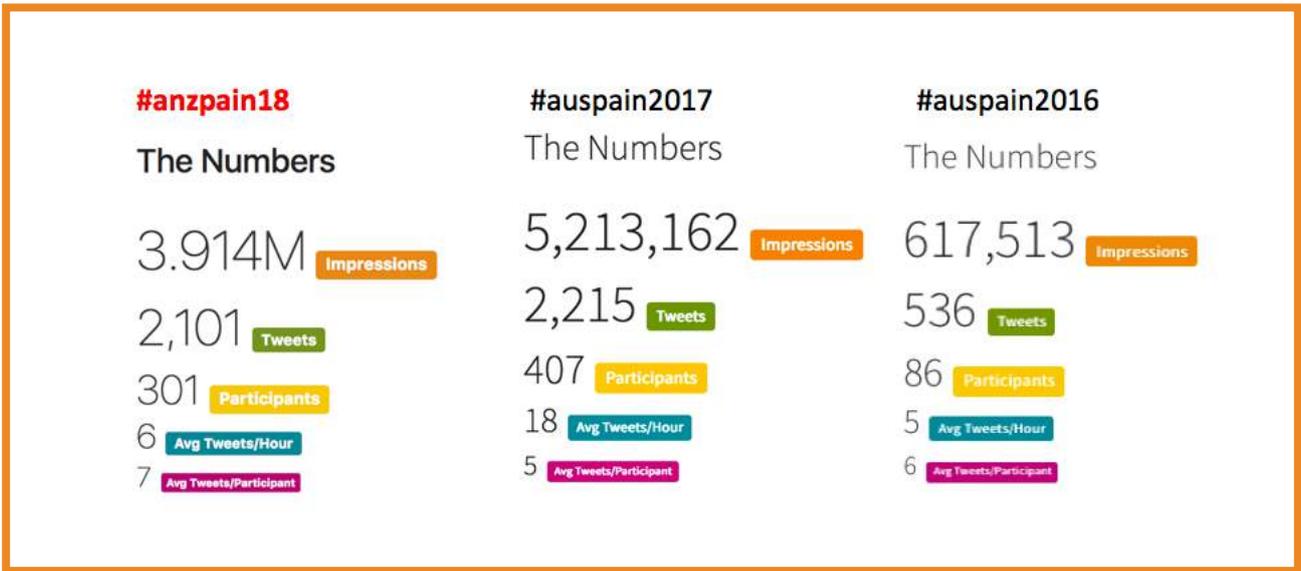
DCC Team L to R: Ms Tracy Hallen, Ms Natalia Kerrilee, Ms Alex Robertson and Ms Jessica Christy



Ms Fiona Hodson with tambourine



Cockatoo Island post conference tour



The #anzpain18 Influencers

Top 10 by Mentions

- @adiemusfree 299
- @AusPainSoc 234
- @paintoolkit2 118
- @anne_burke 114
- @tonyapalermo 71
- @beyondmpain 66
- @MelitaGiummarra 59
- @SimonWatt01 58
- @fionahodson1 51
- @PeteOSullivanPT 46

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Top 10 by Tweets

- @AusPainSoc 597
- @adiemusfree 181
- @paintoolkit2 103
- @anne_burke 75
- @LiesbetGoubert 50
- @FlyingPiegirl 48
- @beyondmpain 48
- @belindabindii 47
- @HemDevan 34
- @SimonWatt01 34

[Tweet](#)

Healthcare Social Graph Score

- @paintoolkit2
- @AusPainSoc
- @tonyapalermo
- @LaPrendergast
- @UONPRCPAN
- @Uni_Newcastle
- @FlyingPiegirl
- @PeteOSullivanPT
- @MelitaGiummarra
- @adiemusfree

[Tweet](#)

The Numbers

3.914M Impressions

2,101 Tweets

301 Participants

6 Avg Tweets/Hour

7 Avg Tweets/Participant

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Twitter data from the #anzpain18 hashtag from Wed, March 28th 2018, 2:45PM to Thu, April 12th 2018, 12:00PM (Australia/Sydney).





Australian Pain Society 38th and
 New Zealand Pain Society
 Conjoint Annual Scientific Meeting
 International Convention Centre Sydney
8 – 11 April 2018

Plenary Videos now available **FREE to APS Members**

Login to the APS Website [Members Area](#)

If you would like to purchase recordings of other APS-NZPS2018 sessions, please use the [EverTechnology online order form](#).



2019 Australian Pain Society 39th Annual Scientific Meeting:

In the IASP Global Year Against Pain in the most Vulnerable



7 – 10 April 2019 Gold Coast Convention and Exhibition Centre, QLD

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Submission Deadlines

Topical Sessions	21 September 2018
Free Papers & Posters	31 October 2018
Rising Star Award	31 October 2018
Early Bird Registration	22 February 2019

Join us online - #auspain19 www.dconferences.com.au/aps2019



Readers are almost certainly aware that this year is the IASP Global Year for Excellence in Pain Education. In the March edition of the APS newsletter, readers were reminded of the wealth of resources that have been provided by the IASP for this occasion.

In particular, there are 4 domains that are being addressed by the Global year: public and government education, patient education, professional education and pain education research. As part of attempts to address these domains, the IASP has put together a number of “Fact Sheets”, and we will bring some of these to your attention in this and future APS newsletters.

The first Fact Sheet brings the reader’s attention to the gap between knowledge and practice in the field of pain management. Somewhat depressingly, the challenges of the opioid epidemic in the West are identified. However, notably, it has been the need to address this issue from a de-prescribing and addiction point of view that has diverted attention from the performance of good quality pain assessment. The fact sheet also notes the world-wide paradox that the immensity of the problem of pain is not appreciated or adequately addressed by governments or other policy makers.

Another interesting fact sheet identifies the typical dearth of pain science and management content in health professional curricula. This relates to all professions; medical, allied health and nursing. In the light of this interesting fact sheet, Julia Hush’s article in this month’s Newsletter is encouraging reading.

APS members are reminded of the specific challenges for this global year: What are you doing to advance pain-related education in your professional area? And, secondly, if you are doing something specific this year in the “education” space, please let the rest of us in the APS know!

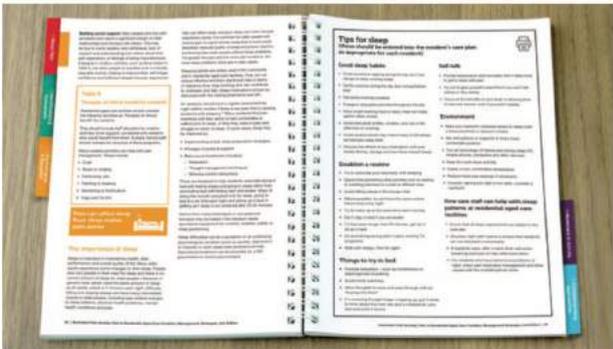


Pain in Residential Aged Care Facilities: Management Strategies
2nd Edition

In the new edition
Improved layout
Colour coded for easy reference
Easy access to printable PDFs
Expanded content
Case Studies

 THE AUSTRALIAN PAIN SOCIETY

- Chapter 1:** About Pain
- Chapter 2:** Identification and assessment of pain in aged care residents
- Chapter 3:** Beyond medication: psychological and educational approaches to pain management
- Chapter 4:** Movement and physical activity
- Chapter 5:** Complementary approaches to pain
- Chapter 6:** Pharmacological treatments
- Chapter 7:** Dementia and cognitive impairment: special considerations
- Chapter 8:** Pain at the end of life
- Chapter 9:** Pain and nutrition
- Chapter 10:** Quality and systems issues



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RECENT PUBLICATIONS

Thank you to APS members Julia Hush and Michael Nicholas and colleague for sharing the following recent publication:

EMBEDDING THE IASP PAIN CURRICULUM INTO A 3-YEAR PRE-LICENSURE PHYSICAL THERAPY PROGRAM: REDESIGNING PAIN EDUCATION FOR FUTURE CLINICIANS

Julia M. Hush PhD, Michael Nicholas PhD, and Catherine M Dean PhD

Article first published online: March/April 2018

PAIN Reports

DOI: 10.1097/PR9.0000000000000645

Link: https://journals.lww.com/painrpts/Fulltext/2018/04000/Embedding_the_IASP_pain_curriculum_into_a_3_year.7.aspx

ABSTRACT

Introduction

Major deficiencies in pain education for health professionals have been recognised. In response, recommendations have been made to better educate health professionals about pain. This paper describes how the 2012 IASP Pain Curriculum for Physical Therapy was prospectively embedded into an Australian pre-licensure Doctor of Physiotherapy (DPT) program at Macquarie University, providing a framework for the redesign of pain education in this context.

Methods

The IASP Curriculum Outline on Pain for Physical Therapy: The pain curricula established by the IASP were designed for teaching courses on pain at the undergraduate and graduate level. The 2012 IASP Pain Curriculum for Physical Therapy consists of 95 specific curriculum elements, structured into four domains: I. Multidimensional Nature of Pain; II. Pain Assessment and Measurement; III. Management of Pain; and IV. Clinical Conditions.

Embedding the IASP Pain Curriculum into the Macquarie DPT Program: The pain curriculum was implemented vertically (in each of the 3 years) and horizontally (in different units in each semester) throughout the DPT program. This was designed to optimise educational outcomes by establishing foundational knowledge at the start of the program, and then extend students' understanding and clinical competencies in the later years.

This paper outlines:

- the guiding pedagogical frameworks that were used to embed the pain curriculum in the program;
- the education model used to synergistically develop the students' pain-related knowledge with the attainment of clinical competencies;
- how the clinical education program enabled students to apply their new knowledge and develop clinical competencies in pain assessment and management throughout their training;
- pain education tools were developed to embed core concepts of pain and a clinical model of pain into the students' education; and
- the blended learning approach used to deliver the pain curriculum, including face-to-face lectures and tutorials, case-based learning, on-line activities, patient simulation activities, clinical education, intensive workshops and flipped classrooms.

Evaluation methods: Pain-related knowledge was evaluated in multiple formats throughout the program. Students' knowledge specifically about pain neurobiology was formally evaluated using a validated questionnaire, the Neurophysiology of Pain Questionnaire (revised 13-item version, NPQ-R). Clinical skills and competencies in the assessment and management of patients with painful conditions were assessed during block clinical education placements by the clinical educators using the Assessment of Physiotherapy Practice tool, which has established reliability and validity and has been implemented across Australia.

Results

Curriculum Mapping: The 95 elements of the 2012 IASP Curriculum on Pain for Physical Therapy were successfully embedded into the Macquarie DPT program. Each curriculum element has been explicitly mapped at the level of each unit and learning outcomes within units.

Pain Neurobiology Knowledge: The students' knowledge of pain neurobiology on entry into the DPT program was consistently low, with a mean NPQ-R score of 56% (95%CI 54 to 58), n=236. By the end of the first Semester, the students' pain neurobiology knowledge had improved to a mean NPQ-R score of 78% (95%CI 76 to 80), n=192. This improvement is maintained throughout the program, indicated by re-assessment in 3rd year (mean NPQ-R score of 77% (95%CI 75 to 79), n=100).

Clinical Skills and Competencies: The first 100 DPT graduates demonstrated a high level of clinical skills and competencies, as indicated by the mean Assessment of Physiotherapy Practice tool mark of 78% (SD: 4). Students who completed a 5-week pain management clinical placement had a mean clinical performance score of 86% (SD: 6). This performance was 10% higher (95% CI 3 to 17) than the mean score of their peers who completed elective placements in non-pain management settings, and higher than normative scores of 76% (SD: 15) of Australian physiotherapy students on clinical placements.

Discussion

In this paper, we describe the design and development of a pre-licensure physical therapy program in which each of the 95 elements of the IASP Pain Curriculum for Physical Therapy has been prospectively and explicitly embedded across a 3-year DPT program, and mapped at the level of specific units and learning outcomes. As far as the authors are aware, this is the first time this has been achieved in any pre-licensure physical therapy program in the world.

We provide evidence that across the Macquarie DPT program physical therapy students improve their knowledge about pain and also that they achieve a high level of clinical competencies in pain management. While we will continue to evaluate

the clinical outcomes of students and graduates of this program, it is hoped that the education provided to the first 3 Macquarie DPT graduate cohorts, and future graduands, will help to achieve the key educational goal of Australia's National Pain Strategy, which is "to increase the skill of health professionals through comprehensive education and training in evidence-based pain management."

Conclusions

Pain education for health professionals can be integrated into pre-licensure university programs using the IASP Pain Curricula. This approach addresses current educational recommendations from national and international pain authorities and will help to transform the future of our healthcare workforce to competently manage patients suffering from pain.

Declaration

The authors have nothing to declare.

THE PLACE OF INTERVENTIONAL PAIN PROCEDURES

Stephanie Davies

STEPHANIE DAVIES

MB BS, FANZCA, FFPMANZCA

Dr Davies is a Pain Medicine Specialist Physician; Founder of Painless Clinic; Co-Chair, WA Persistent Pain Framework; Adjunct Associate Professor, School of Physiotherapy, Curtin University; and Senior Lecturer, School of Medicine and Pharmacology, University of Western Australia, Perth, WA.

Interventional pain procedures are used for diagnosis and localisation of pain, and are also used for therapeutic purposes. They can be an additional tool to manage pain symptoms and must be considered part of the range of strategies for pain management.

Interventional pain procedures are part of an integrated, broader pain management plan. The aim of these procedures is to treat people with chronic pain. They are performed in conjunction

with specific rehabilitative interventions and pain education that is taught by doctors, physiotherapists, occupational therapists, chiro- practors, exercise physiologists and pain psychologists. These practitioners teach active pain strategies and skills such as coaching for daily walking and activities (pacing), simple movements and stretches, muscle retraining, short-term goal setting, motor-guided imagery, mindfulness, meditation and relaxation. Yoga and Tai Chi are good group-based options for some of these skills and are readily available in the community.

Before considering an interventional pain procedure, the person in pain should be engaged in their own prehabilitation, movements and pacing activities. After the patient assessment, pain options relevant to the individual patient should be discussed. A pain management plan is then agreed on and understood by the patient (and their partner or family members) and the treating medical doctor, and communicated to other relevant healthcare professionals ('coaches').

There are individual and societal complexities relating to the person in pain, and pain can have the added complication of many inputs from multiple separate anatomical structures.



KEY POINTS

- If the patient has a dominant anatomical pain source, pain procedures can be part of the range of sociopsychobiological strategies for pain management.
- Pain medicine physicians are trained to incorporate active behavioural strategies with conventional medical options.
- Pain medicine physicians decide whether pain procedures are suitable and which procedures to perform.
- People with pain should be encouraged to undertake daily walking, simple movements, pacing activities, mindfulness meditation and threat-reduction activities before pain procedures.
- Pain cannot be localised using current imaging techniques, so pain procedures are used to help diagnose anatomical pain sources.
- Therapeutic pain procedures can provide three to 12 months of pain reduction, which can provide a therapeutic window for the patient to progress with their active behavioural pain strategies.
- If therapeutic procedures provide the patient with pain relief and the pain then recurs, a repeat procedure will usually provide similar relief if the pain sources are shown to be the same.

DEFINITIONS RELATING TO DIAGNOSTIC AND THERAPEUTIC INTERVENTIONAL PAIN PROCEDURES^{5,6}

Prehabilitation: preoperative optimisation of a patient's physical functionality to enable them to maintain a normal level of function during and after surgery.⁶ In this context, it refers to the patient being coached in global and local movements and pacing activities before the procedure.

Interventional pain procedure: piercing of the skin with needles, probes, catheters or stimulation leads to reach a precise anatomical location to deliver medicines or modulate nerve transmission for diagnosis or treatment of pain, as a trial or therapeutic procedure. Usually performed in conjunction with imaging to confirm correct needle positioning with radio-opaque contrast, or with fluid-volume effect if using ultrasound.⁵

Diagnostic interventional pain procedure: instillation of local anaesthetic (LA; usually a low volume) with a precisely placed needle in the anatomical structure or over the anatomical path of the sensory nerve from the pain source being investigated. The procedure is performed with imaging to confirm correct positioning of the needle with radio-opaque contrast, or with fluid-volume effect if using ultrasound. This allows reproducibility if a significant reduction in pain is achieved during the LA phase. Placebo-controlled diagnostic blocks or comparison between durations of LA action require repeated procedures and are the gold standard. These diagnostic procedures are to determine the relative contributions of anatomically linked sources of pain because people can have multiple pain inputs from multiple structures. Co-instillation of corticosteroids and other adjunctive medicines in some patients may prolong benefit and, in these instances, the procedure can be both diagnostic and therapeutic.⁵

Therapeutic interventional pain procedure: piercing of the skin with needles, probes, catheters and/or stimulation leads to reach a precise anatomical location to deliver medicines to the targeted areas or modulate nerve transmission, with the expectation of pain relief for weeks, months or years. These therapeutic procedures are usually performed in conjunction with imaging to confirm correct positioning of the needle with radio-opaque contrast, or fluid-volume effect if using ultrasound.⁵

Neurotomy: precise placement of needles or probes over the anatomical path of a sensory nerve from an established pain source; pulsed radiofrequency modulates nerve or spinal cord conduction; cryotherapy (freezing) and thermal continuous radiofrequency (heating) interrupt sensory and motor nerve conduction.

Pain proceduralist: a specialist in interventional pain procedures; can include pain specialists, radiologists, rheumatologists, neurosurgeons and orthopaedic surgeons. Practitioners usually perform some procedures commonly and some occasionally. Some practitioners do not perform some procedures.

Corticosteroid: The corticosteroids that tend to be used for interventional pain procedures are glucocorticoids: triamcinolone, betamethasone, methylprednisolone and dexamethasone.

T1 and T2 MRI: cerebrospinal fluid appears dark on T1-weighted imaging and appears bright on T2-weighted imaging. A third commonly used sequence is fluid-attenuated inversion recovery (FLAIR), which is similar to a T2-weighted image except that the echo time and repetition time are very long.

T2-weighted image: one of the basic pulse sequences in MRI. The sequence weighting highlights differences in the T2 relaxation time of tissues.

STIR: short-TI inversion recovery; typically used to null the signal from fat. In STIR imaging, the effects of increased T1 and increased T2 are additive. This means fluid is more brightly seen as 'white dots' in the posterior disc. It also makes plaques due to multiple sclerosis more obvious.

Isolation of specific anatomical targets that contribute significantly to a person's pain can help guide low-risk procedural pain interventions that can provide medium- to long- term relief. These interventions modulate pain with biological reversal of some pain pathways, rather than providing an anatomical 'fix'. Specifically, the emerging biology of pulsed radiofrequency neurotomies (also known as rhizotomies) shows that these procedures are unique, in that they provide pain relief without causing significant damage to nervous tissue. Animal studies show that modulation of pain transmission in the spinal nerves and spinal cord can be achieved by a range of mechanisms, including modulating gene expression¹ and microglial neurotransmitters.²⁻⁴ These concepts are beginning to provide explanations of the biological mechanisms for pulsed radiofrequency modalities for managing pain.

This article presents a simplified version of anatomical pain and how interventional procedures are used. In clinical practice and research, healthcare professionals and patients need to be aware that the clinical reality is not always straightforward. Patients commonly present with more than one pain source, and so it is common for patients to undergo combined procedures.

The definitions of diagnostic and therapeutic interventional pain procedures have previously been discussed and are outlined in the Box.^{5,6} Here, we will focus on spinal pain because most of our specialist procedural work (about 70 to 90%) is treating spinal pain, with about 5 to 15% of our procedural work being for joint pain and about 5 to 15% being for regional pain. Pain procedures are discussed in two sections; diagnostic procedures and therapeutic procedures.

Diagnostic procedures

FACET JOINT INJECTIONS AND MEDIAL BRANCH BLOCKS

The only way to confirm if facet joints are contributing to back pain is to perform low- risk diagnostic facet joint injections or medial branch blocks using local anaesthetic (LA). Back pain is common, with 80% of people having

a significant episode of back pain during their life. Causative lesions are often not visible when imaging methods such as plain x-ray, MRI, CT or bone scanning are used.⁷ The preferred current method to establish if spinal pain is coming from facet joints is to perform facet joint injections or medial branch blocks. The facet joints and muscles behind them commonly contribute to lumbar and cervical spinal pain, and less commonly to thoracic spinal pain. Facet joint pain can be localised to the back or can radiate to other parts of the body. Cervical facet joint pain can spread up and over the back of the head or down the arm (but not usually into the fingers). Thoracic facet joint pain can spread around the anterior chest, and lumbar facet joint pain can spread down to the legs (but not usually into the toes).

Facet joint injections and medial branch blocks are performed using LA, with imaging to confirm the position of the needle.^{8,9} The LA numbs the facet joints and posterior elements (the structures behind the facet joints) for several hours (the block time varies depending on the LA used). If the patient's pain is reduced by 50 to 70%, a tentative diagnosis can be made that that percentage of pain is coming from the facet joints or posterior elements.

It is often misunderstood that facet joint injections (or medial branch blocks) are performed primarily for diagnosis.¹⁰⁻¹⁴ The confusion occurs because some patients also get ongoing relief, which is a 'bonus' therapeutic effect. If it can be shown that a significant part of the pain is coming from the facet joints, during the LA phase, without ongoing pain relief resulting, neurotomies (at multiple levels) can be performed, which often provide longer-lasting relief, sometimes for many months.¹⁵

INTERVERTEBRAL DISC INJECTIONS

The only way to confirm which (if any) intervertebral discs are contributing to pain is to perform diagnostic disc injections using LA and imaging (discography). Disc injections are usually at a single disc level, or in some cases at two or three levels. The LA numbs the disc for a few hours. If there is pain provocation of 70%, this may indicate that the disc is a pain source, but the false-positive rates are high for this procedure.¹⁶

THE PLACE OF INTERVENTIONAL PAIN PROCEDURES

Stephanie Davies

It is best to maximise use of pain therapies before disc injections because infection in the disc (discitis) after disc injection is more likely and can be more serious than for other spinal pain procedures. The risk of discitis is about one in 100 to one in 1000, even when prophylactic antibiotics are given at the time of the procedure.

Disc injections can be requested by surgeons before they consider spinal fusion and after more common sources of pain have been excluded.¹⁵

PERIPHERAL JOINT INJECTIONS

Injections into the sacroiliac joint, shoulder, hip, knee, and hands and feet, using imaging and contrast dye to localise injections, then using corticosteroid and LA, are often diagnostic and therapeutic.¹⁷⁻²¹ If the corticosteroid does not provide ongoing relief, animal-derived or synthetic hyaluronic acid or platelet-rich plasma are also options to consider.²²⁻²³

MRI AND HIGH-INTENSITY ZONES

If pain radiates to the fingers or toes, radicular pain is considered, and an MRI may further delineate the affected anatomical areas. The most common changes associated with spinal pain that are seen with MRI are high-intensity zones (HIZs; annular tears or fissures), which show as white dots on the scan. The HIZs in the posterior disc are a result of inflammation that can lead to inflammatory fluid accumulating in the epidural space, which irritates the nerve where it exits the spine through the foramen, close to the disc. In our pain practice, we call this characteristic white dot the 'Davies dot of pain'. We have spent the past few decades looking for these white dots and teaching pain registrars, GPs and physiotherapists to look for them, because radiology reports are variable in commenting on them. It is important to note that these white dots look non-threatening, so giving them a non-threatening name can help reduce a patient's concern about anatomical changes. We show the scans to patients because the scans help us explain a person's pain and thus help them gain a better understanding of their pain and their spine.

These HIZs are only seen on the T2-weighted, or extra short-TI inversion recovery (STIR) films, in which the higher magnetic spin makes fluid such as cerebrospinal

fluid (CSF) appear white. Inflammatory fluid in the epidural space can not be identified on MRI scans because it looks the same as CSF on an MRI scan. The inflammatory chemicals irritate the nerves, causing neuralgia (chemical radiculitis). The pain from radiculitis has been described as shooting pain or electric shocks, and it can make the arms or legs feel like they are expanding or 'exploding'. The skin is often sensitive and painful to touch (allodynia), which is a hallmark of nerve pain (neuralgia or neuropathic pain).

Radiological reports vary in whether comments are made about these small HIZ changes, which appear benign. It is often useful to show the HIZs on scans to patients, because it can help them gain a better understanding of their pain and their spine. Telling patients that the white dots are not tears or fissures, but are signs of the body healing itself through the inflammatory process, can be helpful.

Therapeutic procedures

The aim of therapeutic procedures is to provide pain relief for a few or many months.

NEUROTOMY

Neurotomy, a common therapeutic procedure, requires a precisely placed needle or probe over the anatomical path of the sensory nerve from the established pain source. There has been some development of devices and modes, for example, the introduction of cooled thermal radiofrequency.

Pain messages are interrupted by targeting the nerve(s) that supply the pain source. The following percutaneous procedures do not physically cut the nerve; rather, they alter nerve conduction. Nerve conduction can be interrupted using different modalities, needles and probes, as follows.

- Pulsed radiofrequency neurotomy (PRFN) uses neuromodulation to reduce pain messages. This does not destroy the functionality of the nerve and does not inhibit multifidus muscle contractions. Pain flares are uncommon.
- Cryotherapy neurotomy involves freezing the nerve and is commonly used if patients have a pacemaker.



Figure 1. Lumbar peripheral electrical nerve stimulation with expanding-tines probe, left L3 and L4; oblique view.

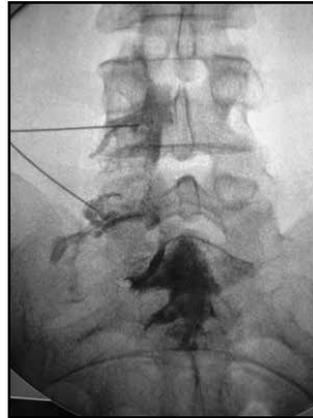


Figure 2. Caudal-entry epidurogram to L5 to S1 with left L4 and L5 transforaminal epidural corticosteroid injections.

EPIDUROGRAMS AND EPIDURAL CORTICOSTEROID INJECTIONS

It is a key point that clinical examination (rather than radiological reports) is the best indicator of the symptomatic nerve root, followed by re-checking of the T2 MRI images for central or foraminal white dots. An epidurogram is used to corroborate pain symptom levels.

Disc bulges, protrusions or extrusions causing neuralgia also respond to targeted epidural corticosteroid injections and anti-tissue necrosis factor antagonists.²⁵⁻²⁹

Many people have a mixed pain pattern with a posterior element (facet joint and multifidus muscle) and radicular pain. Therefore, there can be many pain sources. In these cases, combined procedures can be appropriate, such as PRFN and caudal-entry epidurograms with transforaminal epidural corticosteroid injections, based on the epidurogram (Figure 2).

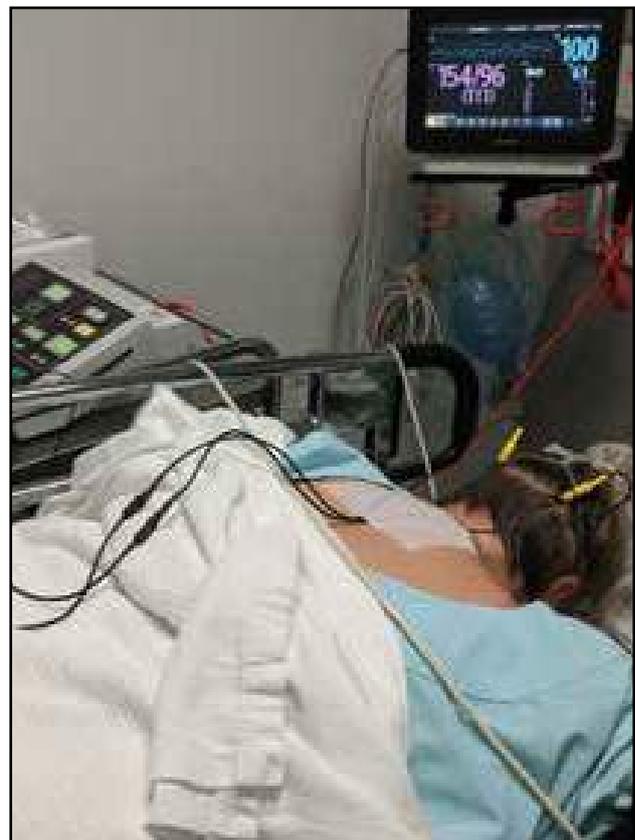
It reduces the functionality of the nerve for a variable period of time. It results in inhibition of multifidus muscle contractions for several weeks and pain flares are uncommon.

- Continuous (thermal) radiofrequency neurotomy (CRFN) causes a thermal burn in the tissues. It is also known as radiofrequency ablation, as it destroys the functionality of the nerve for a variable period of time. CRFN inhibits multifidus muscle contractions for several months and can cause pain flares.
- Probes with expanding tines or a split probe tip enhance radiofrequency and increase the area of modulation (in PRFN) or ablation (in CRFN) (Figure 1).
- For facet joint pain (posterior element pain), pain proceduralists perform neurotomies targeting the medial branches of the dorsal rami nerves that supply the painful facet joints.^{14,24} Intra-articular PRFN can also be used for small joints.

JOINT DENERVATION

Pulsed radiofrequency modulation is useful when injections do not provide relief from peripheral joint pain. Examples of this are the suprascapular nerve of the shoulder, the geniculate and saphenous nerves of the knee and the obturator nerve of the hip.

Figure 3. Peripheral electrical nerve stimulation of the greater occipital nerve; patient in recovery room.



PERIPHERAL ELECTRICAL NERVE STIMULATION

Peripheral electrical nerve stimulation (PENS) probes are used selectively to stimulate peripheral nerves for the relief of chronic neuropathic pain. PENS is used along an identified nerve or in an area of neuropathic pain, using pulsed radio-frequency for 25 minutes in the recovery room after the operation to place the probes (Figure 3).^{30,31} A short electrically conductive probe is inserted either alongside the peripheral nerve (peripheral nerve stimulation) or placed in a painful area that may not be associated with a named peripheral nerve (peripheral nerve field stimulation) with ultrasound to ensure it is positioned correctly.

The NeuroStimulator PENS therapy electrical generator is provided free on loan, and is reusable. The PENS probes are sterile for single use with costs comparable to probes used for neurotomies. Typically either one or two probes are used for each patient. If the pain returns, PENS therapy can be repeated and an implanted device can be considered; however, these are costly. Lower-cost deployable probes with external radiofrequency transmitters may become available in Australia later in 2018.

STIMULATORS

Neuromodulation is a rapidly expanding area of research, with the development of paraesthesia-free stimulation modalities including high-frequency (10,000 Hz) stimulation, burst stimulation and dorsal root ganglion stimulation.³²⁻³⁶ These new modalities provide more options for managing pain than historical devices using only one (tonic) mode.

Sedation for interventional pain procedures

Anaesthetic sedation is used in most pain procedures, especially when there are many needle procedures to perform. It is also used if significant allodynia is present. As in usual anaesthetic practice, the patient fasts before the procedure, which is performed in an operating theatre. Some procedures may not be performed if the patient is receiving anti-coagulation therapy, unless it is stopped, with some patients needing bridging injections of enoxaparin for up to 18 to 24 hours preoperatively.

Advances in spinal procedural interventions

Current practice for spinal procedural interventions involves imaging guidance, including use of C-arm fluoroscopic devices (image intensifiers), CT and real-time ultrasound imaging. The choice depends on factors such as adequacy of visualisation, which varies depending on the target location, potential radiation exposure with CT, cost to the patient and the overall cost to the healthcare system. The choice, therefore, often also depends on the insurance status of the patient.

Access to procedures and funding considerations

Private health insurance or third-party payers (e.g. workers' compensation or motor vehicle insurance) enable access to inpatient private pain specialists. Uninsured patients and patients whose procedures will not be paid for by third parties can pay for procedures themselves, or pain specialists can often refer them to interventional radiologists for selected procedures, some of which are partly covered by Medicare. Private outpatient consultations are usually partially covered by Medicare and third-party payers but not by private health insurance. Public government inpatient and outpatient services are usually performed at no direct cost to the patient, and the cost to the government is similar to the private cost.

Take home message

It must be emphasised that procedural pain interventions can provide an additional tool to manage pain symptoms. They must be considered part of the range of sociopsychobiological strategies in pain management.

REFERENCES

A list of references is included in the online version of this article (<https://painmanagementtoday.com.au/2018/march/regular-series/place-of-interventional-pain-procedures>).

COMPETING INTERESTS

None.

Early in May, it was a delight to meet up with Maria Guadalupe Rosales from the Argentinian Pain Society.

Maria was in Australia for about 6 weeks, collaborating with the Psychology department at Sydney's Macquarie University on her PhD. She has been developing and implementing a questionnaire on rumination as it relates to chronic pain, obviously focussing on the Spanish language equivalent.

Maria is the Scientific Secretary on the Council of the Argentinian Pain Society. She was able to share the challenges and current foci of her national pain society. Not unlike Australia, Argentina has challenges incorporating true inter-disciplinary care, and this is particularly difficult in rural areas. Argentina, quite like Australia, is a large country, with vast distances separating the different states, and there are many regional towns in between.

However, whilst discussing our respective countries, it was apparent how we are relatively blessed in this country with regard to the many facilities that we do have. Whilst we cry out for more pain services and better funding for those that already exist, it is appropriate to remember that we have had many dedicated clinicians, researchers and educators go before us in Australia. The world-first Pain Summit, in 2010, is something of which Argentina could only dream.

One continuing education item that Maria has been involved in may well be of interest to us in Australia. That relates to episodic meetings being held specifically to bring pain society members together to promote dialogue



By Tim Austin, APS Treasurer

and provide updates from the literature. In particular, it has been a great way for Argentina to implicitly stimulate a multi-disciplinary approach to the management of pain. Would APS members be interested in regular informal gatherings such as these across the country?

The meeting with Maria was a great reminder of the worldwide community of pain management in which we are involved. Both the Argentinian and Australian Pain Societies are chapters of the IASP, espousing those beliefs and intents. If you are going to Boston to the IASP Congress, catch up with Maria. She hopes to be there and would love to continue to discuss all matters "pain"!

HAVE YOU HAD AN ARTICLE ACCEPTED FOR PUBLICATION THIS YEAR?

Reminder that we are keen that members inform us when they have publications so that this can be shared with your APS colleagues. Please send the newsletter editor (via the APS Secretariat, aps@apsoc.org.au) the title, authors and reference (i.e. the journal, volume etc.) of the article, preferably with a short explanatory note to give our readers the gist of the article, e.g. the conclusions part of the abstract; if you would like to supply a short commentary on the article, even better.

Christin Bird, Assistant Editor

WE ARE REVIEWING OUR WEBSITE!

The APS website is one of the main ways the Society communicates with its members. It also explains the role of the Society and the work of its members to the general public. So we want to make sure the website works as well as it can, and we'd like your input to make sure it works well for you. We would appreciate if you could spend a few minutes on the website and consider the following questions:

- Do you find the website easy to navigate? Can you find information you need quickly? If not, how do you think this could be improved?
- Do you use the website regularly? If not, why not?
- What features would make the website more useful to you? This might include more resources, education and continuing professional development, or contact with other members, or other features we haven't considered.
- How well does the website present the purpose of the Society, and the work of its members?
- If you work with the general public, would you direct them to the APS website for information? (Keep in mind that the APS is mainly for health professionals and researchers who work with pain, rather than consumers, and there are other consumer-specific websites about pain and pain management, including those from Pain Australia and ACI Pain Management Network).

Please email any suggestions for website improvement to the [APS Secretariat](#)

SUBMISSIONS TO THE NEWSLETTER

We welcome submissions, whether brief or extended, about matters of interest to our readers - for example, reports of educational activities or articles about basic science or clinical research. Please allow time for modifications to be made to optimise a submission's suitability for publication. As we release monthly in advance, submissions received by the 15th of each month will be reviewed for publication in the newsletter of the following month

Stephanie Davies, Editor

SPOTLIGHT ON OUR NEW NSW DIRECTOR



We are pleased to confirm that Dr Tim Ho has joined the Australian Pain Society Board as the NSW Director.

Dr Ho is a rehabilitation and pain specialist. Tim also works in work capacity and addiction medicine. His interests are chronic musculoskeletal pain, neuropathic pain, visceral pain and headache. His research interests are management of co-morbid chronic pain and addiction, return to work program, osseointegration and nursing home resident pain management. Tim is also fluent in Mandarin and Taiwanese.

Tim is already a keen contributor to the APS and we welcome his input as a Board member.



MACQUARIE
University



PRIMARY PRACTITIONER SURVEY

Are you a General Practitioner or Physiotherapist who:

- ✓ Has at least 5 years clinical experience
- ✓ Has treated patients with acute low back pain in the past year
- ✓ Works in a primary care setting (e.g. community based or private clinic/practice or outpatients department in a hospital)

Your input in this study will help us in the design of a new treatment model for acute low back pain.

Please help us **improve health care for back pain** and [click here](#) to complete a quick 10 minute online survey.

SCHOLARSHIP FEATURE

Current Scholars

PhD Scholarship Sponsor Scholar Topic	Seqirus #1-APS-APRA Sherelle Casey <i>"Cannabinoids for neuropathic pain"</i>
Clinical Research Grant Scholar Topic	Cops for Kids #1-APS-APRA Dr Adrienne Harvey <i>"A pilot study of gabapentin for managing pain in children with dystonic cerebral palsy"</i>
Clinical Research Grant Scholar Topic	Cops for Kids #2-APS-APRA Dr Tasha Stanton <i>"Reframe the pain: Dividing attention and altering memory to reduce needle pain and distress in children"</i>

Past Scholars

PhD Scholarship Sponsor Scholar Completed Topic	APS #1-APRA Samantha South 1999 <i>"Antinociceptive pharmacology of morphine and its major glucuronide metabolites"</i>
PhD Scholarship Sponsor Scholar Completed Topic	CSL #1-APS-APRA Lara Winter 2004 <i>"Antinociceptive properties of the neurosteroid alphadolone"</i>
PhD Scholarship Sponsor Scholar Completed Topic	CSL #2-APS-APRA Anne Pitcher 2006 <i>"Conditional comfort: A grounded theory study in nursing approaches to acknowledging and responding to pain in nursing home residents with dementia"</i>
PhD Scholarship Sponsor Scholar Completed Topic	Mundipharma #1-APS-APRA Kathryn Nicholson Perry 2007 <i>"Pain Management Programmes in Spinal Cord Injury: Cognitive Behavioural Pain Management Programmes in the Management of Sub-acute and Chronic Spinal Cord Injury Pain"</i>
PhD Scholarship Sponsor Scholar Completed Topic	APS #2-APRA Debbie Tsui 2008 <i>"Preclinical studies in painful diabetic neuropathy"</i>
PhD Scholarship Sponsor Scholar Completed Topic	Mundipharma #2-APS-APRA Zoe Brett 2011 <i>"Individual differences in vulnerability to the development of chronic pain following injury"</i>

SCHOLARSHIP FEATURE

Past Scholars

PhD Scholarship Sponsor Scholar Completed Topic	APS #3-APRA Susan Slatyer 2013 <i>"Caring for patients experiencing episodes of severe pain in an acute care hospital: Nurses' perspective"</i>
PhD Scholarship Sponsor Scholar Completed Topic	APS #4-APRA Amelia Edington 2013 <i>"Defining inhibitor binding sites unique to the glycine transporter, GLYT2: A potential target for the treatment of chronic pain"</i>
PhD Scholarship Sponsor Scholar Completed Topic	Janssen Cilag #1-APS-APRA Mary Roberts Due 2017 <i>"An investigation of the role of sleep in chronic pain"</i>
PhD Scholarship Sponsor Scholar Completed Topic	Mundipharma #3-APS-APRA Audrey Wang 2017 <i>"The cortical integration of tactile sensation in complex regional pain syndrome"</i>
PhD Scholarship Sponsor Scholar Completed Topic	Janssen Cilag #2-APS-APRA Sarah Kissiwaa 2017 <i>"Pain induced synaptic plasticity in the amygdala"</i>
PhD Scholarship Sponsor Scholar Completed Topic	APS #5-APRA James Kang Due 2018 <i>"Epigenetic influence in cognitive impairments in chronic neuropathic pain"</i>

CALL FOR EXPRESSIONS OF INTEREST

\$1 MILLION IN RESEARCH GRANTS

The HCF Research Foundation's mission is to improve the delivery of health services in Australia for the benefit of all Australians. We do this by funding research projects that focus on new ways to provide high quality care to improve patient outcomes.

The HCF Research Foundation has selected research topics to deliver \$1 million in funding to the research community in health care areas that provide opportunity to significantly improve patient outcomes.

The HCF Research Foundation is seeking Expressions of Interest (EOIs) from research teams interested in funding for **health services research** to begin in 2019.

EOI's are invited for research projects that specifically address the following topics:

- **Hospital Acquired Complications:** Research focussed on reducing hospital acquired complications as identified by the Australian Commission of Safety and Quality in Health Care.
- Use of existing **clinical registry data** to positively impact patient outcomes (*please note that funding to develop clinical registries will not be considered*).

- Research projects that aim to reduce the incidence of **low value health care** provided in the hospital setting.

Applications involving collaborations between investigators from a range of backgrounds, including career researchers, practicing clinicians, policy makers, and the private sector, will be given priority.

Recent research grants awarded by the HCF Research Foundation for 2018 ranged in value from \$80,000 to \$240,000.

Applications will be assessed on scientific merit as well their ability to affect meaningful change to health services provision. **Applications that demonstrate a strong opportunity for translation of research outcomes into practice will be looked upon favourably.**

EOIs received after 5:00pm AEST on Thursday, 14 June 2018 will not be considered.

 EOIs will only be accepted on forms available at hcf.com.au/foundation



THE UNIVERSITY OF
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TDM FOUNDATION PHD SCHOLARSHIP - APPLICATION DATE EXTENDED

We are delighted to announce that the **TDM Foundation PhD Scholarship** is open for applications. This is an opportunity for an outstanding PhD scholar to conduct research in the behavioural and psychological management of chronic pain in adults. The research is to be conducted at the Pain Management Research Institute at the Royal North Shore Hospital, St Leonards.

Application closing date has been extended until **18 June 2018**



THE
AUSTRALIAN
PAIN SOCIETY

ANNOUNCING THE APS/APRA/CFK CLINICAL RESEARCH GRANT #3

The [Australian Pain Society](#) (APS) is a multidisciplinary organisation aiming to relieve pain and related suffering through advocacy and leadership in clinical practice, education and research.

The [Australian Pain Relief Association](#) (APRA) is a registered charity with the Australian Taxation Office and works closely with the APS to support education and research in pain.

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

APS/APRA are pleased to announce our partnership with Cops For Kids, for the second Clinical Research Grant Program (<http://www.apsoc.org.au/apra-clinical-research-grant>)

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

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

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

[Clinical Research Grant Application](#) forms are available online and must be submitted by:

5pm on Monday 10 September 2018.



PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Children With Chronic Pain: Response Trajectories After Intensive Pain Rehabilitation Treatment



Simons, L. E., Sieberg, C. B., Conroy, C., Randall, E. T., Shulman, J., Borsook, D., Berde, C., Sethna N. F. & Logan, D. E. (2018). *Children With Chronic Pain: Response Trajectories After Intensive Pain Rehabilitation Treatment*. *The Journal of Pain*, 19(2), 207-218. <https://www.ncbi.nlm.nih.gov/pubmed/29102693/>

Reviewers:

Joseph Bang & Renee Dana Yee, UNSW Medical Students, Department of Pain & Palliative Care, Sydney Children's Hospital, Randwick, NSW.

Study Group:

Participants were children, adolescents and young adults aged 8-22 years who completed an intensive interdisciplinary paediatric pain rehabilitation day program. 280 patients consented to study participation, with 253 having sufficient follow-up data for trajectory analyses.

Aims:

The study aimed to investigate trajectories of functional impairment and pain symptoms within this population, and to identify characteristics at baseline that were predictive of long-term success or non-response using this program.

Methodology:

This was a longitudinal study with patients who completed an intensive interdisciplinary paediatric pain rehabilitation day program in the US. Measures were taken at admission, discharge, and three follow-ups (1-month, 4-months & 12-months).

Outcomes assessed over time included pain intensity and functional disability. Baseline variables assessed included demographic and pain condition characteristics, social and school functioning, pain catastrophising, pain-related fear, readiness to change, depressive symptoms, and anxiety symptoms. Emotional and functional measures were collected from the child and one parent (asked to complete independently).

Outcome trajectories were grouped using the SAS Trajectory Procedure, with logistic regression analyses examining the relative risk associated with baseline variables and responder trajectories.

Summary of the results:

Most participants perceived significant functional and pain improvements during the first-year post-discharge. Two functional disability trajectories were found: treatment responders (88%) and nonresponders (12%), with no baseline differences found.

Conclusions:

This study suggests that most patients participating in an intensive paediatric pain rehabilitation program will regain day-to-day functional ability, functioning better at discharge and maintaining improvements. This study also found three pain intensity trajectories, with modifiable risk factors for nonresponders (higher anxiety symptoms, precontemplative/contemplative stage of change).

Reviewers critique & take-home message:

Attrition was acknowledged as a limitation (non-random factors likely to influence patients' decision to not return). However, 90% of consenting patients had at least 3 data points included in the trajectory analyses which is commendable in this type of research.

Results were aggregated for participants aged 8-22 years (mean 14.5) without exploring possible age differences in outcome trajectories. Different factors may contribute to patient outcomes at either end of this age spectrum.

This study provides valuable information about the baseline characteristics of paediatric chronic pain patients which may influence outcome trajectories following an intensive pain rehabilitation program. Identifying modifiable

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Children With Chronic Pain: Response Trajectories After Intensive Pain Rehabilitation Treatment



baseline risk factors provides potential treatment targets to optimise a child's treatment response.

The authors suggest that patients with higher anxiety levels may benefit from interoceptive exposure, and that precontemplative/contemplative patients may benefit from motivational interviewing, education and/or possible screening prior to treatment enrolment. They suggest future research consider whether matching baseline patient profiles with tailored treatment approaches alters treatment response trajectories.

Declarations:

No conflicts of interests to declare.

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Genetic and Environmental Influences on Sleep, Pain, and Depression Symptoms in a Community Sample of Twins



Gasperi, M., Herbert, M., Schur, E., Buchwald, D. & Afari, N. (2017). Genetic and Environmental Influences on Sleep, Pain, and Depression Symptoms in a Community Sample of Twins. *Psychosomatic Medicine*, 79,646-654. <https://www.ncbi.nlm.nih.gov/pubmed/28658193>

Reviewer:

Panchalee Perera, Medical Student Researcher, Pain Research Unit, Sydney Children's Hospital

Study Group:

102 monozygotic and 98 dizygotic same sex twin pairs aged 18-65 from the University of Washington Twin Registry.

Aims:

To determine whether sleep quality, current pain, and depression symptoms share a common genetic diathesis and to evaluate potential genetic and environmental sources of covariance and possible causality.

Methodology:

Standardized self-reported questionnaires were used to assess sleep, pain and depression –

- Sleep quality: Pittsburgh Sleep Quality Index
- Pain: Brief Pain Inventory applied to current pain (unspecified)
- Depression: Brief Symptoms Inventory.

Standard biometric modelling was used to determine the heritability of each condition. The classic twin model was used to determine heritability (variance component attributed to additive genetic effects) as well as variance due to non-additive genetic effects (result from the interaction between alleles), shared environmental influences (environmental influences that contribute to twin similarity) and non-shared environmental influences (environmental influences that contribute to twin differences). A series of trivariate Cholesky

decompositions were used to delineate the extent to which the genetic and environmental influences are common or specific to each phenotype.

Summary of the results:

Individually, heritability for sleep quality was estimated at 37%, for pain 25% and depression 39%, the rest of the variance was attributed to non-shared environmental influences. Significant genetic correlations were found between the phenotypes, an r value of 0.69 was found in the correlation between sleep quality and pain score, 0.61 between sleep quality and depression and 0.56 between pain and depression. The corresponding environmental correlations were smaller, suggesting significant overlap in the genes contributing to variance and little overlap in environmental effects.

Conclusions:

Most of the covariation amongst the three conditions was attributed to genetic factors, with non-shared environmental factors making a smaller contribution. A potential causal association was observed in the correlation pattern between sleep and pain as well as pain and sleep and depression. The correlation between pain and depression was more consistent with genetic pleiotropy or a common underlying pathology in the absence of causality.

Reviewers critique & take-home message:

It has been established that sleep impairment, pain (especially chronic) and depression frequently co-occur, with an increased risk of negative outcomes with each additional condition. This study is the first to demonstrate that much of the co-occurrence of these three phenotypes is primarily due to shared genetic factors, supporting clinical efforts to address sleep impairment, pain and depression symptoms together rather than in isolation. The nature of the current pain was not explored, and this merits

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Genetic and Environmental Influences on Sleep, Pain, and Depression Symptoms in a Community Sample of Twins



further attention. The cross-sectional nature of this study means that the direction of these relationships cannot be evaluated, highlighting the need for longitudinal research into these associations to further examine mechanisms of causality.

Declarations:

No conflicts of interests to declare.

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Predictors of the transition from acute to persistent musculoskeletal pain in children and adolescents: a prospective study



Holley, A. L., Wilson, A. C., & Palermo, T. M. (2017). Predictors of the transition from acute to persistent musculoskeletal pain in children and adolescents: a prospective study. *Pain*, 158(5), 794-801 <https://www.ncbi.nlm.nih.gov/pubmed/28151835>

Reviewer:

Anna Kersch, Medical Student Researcher, Department of Pain & Palliative Care, Sydney Children's Hospital, Randwick.

Study Group:

The study recruited 88 participants (aged 10 to 17 years) who presented to the emergency department or orthopaedic clinic for an acute musculoskeletal pain complaint of <1 month duration. Participants were excluded if there was a serious pathology associated with the pain, a surgical procedure conducted/planned at the site, or a history of chronic pain. The average age of participants was 13.76 years and 60.2% were female.

Aims:

This prospective longitudinal study aimed to identify biopsychosocial factors in the acute pain period that predict persistent pain at 4-month follow up in children and adolescents with acute musculoskeletal pain.

Brief Methods:

All participants completed questionnaires (assessing pain characteristics, psychological factors and sleep quality) and participated in laboratory assessment of conditioned pain modulation (CPM) to thermal stimuli at two time points (T1 \leq 1-month post pain onset; T2 4-month follow-up). T1 predictors of three T2 outcomes (pain persistence, pain-related disability, quality of life (QOL)) were analysed using logistic and linear regressions.

Summary of the results:

Of the 77 participants who completed follow-up

assessment at T2, approximately one-third had persistent pain, and, of these, the majority were female. Following regression analyses, results indicated that:

- Female sex and impaired descending pain modulation (assessed with CPM) at T1 significantly predicted persistent pain;
- Depressive symptoms and impaired descending pain modulation at T1 significantly predicted poorer pain-related disability at T2;
- And, poorer QOL and depressive symptoms significantly predicted poorer QOL at T2.

Conclusions:

The authors concluded that identification of factors associated with the transition from acute to chronic pain was possible. Notably, impaired descending pain modulation and depressive symptoms were associated with longitudinally poorer pain outcomes in children and adolescents with acute musculoskeletal pain; lending support for their potential mechanistic role in persistent pain. By identifying these biopsychosocial factors in the acute pain period, at-risk children and adolescents may benefit from targeted interventions.

Take-home Message from the Article:

The article presents promising results that identify and characterise children and adolescents who are at risk of developing persistent pain. As acknowledged, such positive results require further support with larger samples and a longer duration of follow-up. Moreover, caution must be taken when applying these findings to non-musculoskeletal pain given the heterogeneity of pain conditions and consequently, similar research in other pain conditions would be welcome. Depression consistently predicts impaired function in patients with chronic pain.

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

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In addition to self-reported biopsychosocial measures, the study includes experimental pain measurement with the laboratory assessment of CPM to evaluate descending pain modulation, an inhibitory pathway in this context. In future, it would be fruitful to longitudinally investigate an excitatory pathway in a similar cohort, particularly somatosensory tests inferring central sensitisation. Such somatosensory stimulus-response methods are increasingly being applied in office contexts, while at present CPM remains a laboratory procedure.

Ultimately, this study has highlighted that apart from self-reported measures, clinical assessment of experimental pain may be integral to bridging the gap between identifying biopsychosocial predictors for persistent pain and improving long-term clinical outcomes by targeting interventions to children and adolescents at greatest risk.

Declarations:

No conflicts of interests to declare.

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Treatment of disabling headache with greater occipital nerve injections in a large population of childhood and adolescent patients: a service evaluation



Puledda, Francesca, Goadsby, Peter J. & Prabhakar, Prab. (2018). Treatment of disabling headache with greater occipital nerve injections in a large population of childhood and adolescent patients: a service evaluation *The Journal of Headache and Pain*, 19(1), 1-6. doi:10.1186/s10194-018-0835-5 https://www.researchgate.net/publication/322533381_Treatment_of_disabling_headache_with_greater_occipital_nerve_injections_in_a_large_population_of_childhood_and_adolescent_patients_a_service_evaluation

Reviewer:

Dr Joel Champion, Advanced Trainee General Paediatrics/Trainee Faculty Pain Medicine, Sydney Children's Hospital, Randwick, NSW.

Aim:

This study investigates the safety and efficacy of greater occipital nerve (GON) blocks for the management of paediatric primary headache disorders. With a cohort of 159 children and adolescents it is the largest to date and it follows on from an earlier study showing positive results in a North American study (Gelfand 2014).

Study Group:

It is an open labelled, uncontrolled series and involved a retrospective chart review on all GON infiltrations performed between 2009-2016 at the Specialist Headache Centre, Great Ormond Street Hospital for Children. Improvement was the primary outcome and this was defined as more than one third decrease in headache intensity or frequency, or by documented headache improvement in the clinical notes. Of the population, 79% had chronic migraine (CM), 14% new daily persistent headaches (NDPH), 4% trigeminal autonomic neuralgia (TAC), 3% secondary headache and one patient had chronic tension type headache. Nerve infiltration consisting of 30mg 1% lignocaine and 40mg methylprednisolone was performed unilaterally on the side most tender to palpation over the GON.

Summary of the results:

An improvement occurred in 66% (n=105) of all subjects with a mean duration of 9 +/- 4 weeks, with a minimum of three weeks in five patients. 16% of all subjects achieved freedom from headaches for greater than three weeks, of these chronic migraine sufferers were the majority.

There was no significant difference in the response rate and type of headache (migraine 68%, NDPH 59%, and TAC 67%), with secondary and tension type headaches excluded for insufficient numbers.

62% (n=99) of subjects went on to have subsequent injections and 52% (n=51) of these had more than two. Of these 15% were headache free and 67% had an improvement.

Adverse effects were reported in 8% of patients with 11 patients experiencing worsening headache, five of these went onto experience an improvement.

Analysis was undertaken for variables effecting the primary outcome. None were significant although being of older age, female, having chronic migraine, medication overuse, and increased number of past preventer use all had a trend to a positive outcome.

Conclusions:

This research would benefit from long term and functional outcome data including headache related disability and psychosocial assessment.

Around two-thirds of patients experienced an improvement regardless of the phenotype of headache, potentially the result of a common mechanism of action or placebo response. As acknowledged by the authors, the latter cannot be excluded by this study design. There is however supporting evidence from adult data including double-blinded, randomized controlled clinical trials.

PAIN IN CHILDHOOD SIG: JOURNAL WATCH

Treatment of disabling headache with greater occipital nerve injections in a large population of childhood and adolescent patients: a service evaluation



There are low rates of side effects reported. However, there is significant risk of bias, given greater than 20% of the initial cohort of 205 patients were lost to follow up.

Take-home Message from the Article:

This study supports the use of GON infiltration in paediatric patients for the management of treatment refractory primary headache disorders. The high levels of disability and rates of chronicity into adulthood, together with the few evidenced based management options available to clinicians makes this an important study. It also paves the way as a priori power analysis for blinded placebo control studies. Future studies may benefit from the use of a nerve stimulator to isolate the GON, pin-prick testing to determine anaesthesia and rating of the severity of GON tenderness to palpation.

23% of subjects were diagnosed with medication overuse which underscores the importance of the recognition and mitigation of medication overuse headaches in the management of chronic headaches.

The mechanism of action for GON infiltration is uncertain but may be via modulation of the synaptic convergence of somatic and durovascular afferents on the trigeminocervical complex. This study contributes to the growing body of research supporting a commonality in the pathophysiology of paediatric chronic primary headaches as a sensory processing disorder.

Declarations:

No conflicts of interests to declare.



Recent history of pain management services in Australia and New Zealand

Many of the paediatric pain management services in Australia and New Zealand had their genesis within 2 key centres in Sydney where many of the pain management specialists and palliative care specialists began their careers. This has helped develop a very close collaborative paediatric pain management community in both countries. Paediatric pain management clinicians and researchers meet yearly in the Australian Pain Society (APS) and New Zealand Pain Society (NZPS) pain conferences and their respective Pain in Childhood Pain workshops. Every few years the APS and NZPS have a combined conference, as they did this year. The community is close and there is a lot of collaboration between paediatric services. For example there is a new initiative using Telehealth systems to have group discussions between teams or individual clinicians in both countries to meet to discuss cases and to share resources.

In both Australia and New Zealand most children are cared for in the public health care system. Therefore all children, in both countries, with pain issues, have access to high level care at minimal or no direct cost to them or their parents. Private pain management clinics also exist.

In the vast non-urban areas of Australia and New Zealand here there are no centres with paediatric pain management specialists. Clinicians treating children have the ability to contact paediatric pain management centres due to the supportive nature of the Australian

and New Zealand public health systems.

Both countries also have government funded Telehealth systems which allows many patients who require specialist care that is only offered in major centres, to stay at home or in a hospital close to home and still access specialist care.

Interdisciplinary pain management care is the norm in both countries. Even education has an interdisciplinary focus with all clinicians having access to high level pain management education. For example, Sydney University school of medicine offer a masters in medicine/science in medicine – pain management course open to doctors, nurses, physiotherapists etc. and the APS provides members with access to the ANZCA (Australia and New Zealand College of Anaesthetists) Faculty of Pain Medicine Pain modules, usually only accessible to ANZCA members. These interdisciplinary teams are made up of paediatric pain management medical specialists, pain management nurses, psychologists, physiotherapists and social workers. Some also have occupational therapists, play therapists, teachers and others. Most centres have services that are integrated with palliative care services with teams working closely together. This team approach to care promotes the development of a single set treatment goals and therefore consistency in care. Another advantage of our public health systems is that it is the norm for individuals within pain management teams to collaborate with the community health services and schools that will be supporting the child and family in the community. This help promotes the collaboration of care and the development of realistic post discharge goals.

Children with ongoing pain issues transition to adult services when they have reached 16 or finished school. Some hospitals, such as Sydney Children's Hospital, have a formal, but fun, graduation ceremony for patients transitioning to adult services.

Most major centres offer both inpatient and outpatient care for acute, persistent and chronic pain. Most also have pain programs for children and adolescents with persistent and/or chronic pain. Some are intensive programs held in school holidays, some are a day or two each week over a few months.

All major centres in Australia and New Zealand participate in ePPOC, (electronic Persistent Pain Outcome Collaboration). ePPOC is a program developed by the University of Wollongong in collaboration with the Faculty of Pain Medicine, the APS and PainAustralia. It has been designed to help improve services and outcomes for patients suffering with chronic pain through benchmarking of care and treatment.

Basic Pain Research



AUSTRALIAN PAIN SOCIETY
SPECIAL INTEREST GROUP

EXPERT DATABASE

Thank you to those who have already contributed to the BPR SIG Expert Database Survey.

To view the results and complete the survey, login to the APS Website [Members Area](#) and check out the Latest News section

Calling all users of the **painHEALTH** website

Share your views and rate the **painHEALTH** website for a chance to win \$500!

painHEALTH is a web-based resource for people with musculoskeletal pain, providing evidence-based practical tips and guidance about how to help people manage their pain. Based on Google analytics, the website is widely used by consumers, health professionals, Government and non-government organisations.

Curtin University is undertaking a review of the painHEALTH website to understand what works well for end users, what's missing or not working well. The objective is to improve the resource and make sure it is meeting its purpose so people get the right information and practical tips, at the right time. The review is being led by Professor Helen Slater.

Members who use the painHEALTH resources are encouraged to complete the online survey (5 minutes) – [click here](#) to access the survey or go to painhealth.csse.uwa.edu.au

Complete the survey by 30 June 2018 and be entered into a prize draw to win \$500

THE PROJECT HAS BEEN APPROVED BY THE HUMAN RESEARCH ETHICS COMMITTEE AT CURTIN UNIVERSITY (PT0196)



THE LANGUAGE OF CHRONIC PAIN – UNIVERSITY OF TECHNOLOGY SYDNEY

The aim of this study is to explore the language (in particular, the metaphors) which people living with chronic pain use to describe their pain experience. As there is currently no objective biomedical test for the existence or nature of pain, language is of vital importance to the chronic pain experience.

After completing the survey, you will have the chance to enter the draw to win one of five **\$100 Visa Gift Cards.**

To participate, you will need to have chronic pain (pain lasting 12 weeks or longer) and be aged 18 years or older, with good English comprehension and writing ability.

What is involved:

Completion of an anonymous online survey, which should take approximately 15-20 minutes to complete.

To read the Participant Information Sheet and Consent Form and complete the survey please [click here](#).

2018 INTERNATIONAL
MASTER CLASS SERIES



Leading International presenter coming to Australia Associate Professor Kevin Vowles, USA

Changing patient behaviour:
promoting motivation, engagement and rapport.

When and Where?

NSW Tuesday 12 June 2018
VIC Thursday 14 June 2018
WA Saturday 16 June 2018
SA Monday 18 June 2018
QLD Friday 22 June 2018

This event will also be available as a live virtual classroom for delegates all around Australia who cannot attend in person. This will be on Thursday 14 June, 2018.

This is the event of 2018 not to miss! For further details and to register online



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Extend your clinical skills with this interactive 2 day workshop

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"Helps identify ways to work with resistance and challenge" - Psychologist

Melbourne 24th May, 15th November
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THE UNIVERSITY OF SYDNEY

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Specialising in Clinical Pain Management

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Endorsed by the International Society for the Study of Pain (IASP), this leading degree program provides advanced evidence-based and clinically relevant education in pain management for graduates in medicine, dentistry, nursing, physiotherapy, psychology and other allied health disciplines.

The program has been developed and is taught by Sydney Medical School's Pain Management Research Institute (PMRI), based at Royal North Shore Hospital and the University of Sydney's Kolling Institute.

The program is conducted entirely online and commences in March or August each year, with enrolments closing either late January or late June.



For dates & further information visit:
sydney.edu.au/medicine/pmri/education

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WORLD CONGRESS
2018 OF PAIN
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See You in Boston!

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57th ISCoS
 The International Spinal Cord Society
Annual Scientific Meeting
 Combined with the 29th Australia and New Zealand Spinal Cord Society
 (ANZSCoS) Annual Scientific Meeting

13-15 SEPTEMBER 2018
SYDNEY, AUSTRALIA

ICC Sydney, Darling Harbour
www.iscosmeetings2018.org

REGISTRATION NOW OPEN
EARLY BIRD REGISTRATION CLOSES 16TH JUNE 2018

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ISCoS The International Spinal Cord Society | ANZSCoS



THE UNIVERSITY OF SYDNEY

PAIN REFRESH

**PAIN MANAGEMENT
 MULTIDISCIPLINARY
 WORKSHOP 2019**




NZPS NEW ZEALAND PAIN SOCIETY
ANNUAL SCIENTIFIC MEETING
 7—10 March 2019
 RYDGES LATIMER HOTEL CHRISTCHURCH, NEW ZEALAND




FROM WHERE WE STAND



2019 Australian Pain Society 39th Annual Scientific Meeting:

In the IASP Global Year Against Pain in the most Vulnerable



7 – 10 April 2019 Gold Coast Convention and Exhibition Centre, QLD

Expressions of interest online at
www.dconferences.com.au/aps2019

For sponsorship and exhibition opportunities or more information please contact the APS Conference Secretariat

DC Conferences Pty Ltd
P: 61 2 9954 4400
E: aps2019@dconferences.com.au

Submission Deadlines

Topical Sessions	21 September 2018
Free Papers & Posters	31 October 2018
Rising Star Award	31 October 2018
Early Bird Registration	22 February 2019

Join us online - #auspain19 www.dconferences.com.au/aps2019



Organised by:



Save The Date

Date : 11th – 14th April 2019
Venue : Pullman Kuching, Sarawak, Malaysia



8th Association of South-East Asian Pain Societies (ASEAPS) Congress, Malaysia 2019

www.aseaps2019.com | secretariat@aseaps2019.com

FYI

NEW!

• 2018 Annual Scientific Meeting, Sydney –

Media Coverage:

Refer to Twitter hashtag: #anzpain18

1. Chronic Back Pain

- a. 22MAR18 – Prof Peter O’Sullivan (Curtin Uni), ABC Perth: <https://soundcloud.com/user-857774869/prof-peter-osullivan-22318>

2. Diet and Chronic Pain

- a. 26MAR18 – Katherine Brain (Newcastle Uni), ABC Newcastle: <https://soundcloud.com/user-857774869/katherine-brain-abc-newcastle-26318>

- b. 03APR18 – Katherine Brain (Newcastle Uni), Nine News digital: <https://www.nbnnews.com.au/2018/04/03/could-fruit-and-veg-help-alleviate-chronic-pain/>

3. Pain in Children and Adolescents

- a. 28MAR18 – Dr Tinna Jaaniste, Dr Meg Goodison-Farnsworth, Broke Peterson, ABC RN Life Matters: <http://www.abc.net.au/radionational/programs/lifematters/kids-chronic-pain/9587850>

- b. 05APR18 – Dr Meredith Craigie, ABC Adelaide: <https://soundcloud.com/user-857774869/abc-adelaide-5418-paediatric-pain>

4. Sea Snail Venom as Pain Relief

- a. 04APR18 – Prof Macdonald Christie (Sydney Uni), ABC RN Breakfast: <http://www.abc.net.au/radionational/programs/breakfast/venomous-sea-snails-could-help-fight-the-opioid-epidemic/9616702>
- b. 04APR18 - Prof Macdonald Christie (Sydney Uni), ABC News: <http://www.abc.net.au/news/2018-04-04/sea-snail-venom-could-be-the-holy-grail-in-pain-therapeutics/9617670>
- c. 04APR18 - Prof Macdonald Christie (Sydney Uni), SBS News: <https://www.sbs.com.au/news/sea-snail-venom-a-source-of-pain-relief>
- d. 04APR18 - Prof Macdonald Christie (Sydney Uni), Yahoo 7 News: <https://au.news.yahoo.com/sea-snail-venom-a-source-of-pain-relief-39725063.html>
- e. 04APR18 - Prof Macdonald Christie (Sydney Uni), Daily Mail: <http://www.dailymail.co.uk/wires/aap/article-5576359/Sea-snail-venom-source-pain-relief.html>

5. Placebo Power

- a. 08APR18 – A/Prof Damiem Finniss (Sydney Uni), ABC RN All In The Mind: <http://www.abc.net.au/radionational/programs/allinthemind/placebo-power/9613346>

6. Psycho Social Factors of Pain

- a. 11APR18 – Anne Burke and Dr Tonya Palermo (Uni Washington), ABC RN The Drawing Room: <http://radio.abc.net.au/programitem/pgab6E383G?play=true>

For more information about ePPOC, refer to the website: <http://ahsri.uow.edu.au/eppoc/index.html>

- **PainHEALTH website**
<http://painhealth.csse.uwa.edu.au/>
- **Pain Series**
An excellent series of articles run late 2015 by The Conversation: <https://theconversation.com/au/topics/pain-series>
- **ANZCA/FPM Free Opioid Calculator App**
Smart phone app that converts opiates to milligrams of morphine, available for both iPhone and Android: <http://www.opioidcalculator.com.au>
- **Stanford University**
CHOIR Collaborative Health Outcomes Information Registry: <https://choir.stanford.edu/>
- **2018 Global Year for Excellence in Pain Education**
Launched 22JAN18
See information and resources on our website: <http://www.apsoc.org.au/global-year-against-pain>
- **Opioid Podcasts for GPs**
20 week series from the Hunter Postgraduate Medical Institute: <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/>
- **National Strategic Framework for Chronic Conditions**
Final report released 22MAY17: <http://www.health.gov.au/internet/main/publishing.nsf/Content/nsfcc>
- **Podcast: Pain Science and Sensibility Episode 24: Trigger Points, the “Third Space”, and the Merit of Pain Theories with Dr Milton Cohen**
Recorded on 01JUN17: <http://ptpodcast.com/pain-science-and-sensibility-episode-24-trigger-points-the-third-space-and-the-merit-of-pain-theories-with-dr-milton-cohen/>

OTHER ITEMS OF INTEREST FOR OUR MEMBERS

- **Painaustralia eNewsletter** latest issue, available online at <http://www.painaustralia.org.au/media-news/e-news.html>
- **ePPOC: electronic Persistent Pain Outcomes Collaboration**

- **ABC TV “Ask the Doctor”, Series 1, episode 5: Pain**
Broadcast 13JUN17, available until 02SEP20:
<http://iview.abc.net.au/programs/ask-the-doctor/DO1625V005S00>
- **ABC Lateline: Australians’ addiction to prescription opioids soaring**
Broadcast 23JUN17: <http://www.abc.net.au/lateline/content/2016/s4690991.htm>
- **Digital Health Guide**
Developed by Primary Health Network Tasmania:
<https://digitalhealthguide.com.au/Account/Login?ReturnUrl=%2fSpecialtyFormulary%2f2Atlogin,Username:connectingcare,Password:health>
- **ABC Radio Nightlife: Living with Chronic Pain** Interview with Dr Chris Hayes, broadcast 18SEP17: <http://www.abc.net.au/radio/programs/nightlife/pain/8958330>
- **2017 Australia’s Health Tracker by Socio-economic status** Released 28NOV17: <https://goo.gl/ChoJcY>
- **Indigenous Resources**
New webpage on the APS website aggregating Indigenous resources: <https://www.apsoc.org.au/Indigenous-Resources>
- **IASP Statement on Opioids**
Approved February 2018: <https://www.iasp-pain.org/Advocacy/OpioidPositionStatement>
This reference can also be found on the [APS Position Papers](#) webpage.
- **NSW Cannabis Medicines Advisory Service (CMAS)**
Launched 29JAN18
Fact Sheet on our website: https://www.apsoc.org.au/PDF/Fact_Sheets/20180129_NSW-CannabisMedicinesAdvisoryService-CMAS_Fact_Sheet_FINAL.PDF
Service available 9am–5pm Monday–Friday
Hotline: (02) 4923 6200 or email: HNEL-HD-CMAS@hnehealth.nsw.gov.au

HEALTH CARE HOMES

- **Health Care Home resources:** <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes#one>
- **Update 10MAY17:** <http://healthcarehomes.cmail19.com/t/ViewEmail/r/7237191369B-01B262540EF23F30FEDED/1FA9272E4DDC-2B64A29558A201773426>

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE (ACSQHC) RESOURCES:

- **The Second Australian Atlas of Healthcare Variation 2017, released 07JUN17:** <https://www.safetyandquality.gov.au/atlas/atlas-2017/>
- **Online interactive Second Australian Atlas of Healthcare Variation 2017, released 07JUN17:** <http://acsqhc.maps.arcgis.com/apps/MapAn-dAppGallery/index.html?appid=fd3b04ebe-3934733b7ecb8514166c08f>
- **Australian Atlas of Healthcare Variation released 26NOV15:** <http://www.safetyand-quality.gov.au/atlas/>
- **Chapter 5: Opioid medicines: NEW LINK** <http://acsqhc.maps.arcgis.com/apps/MapJournal/index.html?appid=4d683b6e1df04a658cfd3a3f-b9c46f24>
- **Online interactive Australian Atlas of Healthcare Variation released NOV16:** <http://acsqhc.maps.arcgis.com/home/index.html>

NPS MEDICINEWISE RESOURCES

- **Chronic Pain edition issued 01JUN15:** <http://www.nps.org.au/publications/health-professional/nps-news/2015/chronic-pain> and https://www.nps.org.au/medical-info/clinical-topics/news/chronic-pain?utm_medium=twitter&utm_source=17-07-24&utm_campaign=pain&utm_content=pain-week-MN#key-points

FYI

- **Choosing Wisely Australia – News & media:** <http://www.choosingwisely.org.au/news-and-media>
- **Over the counter codeine – changes to supply:** <https://www.nps.org.au/medical-info/clinical-topics/over-the-counter-codeine-changes-to-supply>
- **Medicines with codeine – what you need to know:** <https://www.nps.org.au/medical-info/consumer-info/medicines-with-codeine-what-you-need-to-know>
- **Quick Steps 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>

TGA

- **Codeine information hub:** <https://www.tga.gov.au/codeine-info-hub>
- **Guidance for the use of medicinal cannabis in the treatment of chronic non-cancer pain in Australia, v1-DEC17:** <https://www.tga.gov.au/publication/guidance-use-medicinal-cannabis-treatment-chronic-non-cancer-pain-australia>

NSW AGENCY FOR CLINICAL INNOVATION RESOURCES:

- **Our Mob: Resources for Aboriginal People:** <https://www.aci.health.nsw.gov.au/chronic-pain/our-mob>
- **A Framework for working effectively with Aboriginal people, NOV13:** <http://www.aci.health.nsw.gov.au/about-aci/cultural-respect>
- **Pain Management Network Multicultural report 2015:** http://www.apsoc.org.au/PDF/CALD_Resources/ACI_Report_multi_cultural_focus_groups_2015.pdf
- **Brainman and Pain Tool Kit translations, SEP15:** <http://www.aci.health.nsw.gov.au/chronic-pain/translated-resources>
- **Pain Management Resources:** <http://www.aci.health.nsw.gov.au/resources/pain-management>

- **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>

MEMBERS ONLY AREA OF APS WEBSITE:

- **APS Plenary Recordings:** As an exclusive benefit to APS members, the following Plenary videos are now available for free access:
 - 2018 conference in Sydney
 - 2017 conference in Adelaide
 - 2016 conference in Perth.
- **Better Pain Management online learning modules:** APS members receive a 20% discount.
- **Centric Wealth Newsletters:** APS member funds are invested with Centric Wealth. Market reports are available on the Members Only Area of our website.

APS MEDIA RELEASES:

- Refer to our website for a full listing of media releases: <http://www.apsoc.org.au/Media>

NEW MEMBERS

TITLE	FIRST NAME	LAST NAME	DISCIPLINE GROUP
Dr	Navid	Amirabadi	Pain Medicine Physician
Dr	Patricia	Carroll	Anaesthesia
Mr	Ian	Cheok	Occupational Therapy
Dr	Chui	Chong	Anaesthesia
Mr	Tom	Crouch	Physiotherapy
Mrs	Georgina	Davidson	Physiotherapy
Dr	Charlotte	Elder	Gynaecology
Ms	Alison	Gargan	Physiotherapy
Dr	Samanthi	Goonetilleke	Psychology
Ms	Irina	Grassi	Physiotherapy
Dr	K M Mominul	Hassan	Pain Medicine Physician
Dr	Charles	Howse	Sports Medicine
Miss	Laura	Jordan	Psychology
Dr	Ksenia	Katyk	Gynaecology
Dr	Peter	Lange	Geriatrics
Ms	Hayley	Leake	Physiotherapy
Dr	Justin	Lees	Neurology
Mr	Arthur Sone-Wai	Li	Psychology
Mr	Nick	Olthof	Physiotherapy
Mrs	Julie	Peacock	Physiotherapy
Dr	Fariborz	Rad	Rehabilitation Medicine
Ms	Alethea	Sifis	Occupational Therapy
Dr	Judith	Silberberg	General Practice
Mrs	Alison	Sim	Osteopathy
Mrs	Eira	Taylor	Occupational Therapy
Mr	Alan	Wainwright	Science Research
Ms	Belinda	Wakefield	Nursing
Miss	Daiqing	Yu	Dietetics

CALENDAR OF EVENTS

7-9 Jun 2018

Ukrainian Association for the Study of Pain

3rd East-European Congress on Pain

NSC Olimpiyskiy, Kyiv, Ukraine

<https://paincongress.com>

9-15 Jun 2018

Children's Institute for Pain and Palliative Care, Children's Minnesota

11th Annual Pediatric Pain Master Class

Windows on Minnesota, Minneapolis, USA

<http://www.cvent.com/events/11th-annual-pediatric-pain-master-class/event-summary-8b1ce50f8c844dbd92069810b5777e80.aspx?fqp=true>

10-17 Jun 2018

European Pain School an education project of IASP - EPS 2018

Pain: from Fetus to Old Age

University of Siena, Siena, Italy

<https://eps2018.azuleon.org>

16-17 Jun 2018

Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) Snapshots

Rehabilitation Snapshots 2018

Pullman Melbourne on the Park, Melbourne, VIC

<https://www.dconferences.com.au/snapshots2018/>

21-22 Jun 2019

Empower Rehab

Pain Management in Practice 2 day workshop

Various Venues Brisbane, QLD

<http://www.empowerrehab.com/Workshops/>

24-28 Jun 2018

North American Pain School an educational initiative of IASP - NAPS

To Boldly Go ...: The Future of Pain Treatment

Fairmont Chateau Montebello, Montebello, Quebec, Canada

<http://northamericanpainschool.com/2018-program/>

27-29 Jun 2018

Australian & New Zealand Society for Geriatric Medicine (ANZSGM)

Cutting Edge: Optimising the Journey for Older Surgical Patients

International Convention Centre, Sydney, NSW

<http://www.anzsgmconference.org>

27-29 Jul 2018

Pharmaceutical Society of Australia - PSA18

Leading Pharmacy Innovation

TBA, Sydney, NSW

<https://www.psa.org.au/connecting-with-my-profession/major-events>

CALENDAR OF EVENTS

1-3 Aug 2018

Indigenous Conference Services

2018 International Indigenous Chronic Diseases Conference

Pullman, Cairns, QLD

<http://www.indigenoushealth.net>

28-30 Aug 2018

Australian College of Nursing

The National Nursing Forum 2018 - Diversity and Difference

Gold Coast Convention and Exhibition Centre, Gold Coast, QLD

<https://www.acn.edu.au/nnf2018>

12-16 Sep 2018

International Association for the Study of Pain (IASP)

18th World Congress on Pain

Boston Convention and Exhibition Center, Boston, USA

<https://www.iaspworldcongressonpain.org>

13-15 Sep 2018

International Spinal Cord Society

ISCoS 2018 57th Annual Scientific Meeting of the International Spinal Cord Society with the 25th Australia and New Zealand Spinal Cord Society Annual Scientific Meeting

International Convention Centre, Sydney, NSW

<http://www.iscosmeetings2018.org/>

21 Sep 2018

Pain Interest Group Nursing Issues (PIGNI) Professional Development Day

EOI

SMC Conference & Function Centre, Sydney, NSW

<https://dconferences.eventsair.com/pigni-2018/eoi/Site/Register>

6-9 Oct 2018

Australian Society of Anaesthetists

National Scientific Congress 2018

Adelaide Convention Centre, Adelaide, SA

<http://asa2018.com.au>

11-13 Oct 2018

RACGP - GP18

General practice: The centre of health in Australia

Gold Coast Convention and Exhibition Centre, Gold Coast, QLD

<http://gp18.com.au>

CALENDAR OF EVENTS

25-27 Oct 2018

Australian College of Rural and Remote Medicine (ACRRM) and Rural Doctors Association of Australia (RDAA)

Rural Medicine Australia - RMA 2018

Darwin Convention Centre, Darwin, NT

<http://www.acrrm.org.au/the-college-at-work/rma>

21-24 Nov 2018

AOCPRM 6th and Rehabilitation Medicine Society of Australia and New Zealand (RMSANZ) 3rd Annual Scientific Meeting

North to South, East to West

SkyCity, Auckland, New Zealand

<http://www.aocprm2018.com/aocprm18>

4-14 Feb 2019

Pain Management Research Institute, The University of Sydney

Pain Refresh - Pain Management Multidisciplinary Workshop

Royal North Shore Hospital, St Leonards, Sydney, NSW

<http://sydney.edu.au/medicine/pmri/education/continuing/workshop.php>

7-10 Mar 2019

New Zealand Pain Society Annual Scientific Meeting - NZPS19

From where we stand

Rydges Latimer Hotel, Christchurch, New Zealand

<http://www.nzps2019.nz>

7-10 Apr 2019

Australian Pain Society 39th Annual Scientific Meeting

In the IASP Global Year Against Pain in the Most Vulnerable

Gold Coast Convention and Exhibition Centre, Gold Coast, QLD

<http://www.dconferences.com.au/aps2019/>

11-14 Apr 2019

ASEAPS 2019 - 8th Association of South-East Asian Pain Societies Congress

Building Collaborations In Pain Management

Pullman Kuching, Sarawak Malaysia

<http://www.aseaps2019.com>



THE
AUSTRALIAN
PAIN SOCIETY

VISION:

All people will have optimal access to pain prevention and management throughout their life.

MISSION:

The Australian Pain Society is a multidisciplinary organisation aiming to minimise pain and related suffering through advocacy and leadership in clinical practice, education and research.

AIMS:

- To promote the provision of healthcare services for pain management
- To promote equity of access to pain management services
- To actively engage with key stakeholders and contribute to their activities
- To provide a contemporary forum to discuss issues relating to pain research and treatment
- To foster and support pain-related evidence-based research
- To share and promote the expertise of all disciplines involved in the treatment of pain
- To promote and facilitate evidence-based pain related education for health professionals and the community
- To promote the development and use of standards and outcome measures in everyday clinical practice

DIRECTORS

President:

Ms Fiona Hodson

Hunter Integrated Pain Service
John Hunter Hospital Campus
New Lambton NSW 2305
Tel: 02 4922 3435 Fax: 02 4922 3438



QLD Director:

Ms Trudy Maunsell

Princess Alexandra Hospital
199 Ipswich Road
Woolloongabba QLD 4102
Tel: 07 3176 5547 Fax: 07 3176 5102



President-Elect:

Ms Anne Burke

Royal Adelaide Hospital Pain Clinic
North Terrace
Adelaide SA 5000
Tel: 08 8222 4770 Fax: 08 8222 5904



SA Director:

Dr Michelle Harris

Royal Adelaide Hospital and
Lyell McEwin Hospital
Adelaide SA
Email: michelle.harris2@sa.gov.au



Secretary:

Dr Will Howard

Director, Pain Service
Austin Health
Studley Road
Heidelberg VIC 3084
Tel: 03 9496 3800 Fax: 03 9459 6421



TAS Director:

Mr Simon Watt

Manager Physiotherapy Services
Royal Hobart Hospital
GPO Box 161
Hobart TAS 7000
Tel: 03 6166 8326



Treasurer:

Mr Tim Austin

Camperdown Physiotherapy
Inner West Pain Centre
100 Carillon Avenue
Newtown NSW 2042
Tel: 02 9517 1787 Fax: 02 9516 2491



VIC Director:

Dr Laura Prendergast

Pain Service, Austin Health
Chronic Pain Clinic, Goulburn Valley Health
VIC
Tel: 03 9496 3134 or 03 5832 3020



ACT Director:

Mrs Joy Burdack

Calvary Health Care ACT
PO Box 254
Jamison Centre ACT 2614
Tel: 02 6201 6854 Fax: 02 6201 6949



WA Director:

Mr Shadreck Tozana

Functional Revival and Baptistcare Bethal
2 Bethal Way
Albany WA 6330
Tel: 0437 541 165 Fax: 08 9841 8480



NSW Director:

Mr Tim Ho

Royal Prince Alfred Hospital
Inner West Pain Centre
100 Carillon Avenue
Newtown NSW 2042
Tel: 02 9517 1764 Fax: 02 9517 1832



NT Director:

Ms Diann Black

Royal Darwin Hospital
PO Box 41326
Casuarina NT 0811
Tel: 08 8931 1029



OFFICE BEARERS:

Immediate Past President:

Dr Geoffrey Speldewinde

Capital Pain & Rehabilitation Clinic
25 Napier Close
Deakin ACT 2600
Tel: 02 6282 6240 Fax: 02 6282 5510



Secretariat:

DC Conferences Pty Ltd

PO Box 637
North Sydney, NSW 2059
Tel: 02 9016 4343 Fax: 02 9954 0666
Email: aps@apsoc.org.au
Website: www.apsoc.org.au

SPC Chair:

A/Prof Kevin Keay

Department of Anatomy
University of Sydney
Sydney NSW 2006
Tel: 02 9351 4132



THE
AUSTRALIAN
PAIN SOCIETY

IASP Liaison:

Professor Michael Nicholas

Pain Management Research Institute
Royal North Shore Hospital
St Leonards NSW 2065
Tel: 02 9926 7894 Fax: 02 9662 6279
Website: <http://www.iasp-pain.org/>



Communications/Website/Social & other Media Coordinator:

Dr Will Howard

Director, Pain Service
Austin Health
Studley Road
Heidelberg VIC 3084
Tel: 03 9496 3800 Fax: 03 9459 6421



Newsletter Editor:

Dr Stephanie Davies

WA Specialist Pain Services
Unit 5/136 Railway St
Cottesloe WA 6011
Tel: 0412 933 419 Fax: 08 9286 8023



Newsletter Assistant Editor:

Mrs Christin Bird

Victoria Pain Specialists
27 Erin Street
Richmond VIC 3121
Tel: 1300 798 682 Fax: 1300 798 385



PhD Scholarship Chair:

A/Prof Michael Farrell

School of Biomedical Sciences
Monash University
Clayton VIC 3800
Tel: 03 9905 6094

