Welcome to this first digital edition of the PIGNI Newsletter. The change from print to digital was prompted by a desire from the PIGNI Committee to better collate and reach out to our membership by using the services of Coconet (see inside story by Sonia). Helping me out with this and subsequent editions will be David Beveridge, Linda Pope and James Tekiko.

The March APS Conference in Brisbane had many outstanding Speakers. This issue of the Newsletter includes a report by David Beveridge on a very impressive talk given by Herta Flor. Jenni Johnson brings us the latest from the hard working ACI and I have included a brief overview of a recent overseas trip.

In future Issues we hope to draw on the experiences of some of the many and wonderful pain nurses from around Australia and overseas. All photos in this issue (apart from Conference Beach and West Suffolk Hospital) are contributed by DC Conferences/Australian Pain Society 35th ASM; Photographer at Large (www.photographeratlarge.com.au)

The title of this newsletter is intended to engender debate on who we are and who we represent as a sub group of the APS; the next edition will return to the PIGNI format.
March 2015 APS - Herta Flor

The 2015 Australian Pain Society 35 Annual Scientific Meeting was held in Brisbane from 15-18 March. The theme of the meeting was Managing Pain: from Mechanism to Policy.

Professor Herta Flor was a keynote speaker and works at Ruprecht-Karls-University, Heidelberg, Germany. Her research focus is on neuronal plasticity and learning and memory in chronic pain. Professor Flor presented two plenary sessions at the conference. An outline of these sessions is provided below.

- When compared with predictable pain, unpredictable pain leads to higher pain intensity. Predictable pain can be controlled. This is why patients who slip, trip or fall have increases in their pain intensity.
- Chronic pain can induce a maladaptive over prediction of pain. In other words it can become a self-fulfilling prophesy, “I knew I was going to have pain if I bent over” therefore avoid bending over in the first place. Healthy people don’t have a memory for pain.
- Muscle tension is higher in chronic pain patients as a consequence of hypervigilance. Patients who demonstrate hypervigilance will report higher pain intensity associated with the thought of undertaking an action before the action is undertaken.
- Videoing the chronic pain patient walking for 20 minutes at the start and then at the end of a pain program provides feedback to the patient of their progress which then improves brain prasticity.
- Long term stress leads to increased pain whereas pain is reduced by stress in healthy controls.
- Reductions in grey matter are associated with chronic pain but with treatment grey matter will increase again.
- Chronic pain patients tend to focus on negative life stories.
- The advantage of behavioural interventions to manage chronic pain is that treatments can be targeted at specific areas of the brain.
- The brain’s neuronal plasticity, the ability to change itself in response to behavioural interventions, continues up until the time of death.
- The more you use a prosthetic limb the less phantom limb pain you will experience.
- For patients with chronic pain avoid talking about the pain and focus on function.
- Avoid use of diaries that record pain, instead focus on what patients can undertake despite their pain.

David Beveridge
Nurse Practitioner
Multidisciplinary Pain Management Clinic
Lismore Base Hospital

David Beveridge and colleague

Trudy Maunsell and Lee Beeston

Lee Beeston and husband with Phillip Siddall and Debbie Wallace.

APS Executive
There is a great need for effective and tolerable medications for patients suffering with severe chronic pain. Although opioids are potent analgesics, they are associated with various moderate to severe side effects.

Tapentadol is one of the more recently developed opioids that has so far displayed associated with various moderate to severe side effects.

Sixty eight percent of patients reported major reductions in pain (Figure 1A). Tapentadol was generally well tolerated: 72% of patients adhered to treatment, 67% of patients reported no side effects (Figure 1B), and 12/15 patients who switched to tapentadol because of prior opioid side effects reported no side effects with tapentadol.

The most common side effects were nausea/drowsiness (12%) and cognitive effects (10%). Less common side effects included leg cramping/weakness, chest pain, itchiness and sweating. Patients concomitantly taking serotonergic medications did not experience additional adverse central nervous system effects.

Tapentadol outcomes were well documented in Europe, although limited data exists in the Australian setting.

The objective of this study was to audit the effectiveness and tolerability of tapentadol sustained release (SR) tablets in the Australian setting following its introduction to the Australian private market in 2013.

Subsequent to the clinical introduction of tapentadol SR to the Australian market in February 2013, an audit as part of Faculty of Pain Medicine Continuing Professional Development was conducted on the first 52 patients prescribed tapentadol at a large, private multidisciplinary pain clinic in NSW Australia. Patients were followed up within a 5 month period as part of their standard care.

Data collected included patient demographics, type of pain (neuropathic, nociceptive, mixed pain), pre-tapentadol opioid use, concomitant analgesics, and tapentadol effectiveness and tolerability. Tapentadol effectiveness was reported qualitatively (“reduction in pain” or “ongoing pain”). Tapentadol outcomes were compared between pain types. The impact of prior opioid use and concomitant analgesic use on tapentadol outcomes was also assessed.

Demographics

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<tr>
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<th>Age (Mean)</th>
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<tr>
<td>Male</td>
<td>45.55 ± 11.68</td>
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<td>Female</td>
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<tr>
<td>Nociceptive</td>
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<tr>
<td>Mixed Pain</td>
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<td>15</td>
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<tr>
<td>2</td>
<td>11</td>
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<td>≥3</td>
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<td>Lack of relief/alternative required</td>
<td>20</td>
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<tr>
<td>Adverse drug effects</td>
<td>16</td>
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<tr>
<td>Additional required</td>
<td>7</td>
</tr>
<tr>
<td>Detoxification/other</td>
<td>7</td>
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</table>

Table 1. Tapentadol cohort baseline characteristics. (n=50; *2 patients failed to take tapentadol)

References

CocoNET

PIJNI has recently implemented an online membership system (360 Membership System) through CocoNET Technology.

All PIGNI members have been allocated a unique member number in addition to electronic membership certificates and receipts of payment. Through this system PIGNI will maintain all email communications services with all PIGNI members including the distribution of the PIGNI newsletters.

Members have been advised of their log in details and are encouraged to review and update their member profile via the member portal.

It is preferred that membership renewals as well as any new membership will be used through this system.

If members are experiencing any difficulties accessing the membership portal please contact the treasurers: 
**Sonia Markocic** at Sonia.Markocic@sesiahs.health.nsw.gov.au or **Sue Lee** at Susan.Lee@sesiahs.health.nsw.gov.au

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ACI Pain Network

In an effort to broadly promote the key messages of the ACI Pain Network, and facilitate greater access to evidence based information for consumers, a partnership with the NSW State Library was established in 2013.

A set of 12 evidence based consumer books was purchased for 72 community libraries that opted to participate in the initiative across NSW. These books were promoted in parallel with the Pain Management Network website along with communications from the Chief Librarian about the initiative. Many of the libraries used local media to promote local relationships with the pain clinics.

In 2014, two further books were purchased and again in 2015, we anticipate another campaign promoting two newly published books for consumers: The spinal cord injury pain book by Phil Siddall et al and the Explain Pain Handbook by Lorimer Moseley and David Butler.

These books will be promoted during National Pain Week at The State Library at an event coordinated through Chronic pain Australia.

The aim of this activity is to promote greater access to evidence based information for the community at large.


**Jenni Johnson**  
Manager, ACI Pain Network

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Study Suggests Morphine After Pediatric Tonsillectomy is Unsafe

Data on pediatric patients who underwent tonsillectomy -- often used to treat sleep apnea in children -- revealed 68% of those who received ibuprofen exhibited improvements in oxygen desaturation events during the first night after surgery, compared with 14% of those on morphine.

Researchers also recorded more desaturation events in the morphine group over time.

The findings, reported in the journal Pediatrics, demonstrate that children with obstructive sleep apnea should not receive morphine treatment following tonsillectomy, researchers said.

Medical News Today (1/27 with acknowledgement to APS Smart Briefs).
A UK Experience

Recently I had the pleasure of accompanying my wife on a study tour of London, Edinburgh, Valencia and Seville. I took the opportunity to visit the Pain Service in West Suffolk Hospital in Bury St Edmund and go on a morning pain round. An anaesthetist who had been working in Dubbo but now relocated to Bury, arranged the visit for me.

It was snowing when I arrived, after an hours train journey up from London. Having around 1600 beds, there were four or five nurses in the pain team but that included sub acute/ chronic as well. The nurse I accompanied on the round had been in the position for about five years. We were not accompanied by an anaesthetist; instead, she was able to prescribe some agreed drugs and only consulted with an anaesthetist when necessary.

The biggest surprise for me was, instead of oxycodone, they relied on immediate and controlled release morphine. The practice was so common that recently the National medication management rules had been changed to allow nurses to check out and give oral morphine on their own, without requiring a second nurse as a witness.

A few days later I ‘cold called’ the Pain Team in the Royal Infirmary in Edinburgh and caught a bus out from the Royal Mile, which was near where we were staying.

The Infirmary was also a large hospital though newer than West Suffolk. The strange thing was when I got there, no one knew where the Pain Service office was, it took nearly twenty minutes to find it.

The nurse I spoke to there specialised in pain associated with back surgery. Unfortunately time was short and I didn’t have time to visit the private orthopaedic ward at the Infirmary, as I was told that, unlike the public ortho ward, PCA’s weren’t used for post op pain.

In Murcia, Spain, I spoke with a doctor who was trying to get her nurses to speak with larger groups of patients, who had chronic pain. I suggested I could put her in touch with Lee Beeston, for which she was grateful.

My brief glimpse of these pain services left me with the impression the challenges are the same overseas and Australia is at the forefront in developing treatment pathways to meet these challenges.

Stuart Leckie

More Than 800 Deaths From Oxycodone Over 11 Years

A recent study assessing data from the Australian National Coronial Information System, reported that more than 800 Australians died from use of the prescription painkiller oxycodone over an 11-year period, and more than half of these people died accidentally.1

Most deaths were caused by combined drug toxicity (63.4%) with the most commonly co-administered drugs including benzodiazepines, alcohol, and other opioids which in combination can cause respiratory depression. Only 11.8% of deaths were identified as due to oxycodone toxicity alone.

The characteristics of people identified as most at risk of death from oxycodone included males (59%), aged 35–44 (27%), with some kind of mental illness (52%), and pain (46%).1

A surprise finding in this study was that about 40% of these cases involved a legitimate prescription for oxycodone for non-cancer pain, such as back pain or chronic pain.

Solutions:

Real-time reporting. The Australian Government recently announced the implementation of a national real-time reporting system for prescription opioids

New tamper-proof formulations. Targin or Tamper-proof OxyContin brand is preferred

Considered prescribing. There is scope for better uptake of guideline recommendations by GPs, for example HNE Opioid Quick Steps.


"Colors are the smiles of nature.”
Leigh Hunt, British poet
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**Hospira Corporate Profile**

Hospira is a global specialty pharmaceutical and medication delivery company dedicated to Advancing Wellness™ by developing, manufacturing and marketing products that improve the productivity, safety and efficacy of patient care. Created from the core global hospital products business of Abbott Laboratories in April 2004, Hospira has a 70-year history of service to the hospital industry.

In February 2007, Hospira acquired Mayne Pharma Limited to become the world leader in specialty generic injectable pharmaceuticals. Through its offering of high-quality, lower-cost alternatives to proprietary medications, Hospira continues to help reduce the overall costs of healthcare – to improve both the affordability of care for patients and the financial strength of the global healthcare system. The company also is a pioneer in providing innovative solutions to improve patient and healthcare worker safety. Its portfolio includes one of the industry’s broadest lines of generic acute-care and oncology injectables, and integrated solutions for medication management and infusion therapy.

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**WHAT’S ON**

**Pigni Conference**   October 2015

*If you wish to advertise an event please send details to the editor.*