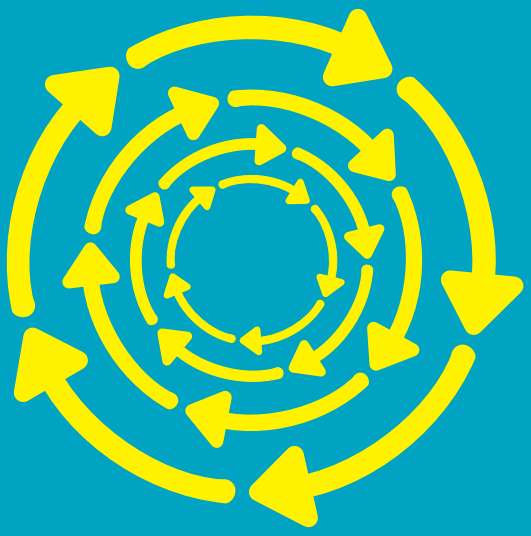
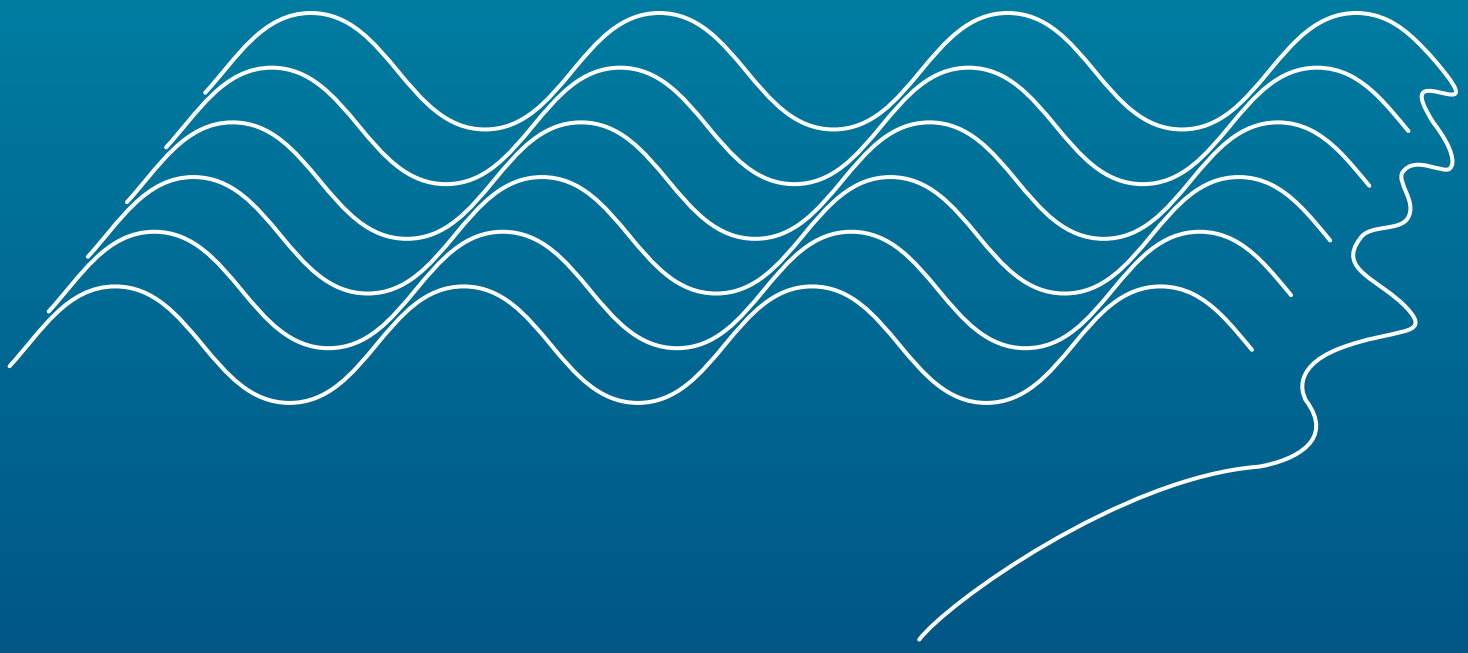
FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND
COLLEGE OF ANAESTHETISTS



2010 SPRING MEETING

TRANSITIONS IN PAIN



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FACULTY OF PAIN MEDICINE
AUSTRALIAN AND NEW ZEALAND
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'TRANSITIONS IN PAIN'

Contents

Welcome

Welcome message from the Dean

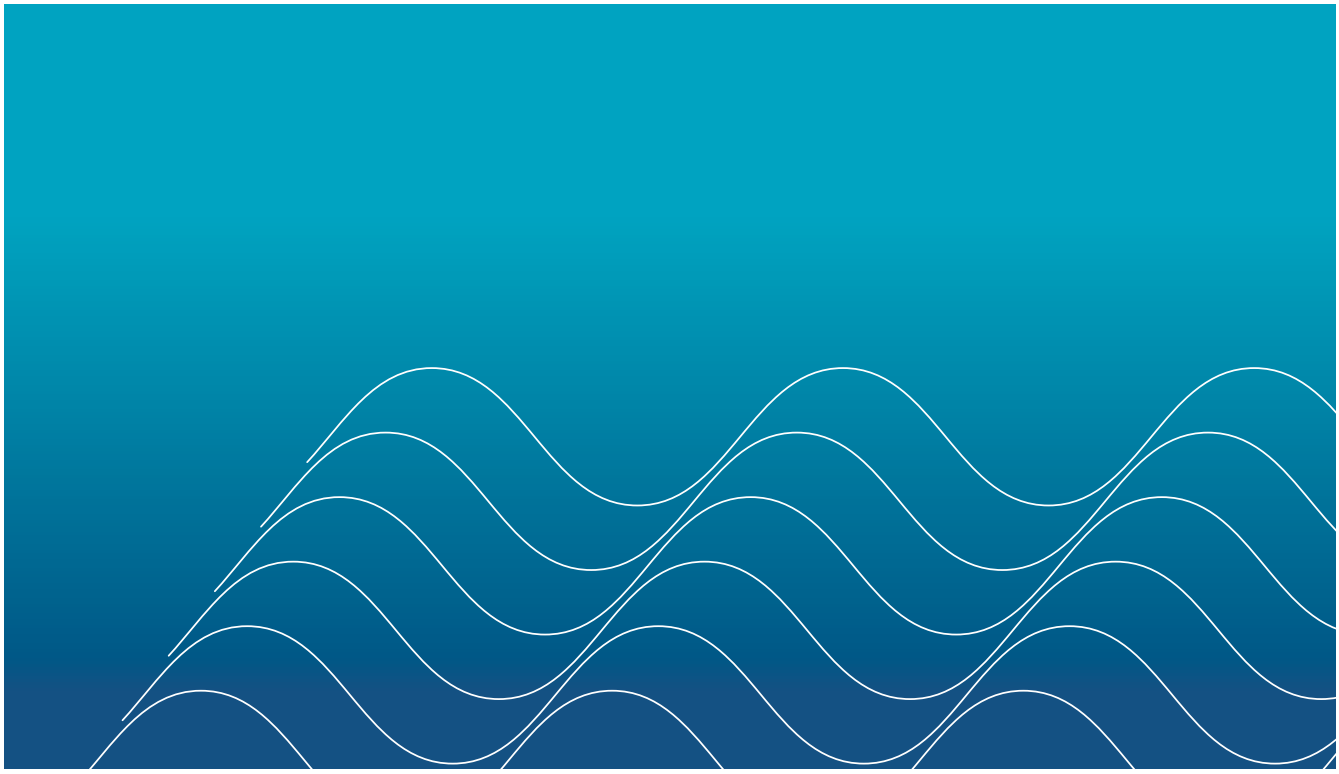
The Faculty of Pain Medicine is pleased to provide you with such a good program for this 2010 Spring meeting in Newcastle, 'Transitions in Pain'. There will be something for all Pain Medicine Fellows and other colleagues working with those suffering pain.

We welcome our invited visiting speakers – Dr Cathy Price (Southampton), Prof Brian Broom (Auckland) and Prof Garry Egger (New South Wales). Our thanks to them, as well as to all our local contributors.

On behalf of the Faculty we wish to thank the organising committee for their excellent work – Chris Hayes, Susie Lord, Di Pacey, Marc Russo and Stephanie Oak. They have constructed a program with some novel yet important subjects for us as we work together to deliver more service to an increasing population of persons in need, but often with less resources. Topics such as 'Models of Care' will likely mean different things to each of you, so this is an opportunity to hear, discuss and exchange ideas about yours and others' approaches to similar problems.

To complement the scientific program there is an excellent social program, at which you have an opportunity to meet colleagues and make new contacts. I look forward to talking with many of you at this, our Faculty's 4th Spring Meeting.

Dr David Jones
Dean, Faculty of Pain Medicine



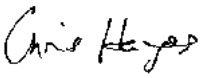
Welcome message from the Convenor

It is with great pleasure that I welcome you to the Faculty of Pain Medicine's fourth Spring Meeting at City Hall in Newcastle.

The theme of the meeting is 'Transitions in Pain'. My hope is that you get a sense of Newcastle's transition from industrial town to a diverse and thriving modern city as we consider multiple transitions in contemporary health care. The exciting program of lectures, topical sessions and problem based learning discussions presented by International and National speakers addresses key aspects of the emerging paradigm in pain medicine. Focus areas include model of service delivery, meaning and personal story and the role of lifestyle and nutritional factors.

Thank you for coming to participate in the conference. I trust that you enjoy the city, the scientific program, catching up with old friends and making new ones as we collectively explore 'Transitions in Pain'.

Thanks are also extended to our sponsors and exhibitors for their generous support of the meeting.



Chris Hayes
Convenor

International Invited Speaker

Dr Cathy Price

Dr Cathy Price is a consultant in Pain Medicine at Southampton University Hospitals Trust in the UK. In 2003 in response to significant pressures on the services the local health community took the innovative step of shifting specialist pain management care out of hospital and adopting a whole systems approach to management. For this Cathy and her manager received a Medical Futures Innovation Award for Leadership in 2005 from McKinsey.

She has been a member of the British Pain Society Council 2006-9 and is currently an executive member of the UK Chronic Pain Policy Coalition. She assisted with production of the Chief Medical Officers report on pain in 2009.

She is also currently vice chair of the clinical leadership arm of the local health board.

Australian and New Zealand Invited Speakers

Prof Brian Broom

Professor Brian Broom is a 'philosopher physician,' with a passion for 'whole person' approaches to illness. He leads the unique post-graduate MindBody Healthcare Diploma and Masters Program at AUT University, Auckland. On the 'body' side of his work he is a Consultant Physician in Clinical Immunology (in the Department of Immunology at Auckland City Hospital, Auckland, New Zealand), but is consulted for many types of physical illness by people wanting a clinician who will look at both physical and non-physical factors that may be playing a part in their illnesses. On the 'mind' side he is a New Zealand registered psychotherapist and has long experience training and supervising psychotherapists working with patients with a wide range of physical conditions. His psychotherapy style is eclectic and strongly interpersonal. He has written two books for clinicians emphasising how the person's personal life story relates to the emergence and progression of illness and disease.

Prof Garry Egger

Dr Garry Egger MPH, PhD has worked in public, corporate and clinical health for nearly 4 decades. He is the author of 30 books (including four texts) over 150 scientific articles and numerous popular media articles on health and fitness. He is an Adjunct Professor of Health Sciences at Southern Cross and Deakin Universities and the University of South Australia, and an Advisor to the World Health Organisation and several Government and corporate bodies in chronic disease prevention. In the 1990s Dr Egger initiated the GutBusters, men's waist loss program, the first of its kind in the world, which has now developed into the Professor Trim's Weight Loss Program for men. He is one of the initiators of the Australian Lifestyle Medicine Association and runs training programs in Lifestyle Medicine for doctors and allied health professionals.

National Invited Speakers

Dr Penny Briscoe
Royal Adelaide Hospital, SA

Prof Clare Collins
University of Newcastle, NSW

Dr Myles Conroy
Barwon Health, VIC

Ms Denise Daunt
John Hunter Hospital, NSW

Mr Carl Graham
Fremantle Hospital, WA

Dr Newman Harris
Royal North Shore Hospital, NSW

Dr Isabel Higgins
University of Newcastle, NSW

Ms Meredith Jordan
John Hunter Hospital, NSW

Dr Michael Katekar
John Hunter Hospital, NSW

Dr Kasia Kozlowska
The Children's Hospital at Westmead, NSW

Dr Stephen Leow
General Practitioner, Adelaide, SA

Dr Susie Lord
John Hunter Hospital, NSW

Dr John Malcolm
General Physician, Newcastle, NSW

Dr Frank New
Psychiatrist, Brisbane, QLD

Mr Sean Nolan
John Hunter Hospital, NSW

Dr Stephanie Oak
John Hunter Hospital, NSW

Dr Di Pacey
John Hunter Hospital, NSW

Dr Matthew Pols
John Hunter Hospital, NSW

Dr Marc Russo
Hunter Pain Clinic, NSW

Prof Rodney Scott
University of Newcastle, NSW

Dr Tim Semple
Royal Adelaide Hospital, SA

Dr Simon Tame
Hunter Pain Clinic, NSW

Dr Rohan Walker
University of Newcastle, NSW

Ms Ruth White
John Hunter Hospital, NSW

Prof Ian Whyte
Calvary Mater Hospital, NSW

Program

Transitions in Pain:

1 **Models of Care**
2 **Lifestyle**
3 **Meaning**
4 **Plasticity**
5 **Lifespan**

FRIDAY 08 OCTOBER

0900–1000	**REGISTRATION**
1005–1015	**Opening Welcome** **Dr Chris Hayes** Mr Mick Davidson *Didgeridoo*
1015–1230	**PLENARY LECTURES – Concert Hall** Chair: Dr Paul Wrigley Dr Cathy Price *Applying a long term conditions model to pain services* Dr Penny Briscoe *The Australian story* Dr Tim Semple *Reworking the interface between primary care and Multidisciplinary Pain Centers: the Adelaide experience*
1230–1330	**Lunch**
1330–1500	**PBLD and Topical Discussion Sessions** **PBLD 01 – Waratah Room** Facilitator – Dr Susie Lord *Transgenerational CRPS* **PBLD 02 – Newcastle Room** Facilitator – Dr Myles Conroy *Managing the Risk – Transition from acute to persistent postsurgical pain* **PBLD 03 – Mulubinba Room** Facilitator – Dr Matthew Pols *Finding meaning in pain* **Topical Session 01 – Concert Hall** Facilitator – Prof Julia Flemming Presenters – Dr Carl Graham and Dr Newman Harris *Hidden drivers of pain: psychological/psychiatric perspectives* **Topical Session 02 – Cummings Room** Facilitator – Dr Brendan Moore Presenters – Dr Frank New, Dr Di Pacey and Dr Simon Tame *Blueprinting pain medicine as a specialty*
1500–1530	**Afternoon Tea**
1530–1730	**LECTURES – Concert Hall** Chair – Dr Chris Hayes Prof Garry Egger *Chronic pain and lifestyle medicine* Dr Rohan Walker *The role of microglia in the regulation of mood state: Implications for depression* Prof Clare Collins *Nutrition and pain*
1900–2200	**Conference Dinner – Jonah's on the Beach***

*Please be aware that the complimentary coach transfer to the conference dinner will depart from the Crowne Plaza Hotel, Newcastle, at **1845** sharp

SATURDAY 09 October

0730–0845	**Mundipharma Breakfast Meeting – Introducing TARGIN Tablets – Cummings Room**
0830–0900	**REGISTRATION**
0900–1100	**LECTURES – Concert Hall** ***Therapeutic opportunities arising through understanding patients' personal meanings and stories*** Chair – Dr Raymond Garrick Prof Brian Broom *Meaning and personal story* Dr Stephanie Oak *The Pain Story: practical approaches* Discussion of story concepts
1100–1130	**Morning Tea**
1130–1300	**LECTURES – Concert Hall** ***Models of Care*** Chair – Dr Milton Cohen Dr Cathy Price *The impact of triage on a pain service* Dr Stephen Leow *Primary care story* Dr Carl Graham *Outcomes of the STEPS programme at Fremantle Hospital*
1300–1400	**Lunch**
1400–1530	**PBLD and Topical Discussion Sessions** **PBLD 04 – Waratah Room** Facilitator – Dr John Malcolm *More than meets the eye: A young main with pain in his head* **PBLD 05– Newcastle Room** Facilitator – Dr Simon Tame *Neuromodulation in a complex case. How did we get there?* **Topical Session 03 – Concert Hall** Facilitator – Dr Toby Newton-John Presenters – Ms Denise Daunt, Ms Meredith Jordan and Ms Ruth White *Implementing short group interventions at Hunter Integrated Pain Service* **Topical Session 04 – Cummings Rooms** Facilitator – Dr David Jones Presenters – Dr Michael Katekar, Dr Marc Russo and Prof Ian Whyte *Hidden drivers of pain: biological*
1530–1600	**Afternoon Tea**
1600–1700	**Panel Discussion – Concert Hall** ***Where will pain medicine be in 10 years time?*** Moderator – Prof Michael Cousins Speakers – Dr Penny Briscoe, Prof Brian Broom, Prof Garry Egger and Dr Cathy Price (5-10 minutes per speaker) Interactive Discussion
1700–1900	**Cocktail Reception**

SUNDAY 10 OCTOBER

0900–1100	**LECTURES – Concert Hall** ***Lifespan*** Chair – Dr Jeniffer Stevens Dr Kasia Kozlowska *Mind, body and relationships: treating pain in context* Prof Rodney Scott *Using functional genomics to understand pain* Dr Isabel Higgins *Ageing well*
1100–1130	**Morning Tea**
1130–1230	**LECTURES – Concert Hall** Chair – Dr Di Pacey Mr Sean Nolan *The role of music in linking mind and body*
1235	**Close** **Dr David Jones** **Dr Geoffrey Speldewinde presents the 2011 Spring Meeting**

Summary of PBLDs and Topical Sessions

PBLD 01
Friday 08 October
1330–1500

Facilitator: Dr Susie Lord

Transgenerational CRPS
What is the genetic contribution to CRPS? What is nature and what is nurture? This case discussion looks at a family in which 3 generations have been given the 'label' of CRPS.

PBLD 02
Friday 08 October
1330–1500

Facilitator: Dr Myles Conroy

Managing the Risk – Transition from acute to persistent postsurgical pain
Discussion of this case will explore the risk of transition for acute to persistent pain. How do you identify a patient at risk and having identified them what can be done about it?

PBLD 03
Friday 08 October
1330–1500

Facilitator: Dr Matthew Pols

Finding meaning in pain
This discussion will be based around a typical persistent pain patient. Links will be explored between the patient's response to life events and the persistence of their pain. The influence of the mindbody connection will be analysed in terms of both diagnostic formulation and practical management strategy.

Topical Session 01
Friday 08 October
1330–1500

Facilitator:
Prof Julia Fleming

Hidden drivers of pain: psychological/psychiatric perspectives
Not all mental health professionals are the same! Beyond the clinical standard of including a mental health practitioner in the pain team, this clinical case discussion examines the different but complementary roles of psychiatrist and clinical psychologist in the pain clinic.

Topical Session 02
Friday 08 October
1330–1500

Facilitator:
Dr Brendan Moore

Blueprinting Pain Medicine as a Speciality
A Faculty of Pain Medicine blueprinting subcommittee has been addressing the challenge of defining a pain medicine specialist. This is of vital importance to service delivery, training, examination and ongoing education. The 3 speakers will put forward perspectives encompassing the spectrum from psychiatry to rehabilitation medicine to procedural pain medicine and across the public and private sectors. Active discussion will be encouraged. Come and express your views about what a pain medicine specialist is or could be.

PBLD 04
Saturday 09 October
1400–1530

Facilitator: Dr John Malcolm

More than meets the eye: A young man with pain in his head
This case has many elements: the difficulty of obtaining an accurate history and the value of detective work to check the facts; persistent pain in a person with a significant psychiatric disorder; managing the relationship with the patient's psychiatrist; problems of polypharmacy; negotiating with and containing the patient without insight; managing the enmeshed and co-dependent parent; and more!

PBLD 05
Saturday 09 October
1400–1530

Facilitator: Dr Simon Tame

Neuromodulation in a complex case. How did we get there?
This case history involves diagnostic uncertainty, a multidisciplinary treatment algorithm, difficult interactions with the insurance industry, significant developmental issues and ultimately trying to enmesh neuromodulation with self management. Come and explore these and other issues.

Topical Session 03
Saturday 09 October
1400–1530

Facilitator:
Dr Toby Newton-John

Implementing short group interventions at Hunter Integrated Pain Service
Can less equal more? This session will describe the ongoing evolution of short group interventions at Hunter Integrated Pain Service. Concepts of stratified service design and emerging information content will be explored and the challenges of short group interventions discussed. Preliminary outcome data will be presented.

Topical Session 04
Saturday 09 October
1400–1530

Facilitator: Dr David Jones

Hidden drivers of pain: biological
Sometimes all is not as it seems. In this Topical session we will be looking at some issues that may occasionally be driving or contributing to the persistent pain state. Dr Michael Katekar will be presenting the world of mitochondropathies and review medications that may adversely affect the mitochondria and 'mitochondrial pain'. Dr Ian Whyte will review the cytochrome P450 system and how genetic or pharmacological interference can contribute to analgesic failure. Dr Marc Russo will be reviewing a potpourri of biological drivers that adversely affect the pain state.

Continuing Medical Education Approvals
Australian and New Zealand College of Anaesthetists
Lecture sessions: Category 1 Level 1: 1 Credit per hour
Topical sessions: Category 1/Level 2: 2 Credits per hour
PBLDs: Category 3/Level 1: 2 Credits per hour
The approval number is **1673**

APPLYING A LONG TERM CONDITIONS MODEL TO PAIN SERVICES

Dr Cathy Price
Southampton University Hospitals Trust, UK

Usual medical care often fails to meet the needs of chronically ill patients. Many years ago Ed Wagner proposed a model for the management of long term conditions that has been adopted worldwide with carrying levels of success.

The essential components of this model are:

- The use of evidence based planned care
- Rapid access to specialist expertise
- self management support
- decision support systems
- shared information systems

This requires carers and people with their long term condition to be health literate. It requires information to be shared amongst professionals and an agreement on the best way to manage a person from all parties. Information systems need to have registration, recall and review procedures and recognize those with more than one long-term condition. People and carers need support, to self-care. The more activated and confident are more likely to self care. Appropriate patient education needs to form part of this approach.

Admission to hospital needs to be accepted as a part of managing someone with severe long-term condition. However, stays need to be minimized although there are often barriers to achieving this. Financial incentives that can address this include a Year of Care approach, penalties for frequent admissions and readmissions and risk sharing amongst organizations.

Gathering the evidence for the efficacy of this model has to be approached in a variety of ways. Examples of sensitive indicators are emergency room visits, self efficacy, use of expensive second line agents to manage the condition. The effectiveness of primary care in this remains unanswered. Often the knowledge and skills of primary care staff especially in supporting self care are insufficient to support self care, most so amongst physicians.

In the past four decades there have been significant advances in our understanding of the complexity of the nervous system, and in our knowledge about the causes of pain. Increasing evidence shows that chronic pain is in fact a separate disease entity with associated patterns of central nervous system abnormalities. We know that for most people chronic pain can be successfully managed in a variety of simple ways. However, a long-term conditions model as outlined above has rarely been applied to chronic pain in a systematic fashion. This has been partly due to the lack of appreciation of the underlying pathophysiology and outcomes from epidemiological studies.

In the UK there is evidence that some regions have started to do this. These have focused mainly on the use of patient education and supported self care. Less well organized are shared information systems and decision support systems. Even less well organized is rapid access to specialist care and management of inpatients. Outcomes from systems are poorly developed. Primary care management of pain is in its infancy. Emerging models will be presented that give some grounds for optimism.

If chronic pain is to be managed effectively as a long -term condition then it is likely that pain management services will need to drive change in ensuring that all elements of the system are adopted. Greater use of population measures of health that include measures of pain will also support such change.

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Chief Medical Officer for England's report on the health of the nation. 150th annual report. 2008: Pain: breaking through the barrier.

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THE AUSTRALIAN STORY

Dr Penny Briscoe
Royal Adelaide Hospital, SA

Pain Management Units were first set up in the United States by John Bonica following World War 2.

Within Australia a number of units were set up in different States in the early 1970's, and Australia really has been a leader in pain management internationally.

Multidisciplinary pain clinics now operate out of every State, providing true multidisciplinary management for our patients.

In the 1990's a group through the Australia and New Zealand College of Anaesthetists started to work towards forming a pain management group, culminating with the formation of the Faculty of Pain Medicine under the auspices of the Australia and New Zealand College of Anaesthetists in 1999.

The first examination in Pain Medicine was held in 1999 at Royal North Shore Hospital in Sydney, and the current Faculty examination is one of the true multidisciplinary examinations in the world.

We have had observers from the United States and observers from the five primary colleges associated with the Faculty to our examination process. Dr Grady from the British College is coming out to observe the examination in 2011.

In 2005 Pain Medicine was recognised as a specialty within Australia.

Recognising the extreme burden of chronic pain on our community, for the last 18 months there has been a pain strategy working group working towards raising the profile of chronic pain within Australia, legitimising the problem, and for our patients de-stigmitising chronic pain, and this culminated in the launch of the National Pain Strategy at the Pain Summit in Canberra in March of this year.

Moving forward now, an interim Executive has been set up to set up a Board for a new group called 'painaustralia'.

This now needs to take the recommendations from the strategy working group forward, which are:

- People in pain is a national health priority
- Knowledgeable empowered supported consumers
- Access to skilled professionals and evidence based care
- Access to interdisciplinary care at all levels
- Quality improvement in evaluation
- Research

Australia has been lucky enough to have been a leader in pain management over the last 40 years, and hopefully we can keep moving forward to improve access to appropriate pain management for all Australians.

REWORKING THE INTERFACE BETWEEN PRIMARY CARE AND MULTIDISCIPLINARY PAIN CENTRES
The Adelaide Experience

Dr Tim Semple
Royal Adelaide Hospital, SA

Whilst the South Australian multidisciplinary pain centres have long had involvement in general practitioner education and close working relationships with individual general practitioners, the commencement of the South Australian Collaborative Pain Project(SACoPP) in 2005 has led on to a much closer integration between the pain centres and primary care medicine.

In 2005 Drugs and Alcohol Services South Australia (DASSA) and senior staff from the Royal Adelaide Hospital and Flinders Medical Centre Pain Management Units initiated the SA Collaborative Pain Project (SACoPP) with a core goal of improving general practitioner prescribing of opioid S8 medications. South Australian legislation, similar to that in Western Australia and Queensland, requires a higher level of overview and regulation of long term opioid prescribing for chronic noncancer pain(CNCP) than in some other states. DASSA retrospectively reviews all opioid prescriptions and were aware of a substantial and disturbing increase in both the numbers of individuals on longterm opioids (currently exceeding 7000) as well as apparent high dose prescribing in the absence of specialist review or use of non-opioid pain management modalities.

The project was funded mainly by a grant from the Intergovernmental Committee on Drugs supplemented by healthcare industry support. There was consensus from all collaborators that improving general practitioner knowledge and clinical expertise was essential prior to achieving any positive outcome in the management of the overwhelming unmet burden of CNCP in SA and changing opioid prescription practice.

The prevalence of CNCP in SA and impact upon healthcare workload can be predicted from a range of sources. Focus group surveys of SA general practitioners prior to SACoPP estimated CNCP occupied 25% of their workload. This is similar to the recent results from the BEACH survey of Australian general practice in which 19.6% of patients had chronic pain[1]. The South Australian Health Omnibus Survey in 2006 utilising 2973 face-to-face interviews reported that the prevalence of chronic pain was 19.7% and that 5% (65000 individuals in real terms) experienced pain interfering severely with daily activities[2].

Of these 65,000 individuals, how many are getting access to multidisciplinary pain centre (MPC) management? The Australian Pain Society *Waiting In Pain : a systematic investigation into the provision of persistent pain services in Australia* interim report 2010 reveals that 2418 patients per annum with 'non-urgent' CNCP are assessed in SA at a MPC with a mean waiting time of 205.5 days (Australian mean waiting time 143 days). It is not clear whether those assessed are in the most needy categories.

SACoPP focused upon two approaches – firstly, the generation of a guideline for opioid prescribing for SA general practitioners and secondly, providing funded training attachments of up to 52 hrs duration for interested GPs at either RAH or FMC PMUs.

Opioid Prescription in Chronic Pain – Guidelines for South Australian GPs[3] was based upon a document from USA and was developed to provide a comprehensive educational resource to optimise prescribing practice. Whilst a range of further resources focused on opioid prescribing have since emerged, this remains a valuable tool.

The training attachment to pain centres undertaken by 10 general practitioners proved to be very valuable at a number of levels.

(CONTINUED)

The goal of generating a group of general practitioners with a specific interest in pain management (GPsi-Pain) was achieved. Several of the metropolitan-based GPs have gone on to provide input and patient review for their primary care colleagues as well as undertaking a shared care approach to complex pain patients with the pain centres.

Two rural practitioners from the same practice have commenced a pain management project in their town, utilising an interdisciplinary model with mental health-trained practice nurse and an occupational therapist with a specific pain management background as well as utilising a visiting psychiatrist with extensive pain expertise.

The recognition of the need for improved basic pain education for all general practitioners led to engagement with the SA branch of RACGP and eventual formation of the Chapter of Pain Management within the Faculty of Specific Interests. A Pain Education Group has been meeting over the past two years and collation of educational resources for GPs is underway including input from the pain centres.

Bridging the gap between tertiary hospital-based services and primary care for management of chronic disease is now a major focus of the SA Health strategic plan. The new SA HEALTH GP PLUS centres are aimed at increasing the capacity of the primary care sector to respond to chronic conditions and clearly provide an opportunity to improve chronic pain management. In conjunction with two of the local GPsi-Pain practitioners (Dr S Leow and Dr R Heah), RAH Pain Management Unit is initiating a pilot project at the Elizabeth GP PLUS. FMC PMU has proposed both pain medicine assessment and a modified PMP for Marion GP PLUS. Allied health practitioners and nurses with chronic disease management expertise will be available at these centres – translating these skills to contribute to CNCP management will be critical to achieving the best outcomes from this opportunity.

In the five years since the project began, has much been actually achieved? Waiting lists for the pain management centres remain unacceptably long and access to services in the primary care sector limited. However, the core aspects of an improved future model of care involving an integrated pain network are beginning to fall into place. There are GPs setting up services for their colleagues and patients to expand options at a primary care level. The first steps of integrated interdisciplinary secondary care services at the GP PLUS centres are underway.

Perhaps most importantly, the concept of GP ownership of and responsibility for CNCP appears established. There is a group of enthusiastic GPsi-Pain working with their parent college to improve basic pain knowledge in all GPs and to provide a training pathway for those GPs who wish to take their interest in pain management further.

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3. Opioid prescription in Chronic Pain – Guidelines for South Australian GPs @www.dassa.sa.gov.au/website/resources

CHRONIC PAIN AND LIFESTYLE MEDICINE

Prof Garry Egger
Southern Cross University, Lismore
Centre for Health Promotion and Research, Sydney, NSW

Chronic pain is an increasingly common phenomenon in modern societies. It's not coincidental that this corresponds to an increase in several other lifestyle-related chronic diseases or risk factors (type 2 diabetes, depression, cancers etc), which have recently been shown to have a common physiological aetiology in low grade, systemic, inflammation ('metaflammation').

Coupled with findings of increased plasticity in the brain, it is not outrageous to speculate that metaflammation may extend to both central and peripheral glial connections associated with pain perception, thus linking lifestyle-related 'inducers' to non-specific and unresolvable chronic pain. Even without such a biological basis, there is evidence to suggest that lifestyle change may have a positive effect as part of a systems-theory approach to chronic pain management. The potential benefits of a 'Lifestyle Medicine' approach to chronic pain management are considered in this regard.

THE ROLE OF MICROGLIA IN THE REGULATION OF MOOD STATE: IMPLICATIONS FOR DEPRESSION

Dr Frederick Rohan Walker
University of Newcastle, NSW

This presentation will introduce the audience the roles of microglia within the CNS, and also recent work demonstrating the ability of psychological stress to structurally and functionally alter microglia. Microglial cells are pivotal to the production and maintenance of a neuroinflammatory states in the CNS, they have also been implicated in chronic pain. These cells are the first line of defence against pathogens and other threats to the integrity of CNS. As stress is recognized to be a major antecedent of mood disorders and in particular depression our research group has begun to examine the relationship between stress induced microglial changes and alterations in mood state in the rat.

Over several years we have identified that chronic stress (i) decreases an animal's preference for sucrose (ii) reduces their motivation to explore a novel environment (iii) as well as significantly increasing microglial activation in several mood regulatory forebrain nuclei including the medial prefrontal cortex and amygdala. We have more recently shown that reducing microglial activity in the brain can attenuate several of these stress induced alterations. Currently, our group is now functionally characterizing, using a variety of ex-vivo techniques, the precise inflammatory phenotype of microglia within the mood regulatory nuclei where we have observed differences following exposure chronic stress.

NUTRITION AND PAIN

Prof Clare Collins
University of Newcastle, NSW

Does what you eat matter when it comes to pain? Does being in pain affect the decisions made about what to eat and drink? Pain influences dietary intake and nutritional status through a broad range of mechanisms and in ways that can increase the risk for protein-energy malnutrition or increase the risk of excessive weight gain.

The majority of patients with pain report eating less during acute episodes and if frequent, this can contribute to the risk of malnutrition. For those experiencing chronic pain, it is reportedly common to perceive that weight affects pain levels, while being overweight is an important predictor of painful conditions such as lower back pain. The combination of dietary restriction and exercise to achieve weight loss has been shown to improve self-reported physical function and pain levels. This is important as being able to move freely without pain improves a person's ability to shop, cook and feed themselves with enjoyment. Providing appropriate assistance to individuals in order to undertake these tasks can help to prevent malnutrition and functional decline, while improving or maintaining nutritional status. Nutrient requirements may be altered by episodes of chronic pain and there is some evidence that increasing intakes of specific amino acids including administration of D-phenylalanine or diets enriched with tryptophan can increase an individual's tolerance to pain. Supplementation with a class of essential fatty acids referred to as Omega 3s has been sown in a meta-analysis to improve a number of pain outcomes after three months, including patient assessed pain, duration of morning stiffness, number of painful or tender joints and use of non-steroidal anti-inflammatory medication.

Other medications for pain can also negatively impact nutritional status due to side effects such as constipation, nausea and/or appetite changes. While pain that keeps people awake can impair sleep quality, impair glucose tolerance secondary to the altered hormonal response that ensues and thereby increase the risk for type 2 diabetes.

Research in the area of nutrition and pain is limited and studies are required if an evidence base for supportive and effective dietary interventions to support people experiencing pain is to be developed.

MEANING AND PERSONAL STORY

Prof Brian Broom
Auckland City Hospital, Auckland, NZ

The practice of medicine largely operates from dualistic assumptions, that body and mind, physicality, and subjectivity are relatively autonomous dimensions. The severance of body and mind, of illness and personal story, severely restricts clinical and therapeutic opportunity. But if one assumes that mind and body are expressions of a unity, the kind of medicine that emerges is one where physical factors and personal meanings and story factors work together in illness and in treatment. Moreover, the clinician becomes willing and able to allow the body and mind (story) to be responded to in the same clinical time/space.

In short, because all persons have unique stories clinicians become person-centred rather than body or mind or modality or discipline or expertise or institution-centred. How this plays out in practice will be illustrated, particularly in relation to pain management.

THE PAIN STORY: PRACTICAL APPROACHES

Dr Stephanie Oak
John Hunter Hospital, NSW

Recently neuroscientists and philosophers have shifted away from dualistic conceptions of pain, including Engel's biopsychosocial framework. They are beginning to articulate a more complex and integrated way of thinking about the pain experience. Researchers are exploring the intricacies of and complex interplay between mind, brain, body and environment as dynamic processes. However clinicians are struggling to translate these ideas into practical applications that can capture the complexity of intersubjective experiences such as pain, and that will be useful in clinical settings.

This paper argues that patients' stories and the principles of narrative medicine have the potential to broaden our understanding of pain as a unique experience influenced by a multiplicity of interlinked factors. With this understanding, new pain management strategies can be developed.

I will explore the nature of the resistances and challenges that currently exist in medical practice and that we must overcome if we are to benefit from these neuroscientific insights in developing innovative new practices for pain management. I will outline several practical strategies that can be readily integrated into clinical practice without unduly overloading our already demanding schedules.

THE IMPACT OF TRIAGE ON A PAIN SERVICE

Dr Cathy Price
Southampton University Hospitals Trust, UK

Persistent pain, no matter where in the world it is measured, is common, becoming more common. We are now clearer about its causes and what does and doesn't work. People with persistent pain are helped by varying services. However, provision is often poorly matched to needs and resources are often misplaced. Without a clear system it is easy for someone in pain to access help in a scatter gun way.

Mindful of this in 2003 Southampton had the opportunity to reshape its pain services. Prior to this there were multiple queues in multiple services with people often in the wrong place.

Since 2003 Southampton has tried to adopt a whole system approach, especially with regards to musculoskeletal pain. Strengths and weaknesses will be discussed. The system has been evaluated at several differing points. Effective triage is a key component.

However, a whole system health is difficult to measure. The impact on specialist pain services will be specifically discussed. Other services in the UK will also be compared. Future directions will also be discussed. Feedback is especially welcome.

PRIMARY CARE STORY

Dr Stephen Leow
General Practitioner, Adelaide, SA

Anyone who has any involvement in Pain Medicine is well aware of the current demand for Pain Services and the supply of Pain Specialists in Australia. We can count ourselves lucky as we have a relatively good supply of specialists, compared to many other countries in the world. Is there a solution? If so where would it come from?

Often the first place to look for solutions are the generalists. After all, they are the most populous group of doctors, they are not specialized and they are all largely dissatisfied (?). Once given the chance, should many GPs jump at the chance of becoming a specialist?

EDUCATIONAL OBJECTIVES

This address focuses on the complex issues surrounding General Practice and includes topics such as:

- The recognition of Pain Medicine as a specialized field
- The multifaceted nature of Pain Medicine
- Why Pain Medicine is a natural extension of General Practice
- Monetary issues
- Dealing with pain in a primary care setting vs a tertiary setting
- Using primary care practitioners in a tertiary setting
- Moves to engage primary care
- To extend the primary care setting
- To engage primary care practitioners in the tertiary setting
- Managing the interface between primary and tertiary care
- Is there a need for a secondary level of care?
- Education issues
- Pathways to specialties
- Pain Service Delivery Models

OUTCOMES OF THE STEPS PROGRAMME AT FREMANTLE HOSPITAL

Dr Carl Graham
Fremantle Hospital, WA

An historic emphasis towards passive management of chronic pain using primarily medications and procedures had resulted in relatively high, and recurrent, utilisation of health resources amongst persistent pain patients accessing the pain medicine unit at Fremantle Hospital. Chronic disease modelling high-lighted the need for a shift towards increasing utilisation of active self-management strategies to improve both treatment and management outcomes. The STEPS approach was developed to recognise self-management of chronic pain as an integral part of out approach to patient care.

STEPS involves an interprofessional collaboration to provide education and skills based training oriented towards functional improvement alongside the normal emphasis on pain symptom management. By providing patients with a participatory orientation and integrating them in an active role within the multidisciplinary outpatient treatment processes a reduction in medically oriented service utilisation has been achieved while also reducing wait list times and providing improved levels of patient satisfaction.

While persistent pain is the focus of this current project, the underlying emphasis on patient involvement, orientation towards underlying functional improvement in addition to symptom management and the titration of intervention from high patient involvement towards higher health service utilisation serves as a model for the management of other chronic health conditions.

MIND, BODY AND RELATIONSHIPS: TREATING PAIN IN CONTEXT

Dr Kasia Kozlowska
The Children's Hospital at Westmead, NSW

Contemporary research suggests that psychosocial factors negatively affect post-surgical pain and predispose to chronic pain syndromes[1-4]. Psychosocial factors range broadly and include: chronic stress on the mind or body resulting from cumulative life events, unresolved loss or trauma, or chronic relationship stress; the manner in which patients' bodies manage physiological arousal and respond to negative emotional states; and the manner in which patients organise psychologically – whether they try to inhibit subjective knowledge/experience of pain or whether they exaggerate it (catastrophize), how they signal pain, whom they blame for their pain and life predicaments and whom they engage from their relationship network to manage their pain and share their life predicaments. The impact of psychosocial factors appears to be mediated, at least in part, by the manner in which patients' life experiences shape and fine-tune the body's stress systems – those systems involved in a self-protective response on physiological, hormonal, neurological and psychological system levels[1-3, 5, 6]. It is now becoming increasingly clear that patients who suffer from chronic pain syndromes show differences in how they process somatic and emotional stimuli on multiple levels of the mind-body system. For example, patients with functional abdominal pain show an increased auditory startle response[7, 8], and patients with irritable bowel syndrome show altered autonomic and brain responses to neutral, somatic or emotional stimuli[9-14]. Catastrophic thinking, negative recovery expectations, external attributions of responsibility, and patients' capacities to manage negative affective states have all been identified as being associated with poor surgical outcomes and chronic pain syndromes[4, 15-20]. Many of these factors are modifiable with treatment – which requires, however, that the factors be identified and specifically addressed. To that end, I begin by presenting the case of a 15-year-old girl with a seven-year history of chronic pain. I then explore how to translate the case presentation, along with the family's medical history, into psychological language, resulting in a psychosocial story or psychological formulation that enables us to understand the girl's chronic pain in the context of her life story. The goal here is to help pain physicians understand how to move from a medical case history to a psychological case history that will provide insight into their patients' chronic pain and help them to understand and address (with appropriate interventions from other clinicians) the factors that are causing and maintaining it. That is, a comprehensive formulation not only serves to identify the mind, body and relationship factors that contribute and maintain medically unexplained chronic pain, but functions to guide treatment planning, it helps the clinician identify and implement the relevant multimodal interventions that, taken together, will alleviate the patient's pain and emotional suffering.

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USING FUNCTIONAL GENOMICS TO UNDERSTAND PAIN

Prof Rodney Scott
University of Newcastle, NSW

Pain has evolved to alert each and every one of us of environmental factors that cause us harm. It has been recognised for quite some time that there are differences in pain thresholds and perception between individuals and that these two factors alter with age. Similar to many other complex biological processes pain perception is increasingly being scrutinised at a molecular level to better understand the mechanisms involved and to identify potentially new treatment targets.

The different types of pain, acute, allodynia and neuropathic are all underpinned by specific genes. Acute pain is experienced as a result of nociceptors stimulation (after injury) that requires the coordinated expression of genes associated with transducers, ion channels and receptors. Once the initial event is passed a second phase of pain sensation is established to protect the site of tissue injury characterised by an increase in sensitivity to innocuous stimuli. This process is characterised by molecules that sensitize the primary afferent and second order spinal chord neurons. Finally neuropathic pain is generally considered to be 'maladaptive' and a result of long term changes in the processing of pain messages by both the spinal cord and brain stem neurons. Many, if not all, of the changes associated with neuropathic pain are a result of gene induction and loss of control fidelity.

This review will provide a brief overview of how functional genomics can aid in better understanding pain perception and potentially treatment.

AGEING WELL

Dr Isabel Higgins
University of Newcastle, NSW

One of the most crucial aspects of establishing the notion of 'wellbeing' for older persons is whether or not our processes as health care professionals is humanising or dehumanising. Arguably, if we are to make a contribution to maximising the health and welfare opportunities for older people in the community then we need to critically reflect upon what it means to age well. Armed with this knowledge we need to review and align our attitudes, expectations and health care practices accordingly. In this paper I explore Rowe and Kahn's (1999) model of Successful Aging along with some of the more recent science regarding healthy ageing and the meaning that ageing well and successfully has for older people.

Successful ageing is multidimensional with three components including; the low probability of disease and disease related disability, high cognitive and physical functional capacity and active engagement with life. The low probability of disease is not only the absence or presence of disease but the absence of risk factors for disease. Both physical and cognitive capacity highlight potential for activity; they tell us what a person can do; not what they do and active engagement with life includes and individual's interpersonal relations and productive activity. Interpersonal relations however must involve meaningful contact with others and activity with societal value whether or not it is reimbursed (Rowe & Kahn, 1999, p. 27).

On disease and the absence of disease, there are a range of measures for Australians that suggest we are ageing well. According to the latest report from the Australian Institute of Health and Welfare; Australia's Health 2010, we are a healthy nation. Our life expectancy is amongst the highest in the world and it has been so for some time. Australia is ranked third in the world for life expectancy from birth at 79 and 84 years for males and females respectively. For those now aged 65 years, males can expect to live to 84 years and females to around 87 years. These figures contrast life expectancy in the 1900s where it was 55 years for males and 59 years for females. When considering Australia's health within the OECD (Organisation for Co-operation and Development) in terms of mortality, risk and protection, and morbidity, with some exceptions such as obesity and infant mortality, we are mostly in the top third on these measures. However, it seems that "we are a healthy nation, but not in every way" (AIHW, 2010). When the impact of different health problems are compared using the 'burden of disease and injury' measure cancer and cardiovascular disease are the highest. The next highly rated group includes problems such as dementia. Over 200,000 people have dementia and this figure will double over the next 20 years. Clearly, on some of these measures, not everyone is ageing well. In terms of the value of continuing engagement with life however, there is an increasing awareness of the importance of this to the health of older people in later life and in terms of the community at large.

The changing age structure of society amongst Western countries has increased the focus on the implications for both social and economic planning. For example, the UK government's strategy for ageing in the 21st century seeks to change the perceptions and roles of older people from passive receivers of care resources to those of active citizens. In the late twentieth century, policies adopted the viewpoint of disengagement theory (Cumming et al, 1961), where older people were seen as having a gradual lessening of ability with age and an inevitable death. The theory supported older people being disengaged from their employment and freed to engage in more leisurely activities. This was a view founded on the expectation of relatively young death in the older person and the assumption of a steady supply of younger people to take up the vacant employment opportunities left by the retirees. The new trend is to return the role of older people from that of disengagement, where ageing and retirement meant a lessening of social responsibility, to one in which they continue to perform in roles having a more meaningful contribution to society (Baldock, 2000). In addition, it has been recognised for some time that engagement with life through the maintenance of interpersonal relations and productive activity is integral to successful ageing. Indeed, being part of a social network is a significant determinant of longevity. Social isolation and lack of connectedness on the other hand, are known predictors of morbidity and mortality (Rowe & Khan, 1999).

Successful ageing is the combination of the absence of disease, maintenance of functional capacity and active engagement with life. There is little doubt that ageing well/successfully is about avoiding disease and disability, maintaining a high level of functionality and sustained engagement in social and productive activities. This paper will highlight the evidence for ageing well and invite attendees to critically reflect upon its meaning for health care practice and in terms of personal life choices.

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THE ROLE OF MUSIC IN LINKING MIND AND BODY

Mr Sean Nolan
John Hunter Hospital, NSW

The intuitive use of music to affect mind and body in a positive way is documented throughout history. Egyptian 'music healers' combined chant therapies with medical practices (including pain reduction during childbirth) and Chinese healers prescribed music for emotional and physical health. Even further back in antiquity the Greek god Apollo is described as presiding over both music and medicine. The first king of Israel, Saul, was known to listen to lyre music for relief of symptoms of depression and Hippocrates, referred to as the father of medicine, incorporated music and medicine to treat diseases. Modern history records that the therapeutic benefits of music have continued to be used in conjunction with medical treatments to facilitate emotional and physical health, supported by Descartian theories regarding music's ability to influence and regulate emotional conditions, thus affecting physical conditions.

In recent times, advances in medical technology, and increasing research in areas such as biomedical music therapy, functional neuroscience and psychoneuroimmunology (PNI), have demonstrated the measurable effects on the mind as it processes music, and the subsequent effects on the body. For the first time, what has been known intuitively has been underpinned by scientific evidence.

The MindBody Imagery & Music technique has been developed by the presenter over a period of twelve years to take advantage not only of the mind-body connection, but also the powerful and demonstrated effects of music to promote health and wellbeing. This technique can be adapted for the benefit of diverse populations with a wide range of conditions and symptoms.

Participants will be given a brief historical outline of the influence of music on mind and body, the neurophysiological basis of receptive music and its implications for pain management, a description of the components of calming receptive music, and a practical experience of the role of music in linking mind and body through the agency of the *Mind Body Imagery & Music* technique.

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PBLD 01
TRANSGENERATIONAL CRPS

Dr Susie Lord
John Hunter Hospital, NSW

This case discussion looks at a family in which 3 generations have been given the 'label' of CRPS.

OBJECTIVES

- List clinically relevant differences between childhood-onset and adult-onset CRPS
- Define sporadic and familial CRPS
- Apply current knowledge regarding the genetics of pain, and CRPS in particular, to the clinical case. Explain how patterns of thinking about pain and ways of communicating distress are transmitted between generations.
- Apply strategies for managing difficult adult patients to managing difficult families
- Outline the role of the pain specialist in child protection

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PBLD 02
MANAGING THE RISK...TRANSITION FROM ACUTE TO PERSISTENT POSTSURGICAL PAIN

Dr Myles Conroy
Barwon Health, VIC

OBJECTIVES

At the end of this PBLD, participants should be able to:

1. Understand the scope and burden of persistent post-surgical pain in Australia
2. Propose mechanisms for persistent pain related to specific surgery types
3. Identify patients at risk for this problem
4. Propose preventive strategies for patients at risk
5. Initiate appropriate early management when persistent post-surgical pain is identified

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CASE STUDY – PREOPERATIVE

- Tania, 29YO girl
- Chronic Right knee pain & instability
- Booked for knee arthroscopy (MRI normal, suspect 'occult meniscal tear'.)
- 7 previous arthroscopies including ACL repair and revision
- Takes regular panadeine forte, mirtazepine
- Previous treatment with pregabalin for Rt leg pain by GP
- Moved home to live with parents, ceased clerical work due to knee pain

What features about Tania's presentation might predict post-op pain?

What issues should be addressed in pre-operative planning?

How should she be managed peri-operatively?

POSTOPERATIVE

- Acute Pain Service asked to review Tania in recovery
- Had GA, parecoxib, morphine 10mg
- Complaining of severe Right leg pain, unresponsive to further morphine in recovery

What issues are important to consider in assessing Tania?

What strategies can be employed to control Tania's pain?

What is the role of regional analgesia in preventing persistent pain?

REVIEW DAY 1

- Nursing staff report Tania has had a difficult night
- Seen by anaesthesia registrar twice.
- Tania complains of severe constant sharp posterior knee pain, and a constant burning sensation down the medial aspect of the calf, with sudden stabs of sharp pain in a similar distribution
- Currently she is on a ketamine 12mg/h and a morphine PCA (60mg in last 12/24)

What diagnoses should be considered?

What suggestions can be made about further management?

HOSPITAL DISCHARGE DAY 8

At discharge Tania is taking the following medications:

- Prednisolone 50mg
- Duloxetine 60mg Daily
- Oxycontin 60 mg BD
- Celecoxib 200mg BD
- Pregabalin 150mg BD
- Oxycodone 10mg prn

Why had her anti-depressant changed?

Why prednisolone?

What is the role of gabapentinoids in acute pain and neuropathic pain management?

How should she be managed from here?

PAIN CLINIC REVIEW DAY 28

Tania reports ongoing difficulty with pain, poor sleep, and lack of interest in social activities. Her mother has been caring for her at home and brings her to clinic. She is concerned about her medications and enquires about further surgery for Tania, as her pain has not improved.

PBLD 03
FINDING MEANING IN PAIN

Dr Matthew Pols
John Hunter Hospital, NSW

OBJECTIVES

1. To clarify aspects of the patient history with particular attention to the psychosocial aspects of the case.
2. To contribute to the diagnostic formulation. The emphasis will be on psychosocial aspects.
3. To use the case formulation to inform potential management strategies with particular attention to psychosocial aspects.

BRIEF CASE OUTLINE

A 48 year old woman who works as a bus driver presents to a multidisciplinary pain clinic with a history of 2 years of persistent pain in her posterior right forearm projecting down to her fingers. She described her pain as throbbing, burning and tingling. Her pain is exacerbated by lifting. The onset of her pain was after a fall at her home.

She has had several investigations including an ultrasound and nerve conduction studies. The ultrasound soon after the injury showed small partial tears in the deep fibres around the acromion. Nerve conduction studies were normal. Corticosteroid injections provided temporary relief yet her pain has persisted.

Her current medication is Oxycontin 20 mg bd and venlafaxine XR 225 mg daily.

She has a history of a non-melancholic depression associated with prominent anxiety symptoms over the last 2 years.

She is married and has 2 teenage children. She has had a dispute with her neighbour over the last few years. She and her husband have also been having relationship difficulties. There are also more long-standing conflicts in her relationships with her sister and her mother.

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PBLD 04
MORE THAN MEETS THE EYE: A YOUNG MAN WITH PAIN IN HIS HEAD

Dr John Malcolm
General Physician, NSW

This case has many elements: the difficulty of obtaining an accurate history and the value of detective work to check the facts; persistent pain in person with a significant psychiatric disorder; managing the relationship with the patient's psychiatrists; problems of polypharmacy' negotiating with and containing the patient without insight; managing the enmeshed and co-dependent parent; and more!

A young man with facial pain has rather more to his pain problems than was at first apparent. This case presentation and discussion raises issues of clinical assessment, management of long-term opioid treatment on a background of problematic relationships, psychiatric illness and the difficulties in multidisciplinary management in multiple locations.

PBLD 05
NEUROMODULATION IN A COMPLEX CASE. HOW DID WE GET THERE?

Dr Simon Tate
Hunter Pain Clinic, NSW

A complex case of neuropathic pain. This case has prominent biological, psychological and social-developmental aspects. The challenges include diagnostic uncertainty and the application of multimodal therapeutic algorithms where only expert opinion rather than high quality evidence is available. The PDBL also explores the issues surrounding selection of patients for neuromodulation.

OBJECTIVES

1. Explain how developmental issues and personal story impact the presentation
2. Describe the main diagnostic and treatment algorithms for CRPS
3. Describe the evidence base for biological therapy in CRPS
4. Explain how you would justify (or not justify) neuromodulation in terms of its cost

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TOPICAL SESSION 01
HIDDEN DRIVERS OF PAIN: PSYCHOLOGICAL/PSYCHIATRIC PERSPECTIVES

Mr Carl Graham
Fremantle Hospital, WA

Dr Newman Harris
Royal North Shore Hospital, NSW

Not all mental health professionals are the same! Beyond the clinical standard of including a mental health practitioner in the pain team, this clinical case discussion examines the different but complementary roles of psychiatrist and clinical psychologist in the pain clinic.

This session will encourage participant interaction based around several case studies. There will be discussion of the roles of psychologists and psychiatrists in the assessment and management of persistent pain and the evolution of therapy beyond the traditional cognitive behavioural approach.

TOPICAL SESSION 02
BLUEPRINTING PAIN MEDICINE AS A SPECIALTY

Dr Frank New
Psychiatrist, Qld

Dr Di Pacey
John Hunter Hospital, NSW

Dr Simon Tame
Hunter Pain Clinic NSW

A Faculty of Pain Medicine blueprinting subcommittee has been addressing the challenge of defining a pain medicine specialist. This is of vital importance to service delivery, training, examination and ongoing education.

OBJECTIVES

Those attending will be able to:

- Describe the Blueprinting process
- Describe the advantages and disadvantages of the multidisciplinary nature of the Specialty
- Describe some of the tasks for trainees in a multidisciplinary specialty.
- Make effective use of the special perspectives of colleagues

TOPICAL SESSION 03
IMPLEMENTING SHORT GROUP INTERVENTIONS AT THE HUNTER INTEGRATED PAIN SERVICE

Ms Denise Daunt
John Hunter Hospital, NSW

Ms Meredith Jordan
John Hunter Hospital, NSW

Ms Ruth White
John Hunter Hospital, NSW

Can less equal more? This session will describe the ongoing evolution of short group interventions at Hunter Integrated Pain Service. Concepts of stratified service design and emerging information content will be explored and the challenges of short group interventions discussed. Preliminary outcome data will be presented.

1. **LOOKING AT THE BIG PICTURE:**
EVOLVING STRUCTURES IN PAIN MANAGEMENT DELIVERY
Ms Denise Daunt

OBJECTIVES

At the conclusion of the session the learner will be able to:

- define the process for introducing short group interventions for pain management
- incorporate the principles of HIPS integrated holistic model
- explain how patients are coping better with this approach

2. **WHAT ARE THE KEY MESSAGES?**
EVOLVING COMMUNICATION IN PAIN MANAGEMENT
Ms Ruth White

OBJECTIVES

At the conclusion of the session the learner will be able to:

- list 10 key ideas for communicating the pain message
- utilise the language of pain used at HIPS
- identify options for optimising available resources to assist implementation

3. **IS IT WORKING?**
IMPROVING QUALITY BY EVALUATING THE OUTCOMES
Meredith Jordan

OBJECTIVES

At the conclusion of the session the learner will be able to:

- describe how and where shorter programs can improve outcomes
- describe the effectiveness of short group interventions
- identify areas requiring further research and development

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TOPICAL SESSION 04
HIDDEN DRIVERS OF PAIN: BIOLOGICAL

Dr Michael Katekar
John Hunter Hospital, NSW

Dr Marc Russo
Hunter Pain Clinic, NSW

Prof Ian Whyte
Calvary Mater Hospital, NSW

There are various hidden drivers of pain that lie in the biophysical domain. Awareness of these is the first prerequisite for identifying and treating them when they are present. Without a sound knowledge of these factors some pain syndromes will forever remain 'idiopathic'.

It is no secret to pain clinicians that there is a vast array of bio-psycho-social factors influencing the pain experience. This session brings together some less well known biologic factors influencing pain and some of our methods of dealing with it. These items stem from an increasing scientific knowledgebase – especially in the field of metabolic pathways of drug metabolism. For example, an included update will describe enzymatic polymorphisms of the cytochrome P450 system affecting metabolism of common analgesics – NSAIDS by CYP2C9, codeine, tramadol and tricyclics by CYP2D6, and buprenorphine, methadone and fentanyl by CYP3A4/5 enzymes. Prof Ian Whyte will give an overview of this and more during this topical session.

Recent research will be presented (Dr Michael Katekar) on mitochondrial dysfunction and its relationship to nociception, tolerance, neuropathies, migraine and neurodenerative disease plus possible roles in fibromyalgia, chronic fatigue syndromes and treatment resistant depression. And Dr Marc Russo will present on a wide variety of metabolic matters which may either contribute to pain conditions or limit responsiveness to our treatments – including deficiencies of Vit B12, Vit D, Magnesium in connection with NMDA receptor function, nitric oxide signalling, thyroid dysfunction effects on pain and hypercholesterolaemia alteration of response to opioids.

In summary, the three presenters will bring to your attention a host of matters in the biologic domain which may have been lost or hidden from our consideration as to their effects on pain and our efforts to relieve it.

Notes

Notes

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