CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 3 VOLUME 3, FALL 2010

Many of the readers of this CAPM newsletter have recently returned from the IASP (International Association for the Study of Pain) meetings which were held in Montreal from August 31-September 2.

PAIN received a lot of press in Montreal! It also received some almost daily press in Toronto and even in London. Hopefully, PAIN news also made it to your local community as well.

Those of us working in the area of pain appreciate how challenging a problem it can be. Pain delays recovery from surgery and illness, impacts on one's ability to do their personal , work and leisure activities. It also costs a lot of money! **Money? Finally everyone is listening!**

In both plenary sessions and in specialized topics presentations, the word multi-disciplinary was used repeatedly. Dr. Clifford J. Wolf delivered the Bonica Distinguished Lecture on Central Sensitization: How Plasticity Produces Pain. He noted all members of the 'team' needed for these discoveries- including researchers ,clinicians and patients. In the session Teaching People about Pain, Australian physiotherapist and researcher Lorimer Moseley led a panel discussion with educators about working with other health disciplines to provide appropriate educational information for patients.

The membership of CAPM is certainly leading the way for health providers to appreciate the benefits of multi-disciplinary work. Patients are better treated/managed when a team of health providers work together with their patient to establish realistic and appropriate treatment goals.

Your executive has been busy!

An information booth was set up at the Canadian Pain Society Meetings held in May in Calgary. Many people stopped by the booth and were pleased, inspired, and impressed by the Mission Statement of the CAPM.

Several health disciplines are themselves looking at future educational, credentialing or advanced training initiatives . They were pleased by what CAPM would offer them. Members of smaller health disciplines, including students and researchers were excited by the prospect of being able to be 'credentialed' currently through the CAPM.

The **Lead Article** in this newsletter will continue to follow Mr. A.M. who sustained injuries in a motor vehicle accident (MVA) 3 years previously. He has been referred by his lawyer to a physiotherapist (or a chiropractor) who works in a solo private practice.

In order to follow the discussion, the CAPM membership is asked to review the last 2 Newsletters. ***All newsletters are posted on the CAPM web-site (canadianapm.com).***

To date, we have heard from the initial provider- referred to as either a physiotherapist (PT) or chiropractor (DC) - as well as the psychologist.

Members are again reminded to notify your Editor about 'updates in your professions' concerning pain management initiatives and courses.

You may also want to consider reviewing a book or article or presenting your own article for publication in this newsletter.

Respectfully submitted,

Gloria Gilbert, PT, MSc
Secretary CAPM
Fellow, CAPM
Member and Fellow AAPM

INSIDE THIS ISSUE:

Update from the Executive

CAPM has been diligently working on many different initiatives.

We will be participating in the annual Canadian Chiropractic Conference to be held in November in Toronto. Integrative treatment will be discussed and developed using a case study approach.

CAPM is also working with AAPM towards developing our own 'Canadian' credentialing program.

On-going discussions continue to be held with McMaster CME, physicians who do interventional pain as well as chiropractors interested in developing a pain credentialing service.

New to the CAPM table is the American Academy of Cranio-Facial Pain - Canadian Chapter.

Yours sincerely,

Eldon Tunks,MD,FRCPC
President CAPM
Diplomate of CAPM
Member and Diplomate of AAPM

Tribute to Dr. Ron Melzack

On the Saturday preceding the Opening of the IASP meeting, a special tribute was paid to Dr. Ron Melzack. Ron is a founding member of IASP and an honorary board member of CAPM. Several hundred people attended this lovely reception and visual presentation provided by Dr. John Loeser.

We were all honoured to be in Ron and his wife Lillian's company. It is humbling for all of us to be reminded of the major changes to our understanding of Pain since Drs. Melzack and Wall published on the Gate Control Theory (only in 1963!)

Thank you Ron for your years of devotion and service to your patients- and your colleagues.

Interprofessional Highlights & Welcomes

American Academy of Cranio-facial Pain(Canadian Chapter):

CAPM is pleased to introduce Dr. Dennis Marangos, BSc, DDS, DABCP, FAACP, Immediate Past- President of the Canadian Chapter of the American Academy of Cranio-facial Pain (AACP). Members of AACP felt it was a responsibility to have a formal organization in Canada to deal with chronic head, neck and facial pain and to specifically note the important relationship to sleep disorder management. Dr. Marangos reminded us that the relevance of sleep and pain interactions are clear (and have been reported in many evidence-based journal articles). Chronic Pain affects 1/5 of adults with chronic pain. Reports of disturbed sleep is seen in 2/3 of this chronic pain population. AACP publishes a Journal entitled TMDiary. We welcome AACP's relationship with the CAPM membership. *See note on upcoming meeting in Toronto.*

Interprofessional Highlights & Welcomes continued...

***Editor's Note**: At IASP, I met a physical therapist from New Jersey who was a 'certified cervical and tempero-mandibular therapist'. She is a member of the PTBCCT- The Physical Therapy Board of Craniofacial and Cervical Therapeutics.*

Future newsletters will introduce the CAPM membership to initiatives as well as health care providers working on the relationship between head, neck and dental problems.

Occupational Therapy:

CAPM is pleased to introduce Martha Bauer**,** BSc (O.T.), Reg OT (ON) who has recently joined the Multidisciplinary Advisory Board. Martha is in private practice in Burlington, Ontario.

i) Martha reminds us that an O.T. has the training to consider the person's physical/psychosocial/ spiritual strengths and limitations
ii) environmental barriers and resources
iii) the client's current occupations of self-care, productivity and leisure (including the cognitive and physical demands, their normal habits and roles).

Martha will continue the discussion in the **Lead Article** case study.

Pharmacy:

CAPM also welcomes Dr. David Rosenbloom, pharmacist to our Multidisciplinary Advisory Board. David is a Professor in the Department of Medicine at McMaster University.

Meeting Notices

1st Annual Clinical American Academy of Pain Management
September 21-24, 2010
Las Vegas, NV
Exploring the Science, Practicing the Art: Integrative Pain Management for Optimal Patient Care
www.aapainmanage.org

Sleep, Pain, TMD - the Connection
4th Annual International Symposium of the Canadian Chapter of the American Academy of Craniofacial Pain
October 15-16, 2010
Toronto, ON

Canadian Chiropractic Convention- Annual Meeting
November 11-13 2010
Toronto, ON
www.chiroconvention.com

The Canadian Pain Coalition announces that ***NATIONAL PAIN AWARENESS WEEK 2010 is November 7 - 13.*** Check out the Coalition website www.canadianpaincoalition.ca for posted activities. Also consider hosting a program of your own…during this very important week.

Save the Date

2011 Annual Canadian Pain Society Conference
April 13 - 16, 2011
Niagara Falls, ON

2011 British Pain Society and Canadian Pain Society Conference- Scotland
June 11 - 14, 2011
Edinburgh, Scotland

Educational Initiatives and Information Sites

Please review the list of educational resources for both health provider and patients that have been posted in previous newsletters.

Many sponsors of the IASP meeting are using research and development funds to provide family physicians and other health providers easy access to resources tools. This in result will allow for better communication between patient and treatment provider.

You can check some of them on line.

Contact your local pharmaceutical representative to deliver selected material.

i) ***Pain Assessment Tool, Purdue Pharma***
A 2-page inventory based on the Short Form Brief Pain Inventory (BPI). This form can be completed by your patient in the waiting room, making your 1-1 time more efficient.

ii) Also available from Purdue is the ***Opiod Risk Tool*** (to be completed by the patient), an '***Agreement***' form that the patient signs before beginning Opioid Therapy, as well as ***The 6 A's of Monitoring Opioid Therapy*** for the physician (Analgesia, Activity, Affect, Adverse effects, Abuse behaviours and Adequate documentation).

iii) ***Fibromyalgia - A Practical Assessment Tool, Pfizer Canada***
A 2 page tool developed for the physician that includes diagnostic criteria, co-morbidities and proper tests for patient evaluation.

iv) ***Canadian Pain Coalition,*** www.canadianpaincoalition.ca
An excellent brochure for patients is available at no cost. Excellent content on the evolution of the 'chronic pain cycle' (and how to get out of it) as well as current web resources.

v) **Fibrocentre.ca**
An interesting website (*'brought to you by one of Canada's leading research-based pharmaceutical company'*). Short forms for the patient to complete on diagnosis and pain scales that may be helpful for the physician to begin the dialogue on FM.

For additional information on the Global Year Against Musculo-Skeletal Pain, go to www.iasp-pain.org/GlobalYear/MSP

Lead Article: Assessment and Treatment of the Patient with Chronic Pain in the Community: Completing the Assessment Process and Developing Short and Long term Treatment Goals

To date, commentary has been received from Gloria Gilbert, MSc, Physiotherapist Eleni Hapidou, PhD, Psychologist and Howie Vernon, DC, PhD, Chiropractor.

The involvement of the occupational therapist, Martha Bauer is now needed to complete the assessment.

A Quick Review:

Mr. A.M., a 53 years old native of El Salvador, has been in Canada for 15 years, emigrated because he was a political activist and at risk for his life

- worked as soccer coach and dance instructor before MVA, no previous accident, injuries necessitating time off work, no prescription medication
- father of 13 children, 4 different women

MVA December 15, 2007

- physiotherapy treatment initiated 6 months after the MVA; 'stopped' (after 4 months) because Mr. A.M. was not feeling any better
- constipation problems because of Tylenol #3, complete GI work-up ordered (normal); no investigative scans ordered (beyond neck x-rays which were taken in ER in December 2007 (which noted that there were 'no fractures')

Physiotherapy / Chiropractic Assessment : February 6, 2008

- a review of the index of the Medico-legal and/ or Insurer Examination file as well as the initial accident report and ER summary
- of concern was whether there was other relevant information that would be helpful in designing a treatment program *(? documentation to determine the type of trauma Mr. AM. sustained at the time of impact ? unconscious? did air bags deploy? was the car driveable post collision?)*

Patient Concerns & Complaints:

1. constant headaches
2. constant neck pain
3. pins and needles into right arm; more evident when tries to do any activity
4. sleeps on futon, cannot stay asleep for longer than 1 hour because of neck pain
5. financial concerns because has been unable to return to work
6. fear/ anxiety about why he has not been able to get better , fear of what will happen to him in the future

After Assessment by the PT/DC, (see content of previous newsletters)

There was concern that Mr. A.M. had sustained significant physical injuries in the MVA that had not been investigated fully. Symptoms suggested a Grade III Whiplash-Associated Disorder (as per FSCO definition). Associated neurological symptoms needed to be further investigated.

Lead Article continued...

(ii) A rehabilitation psychologist was engaged to delineate any other issues impacting on Mr. A.M.'s recovery.

(iii) An In-Home Occupational Therapy (OT) was requested to report on his functional status at home.

i) It was recommended that the family physician refer Mr. A.M. to a physiatrist for further investigation.

Information obtained from questionnaires (Q) completed by the patient:

McGill Pain Q: 12 areas of the body noted as uncomfortable (confirmed specific anatomic distribution as well as ability to discriminate between different sensations)
Visual Analogue scale (for Pain): currently 6/10
Neck Disability Index: 78%
Oswestry Low Back Q: 54%
DASH (Disorders of the arm, shoulder and hand): 82% for ADL, 100% for work, 100% for leisure activities (soccer, dancing)

Psychology Assessment

Patient Questionnaires:
On this 25-item instrument, the patient indicates which symptoms they were bothered by 'A LOT' during the past month. Mr. A.M. endorsed 12 symptoms (average) and rated his health as 'poor'.
Pain Disability Index:
On this 7-item scale, the patient is asked to rate the extent to which pain interferes with their life in family/ home responsibilities, social activities, recreation, occupation, social behaviour, self-care and life support activities.
Of a maximum score of 70, Mr. A.M. rated his pain-related disability as 58.
Chronic Pain Coping Inventory:
Results of both the physical and psychological assessments noted that Mr. A.M. tended to under-report the severity of his symptoms.
Results of the NDI and DASH note his significant perceived disability. He also had little ability to control/ cope with these symptoms (psychologist results).

Both the PT, psychologist and family physician discussed the short term treatment goals. (A Team meeting in the MD office, by conference call, by shared reports). The need for an in-home OT/assessment was discussed.

Occupational Therapy Assessment

In-Home Assessment:

Before OT initiated contact with Mr. A.M., she considered the following:

- by information presented to date, and by definition, 'chronic (persistent) pain has prevented Mr. A.M. from resuming his pre-morbid work activities
- based on results of the Chronic Pain Coping Inventory, it appeared that Mr. A.M. relied on passive rather than active strategies to manage his pain symptoms. He was reported to be guarding, resting and asking for assistance much of the time.
- it was also apparent that Mr. A.M. considered himself significantly disabled form injuries sustained in the MVA (see results of disability questionnaires)

Lead Article continued...

The OT assessed the following:

i) the key concerns and which activity goals he wanted to pursue (and why he has difficulty doing this independently). Information to date had not provided details about what he is actually doing on a day to day basis, how he decides what to do and when, how he paces his activities (or in fact if he knows about pacing!)
ii) whether the patient was stuck in the 'good day/bad day' vicious cycle (*on days I am feeling better, I overdo it and the it takes me a long time to recover- editor's note)*
iii) assess whether Mr. A.M. is fearful of his pain, of moving because of the pain or has concerns about his future (abilities)
iv) determine what were his responsibilities at home and work. If no formal Job Description or Physical Demands Analysis is available, the OT can interview the patient in detail – to prepare a useful document from which to establish realistic functional treatment goals.
v) Mr. A.M.'s current knowledge of pain management strategies, and his ability to integrate provided thermal, assistive and electrotherapeutic devices into his 24/7 day
vi) whether there are many pain behaviours and whether they are helping or hindering his ability to function
vii) whether his family provides 'too much' (or no) help or support

Martha concludes her report by noting that "*There may be some room for improvement of symptoms through other physician or physiotherapy treatment. The OT will consult with other team members to ensure that a consistent message is being heard*".

CONCLUSION:

All health providers were in agreement that Mr. A.M. had to 'accept' (come to terms with) his changed reality. The persistence of symptoms made it challenging to separate physical from emotional issues. In order to make functional gains, it was important to assist Mr. A.M. to develop and maintain a 24/7 pain management schedule. Key elements were learning to pace and schedule his activities, use thermal, assistive, devices appropriately, reduce his use of medication, and to develop his exercise program to include strengthening work (without exacerbating symptoms). It was likely that Mr. A.M. would only be able to see progress when he could resume some of his pre-accident home, leisure or work-related activities.

The reality of this particular case concluded with the appreciation that there were indeed "other physical factors" impeding Mr. A.M.'s recovery. The 'real' clinical psychologist (not Eleni!) was putting too much emphasis on Mr. A.M.'s past history of involvement in political activism as well as the fact that Mr. A.M. enjoyed the company of women (and had fathered many children). Physiatry (MRI) and anaesthesia (diagnostic cervical blocks for radio-frequency treatment) in fact confirmed severe disc bulges, spinal stenosis and facet joint syndrome at multiple levels. Mr. A.M. unfortunately was NOT a candidate for surgery (fusion) to assist with improved pain control. Vocational pursuits were also severely compromised because of his lack of a formal education.

Mr. A.M. involved himself in a 24/7 pain management program as best he could. He also continued to exercise - in the pool. In order to provide some muscle strength, he had to wear a plastazote collar and use a snorkel- so that he did not have to turn his neck to 'breathe'.

He also benefitted from attending an 8 week Mindfulness Meditation Course.

Lead Article continued...

Mr. A.M. was also encouraged to attend a meeting of the local Canadian Pain Coalition, where he could meet other persons living with a persistent pain condition.

Further vestibular and neuro-optometric testing assessment confirmed that there were both visual field and visual shift problems; explaining some of his balance and focusing concerns (although his vision tested normal!)

It was concluded that Mr. A.M. will not be able to re-enter the competitive work environment.

Once the assessments had been completed, and results of additional investigative studies obtained, treatment objectives also had to be changed.

The PT/DC and the OT would continue to work with Mr. A.M. on developing a meaningful 24/7 schedule.

The psychologist would use a minimum of 12 sessions of therapy, using a CBT approach to help Mr. A.M. cope better and reduce his emotional stress. He needed to be assisted to increase his acceptance of the pain condition and to focus on his strengths, quality of life and hobbies.

Life in fact was going to change!

With appropriate co-ordination of treatments goals and objectives, Mr. A.M. would be able to lead a different but meaningful life. It is likely however, that he would also need and benefit from occasional contact with one of his health care team members at different stages in his recovery.

Editor's Note:

Although we are all caring health providers, we must be cautious of 'making assumptions' about our patient in a chronic (persistent pain) cycle. We must investigate possible other physical (or psychological) issues affecting our patient's recovery. My experience with the complicated and/or complex pain/injury patient- especially with those who are 'coping well' and following a 24/7 schedule of integrating pain including suggests that many patients may have sustained other 'less obvious' trauma.

It remains essential to LISTEN carefully to your patient, to ask them periodically to review the history of trauma and their symptoms with you (try NOT to use the word pain but be specific!).

Patients with complex injuries often have 'mixed' pain sensations- musculo-skeletal, neuropathic, visceral. Time, prolonged use of medication and fear of moving can only add to the confusion for both patient and health provider.

There often is NOT a definitive diagnosis. Assist your patient to attain realistic functional goals.

There are cases where complete pain relief may NOT be possible!

Future areas of discussion will include - assessing some of those 'hidden' injuries- mild traumatic brain injury (mTBI) that often accompany traumatic events.

Lead Article continued...

It was also recommended by a CAPM member that the topics of the newsletters be 'indexed'. Your editor will work on this initiative (in her free time!)

QUESTIONNAIRES:

The following questionnaires can be printed from this document. With some instruction, your patient may be able to complete these Q in your office, while waiting for their treatment/medical session***.***

Copies of the **McGill Pain Q (short-form) with VAS*,*** the **BPI(Brief Pain Inventory)** and the **D4N (Neuropathic Pain*)*** were submitted previously by Dr. Kevin Rod. They are printed in Issue 1, Volume 3. Winter 2010 newsletter (which is probably really the Winter 2009 edition!)

1. ***Standardized Body Map***
2. ***NDI (Neck Disability Index)I***
3. ***DASH (Disorders of the arm, shoulder and hand)***
4. ***Oswestry Low Back Disability***