CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 2 VOLUME 5 SPRING 2012

Educational initiatives in the area of pain management are exploding . . . the pain landscape is changing (as it should!). An increasing number of universities, pain organizations, and interest groups from all health disciplines are offering post graduate training and certification programs. Many of these courses are online allowing for easy access. As these programs are developed, your CAPM Executive is launching a new initiative—ensuring that relevant websites are linked to the CAPM website and newsletter.

So, why would the Academy be doing this? Should we not be soliciting our own membership base? The answer is—we are not in competition with any other bone fide pain organizations or education facility/ program. Our constituency is YOU—all health professionals working in the area of pain management who abide by the Mission and Vision of CAPM. The complete Mission statement and vision can be accessed in its entirely on our website, **www.canadianapm.com**. To highlight several key points—

The Canadian Academy of Pain Management is:

- Dedicated to promoting excellence of care for pain sufferers through comprehensive professional development for professionals who care for pain sufferers.
- Working in a context of inter-disciplinary collaboration and adherence to the core professional attitudes and acquisition of knowledge.
- By its accreditation process, acknowledging that the accredited member demonstrates a high standard of knowledge of the field of pain management and demonstrates the core attitudes requisite for the respectful skills and compassionate care of pain sufferers.
- Dedicated to uniting professionals who are committed to relieving pain suffering.
- (Maintains) each professional identify in the field of pain management and relief.
- Dedicated to provide knowledge of best clinical evidence and promotion of skills, for effective pain management.
- Committed to providing a climate of continuous quality improvement and the sharing of knowledge between pain clinicians and between clinical practitioners and researchers.

Your Academy is the unifying professional organization for everyone! **What are the benefits of membership?** By being part of a larger body of health professionals who share similar goals and objectives, we all become a stronger voice for good pain management. Membership acknowledges that we are truly inter-disciplinary professionals, committed to improving pain relief for our clients; Membership in CAPM acknowledges and salutes the different professionals working within the pain management environment; and—*it is important to emphasize*—that although some pain education and credentialing initiatives are developing from within individual professional groups, CAPM is also available to collaborate with other health professional groups to provide post graduate credentialing programs.

In this edition of the newsletter we will highlight the accomplishments of two of our distinguished members, **Dr. Norman Buckley**, Professor and Chair of the Department of Anesthesia, Michael G. DeGroote School of Medicine at McMaster University and **Dr. Judith Hunter**, Physiotherapist and Assistant Professor in the School of Physical Therapy at the University of Toronto.

A lead article on the temporamandibular joint by Dentist Dr. Dennis Marangos, Immediate Past President of the Canadian Chapter of the American Academy of Cranio-Facial Pain will highlight the role of the specially trained dentist in diagnosing and treating TMJ related problems. Dr. Marangos has included diagrams to highlight the intricate anatomy of the head and face. A TMJ In-take Questionnaire is attached to the newsletter and may assist you with obtaining an expanded inventory of symptoms.

Our second lead article on Topical Analgesics is by Dr. Patricia Morley-Forster, Professor in the Department of Anesthesiology and Peri-Operative Medicine at Western University in London,

INSIDE THIS ISSUE:

Ontario. (previously UWO). Each day, there seems to be more topical analgesic products available to our clients. Some agents require prescription, some can only be obtained in a health providers office or clinic and some are 'over the counter'. What is the difference between the topicals? How do we inform and assist our clients to obtain the formulation that may be right for them?

An important reminder that the Annual Meeting of the CAPM will take place **Thursday May 24, 2012** at the Canadian Pain Society Meeting in Whistler, BC. We hope that all members as well as 'guests' who are interested in finding out more about CAPM will attend the breakfast session at 7:30 am (no one sleeps much at this type of meeting anyway!)
A second attachment to this newsletter is the recent edition of the Canadian Pain Coalition newsletter. I would encourage you to share it with your colleagues as well as your patients. Encourage everyone to become a member of the Coalition – the voice and advocate for the people with pain.

The Canadian Pain Summit was held on April 24, 2012 in Ottawa, Ontario. Over 200+ stakeholders, individuals and MP's attended the event. Discussion has resulted in the initial implementation of a plan to ensure all Canadians suffering pain receive appropriate and adequate care, benefits and services. Plans to continue the work the Canadian Pain Summit and keep the pain agenda forward are ongoing.

Your newsletter editor continues to encourage all members to share their work, their knowledge , professional meetings and opportunities as well as comments and insights with all of us. Enjoy the warm weather . . . and hope to see you at the Canadian Pain Society Meeting in Whistler.

Gloria Gilbert, PT, M.Sc.
Fellow, CAPM

PRESIDENT'S REPORT

BY ELDON TUNKS, MD,FRCPC, PRESIDENT, CAPM

We have over 120 members nationally and numbers are increasing. Our membership includes 72 physicians, 16 psychologists, 15 chiropractors. Other disciplines include dentistry, pharmacy, physiotherapy, occupational therapy, basic science, social work, nursing, veterinary medicine, podiatry, acupuncturist, yoga master and case management. 25% of our members are also credentialed, and many are credentialed by both CAPM and the American Academy of Pain Management.

Purdue Pharmaceuticals has continued corporate membership, and shares in the goals of making pain management accessible to all Canadians who suffer pain.

Your Executive is committed to promoting evidence-based standards of care with a multidisciplinary pain management focus. This has included conducting CAPM comprehensive multidisciplinary pain courses beginning in 2011.

Executive members have been participants as stakeholders in 3 working groups convened by the regulatory/licensing body the College of Physicians and Surgeons of Ontario to develop guidelines for pain management. CAPM president Dr. E. Tunks and board member Dr. Howard Vernon are in a working group with representatives of the Canadian Chiropractic regulatory and licensing body i.e. the College to develop a proposal for a chronic pain subspecialty. Dr. Vernon, a long-time member of CAPM board, is chair of that working group. CAPM board members were invited stakeholders in the working group convened by College of Physicians and Surgeons of Ontario that developed recommendations for pathways for creating Advanced Certificates in Pain Management for Interventional Pain. A related working group of CAPM with four members on the former working group also developed a protocol consistent with the Ontario regulations to offer Advanced Credentialing in Interventional Pain to physicians who practice interventional pain management.

The CAPM newsletter, is edited by CAPM Secretary Gloria Gilbert, who received in 2011 a Lifetime Achievement Award from the Canadian Physiotherapy Association. The CAPM newsletter has an increasingly effective outreach, academic, multidisciplinary focus, and educational content.

With regard to the possibility of CAPM offering advanced credentialing certificates (based on and competencies in a specific area of practice), this will probably be available to credentialed CAPM members in the autumn of 2012. The first credentialed course will be in interventional pain practice for physicians. By 2013, it is anticipated that qualifying chiropractors will be able to take courses on chronic pain management.

CAPM is now at the point where we contributed to the guidelines for interventional physicians being accredited by our regulatory body. This is parallel to CAPM guideline now essentially finished that would allow members of CAPM to apply for Advanced Credential Diploma in Interventional pain management. The guidelines are in keeping with the regulation of our Ontario regulatory body, but will be available through CAPM across Canada.

The other news is that our Advisory Board member Howie Vernon is the chair of a working group of the Specialty Committee of the CFCREAB representing all of Canada, to develop guidelines for a Chronic Pain Subspecialty. Again when completed it will be a template for Advanced credentialing for Chiropractors in Chronic Pain Disability management.

The same process should hold true for physiotherapists, psychologists and other providers who are willing to organize with their regulatory bodies to develop pain specialty guidelines.

The executive of CAPM grateful to the enthusiasm and support of many members who share in our mission and are committed to excellence in care.
Dr. Eldon Tunks, President CAPM on behalf of the Board of CAPM

FOCUS ON MEMBERS OF THE ACADEMY

The Academy CAPM is honoured to have so many distinguished health providers as members. It is evident that the passion and dedication people bring to their professional lives is often mirrored in their personal lives as well.

DR. NORMAN BUCKLEY, MD

Norm is Professor and Chair of the Department of Anesthesia of the Michael G. DeGroote School of Medicine at McMaster University in Hamilton, Ontario.

A member of the Faculty of Heath Sciences since 1988, Norm has a particular interest in acute and chronic pain management, and was instrumental in the development and organization of the acute post-operative pain service for adults and pediatrics as well as the pediatric sedation services. Norm notes that he became interested in pain management when he was an undergraduate student in psychology.

During his anesthesia training, he was fortunate to spend a year at Stanford University when Dr. Michael Cousins was a visiting professor. This personal experience reinforced his goal to improve chronic and acute pain management services to his patients.

A true multi-faceted professional, Norm is also passionate about music and is a trombone player! Besides music, his out of hospital clinical interests include supporting medical ophthalmology missions to Central and South America (medical Missions International). Norm provides anesthesia services for adults undergoing cataract surgery and for children undergoing strabismus surgery. In the past, he has run canoe tripping and winter camping organizations (Camp Outlook - Hamilton). He maintain his interest in music as a trombone and baritone player presently playing with the Western Silver Band. This successful community music organization offers a concert series at Glenn Gould auditorium in Toronto several times a year,

Norm wants to also report that all his adult children are gainfully employed and 'blissfully' independent.

DR. JUDITH HUNTER, PT, M.SC.,PHD.

Judith Hunter is a Physiotherapist and Assistant Professor in the Department of Physical Therapy at the University of Toronto (U of T). She completed a B.Sc. (PT), M.Sc. (anatomy) and Ph.D (Pain Neurosciences) at the U of T. Judi also completed a post-doctoral fellowship at the Lyndhurst Centre, affiliated with Toronto Rehab. Judith is currently an Associate of the Scientific Staff member at Mount Sinai Hospital, the Wasser Pain Management Centre and a member of the U of T Centre for the Study of Pain (UTCS).

Her passion for her profession led her into the area of research (neuroscience) at a time when there were no advanced degrees in physiotherapy.

Judi states that work by Dr. Joel Katz and Dr. Ron Melzack on phantom limb pain as well as work by Dr. Karen Davis on the psychophysics in pain led her to her thesis on somatosensory plasticity after amputation. Since then she has published many articles, including a systemic study of mirror box patterns and the effect of manipulation of sensory stimuli on perceived pain.

Her current research focuses on two relevant aspects of knowledge translation: 1) Theory to practice. Judi is a primary investigator (CHIR/NSERC) working with neuro-scientists, clinicians and engineers to develop and evaluate a tool to assess somato-sensory processing in people with central neuropathic pain after spinal cord injury, as well as (2) Knowledge to action: Inter-professional pain management. **www.cahr-pain.ca**

Always active and involved within her own physiotherapy profession, Judi is a true educator, and active participant in inter-professional educational initiatives.

Judi has been instrumental in the development of the Certificate in Pain Management offered by the University of Alberta. This on-line inter-disciplinary graduate level credit Certificate in Pain Management is to promote and advance education in collaborative pain management for health care professionals. The certificate is granted upon successful completion of three graduate level courses: The Nature of Pain, Assessment and Management of Pain and Integrating and Implementing Pain Management Models **www.rehabmed.ualberta.ca/pain management** or email contact **sdrefs@ualberta.ca**.

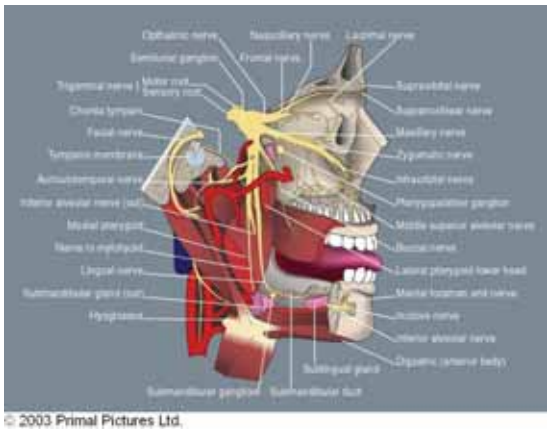
And the most exciting news to report…is that Judith recently became a first time Grandmother! Congratulations. Zoomer grandparents are changing the stereotypes of previous generation—another innovative path for Judi to follow!

HOW DO (SHOULD) DENTISTS APPROACH THE PATIENT WITH TMJ (TEMPERO-MANDIBULAR JOINT DYSFUNCTION?

Dr. Dennis Marangos, DDS

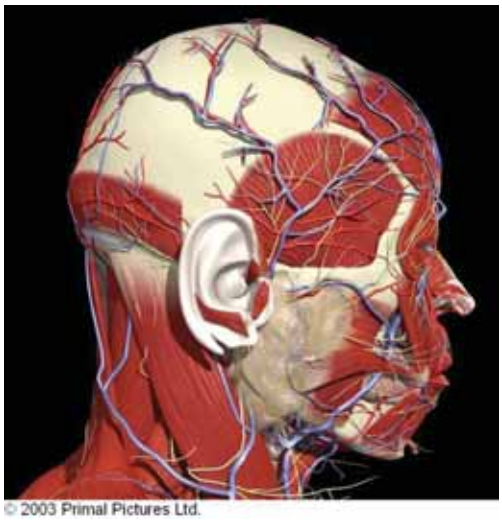
"Doctor, I have TMJ . . ."

"Yes Mrs. Smith, you do. You have two of them and they are both lovely." Any Doctor treating craniofacial pain (pain in the head, neck, face) would have run across a patient with this comment. At the Annual Meeting of the CAPM in Toronto in October 2011, Dr. Dave Rawson and I had the privilege of presenting to the group the dentist's perspective on head, neck and chronic facial pain. We felt it was an eye opening experience for all; we better understood the medical approach to chronic pain management while the doctors, physical therapists, chiropractors and others found out that dentistry could be more than fixing teeth and gums.



The purpose of this short article is to bring awareness to those unable to attend the meeting a brief summary of what dentistry today can offer in the area of chronic pain management. I hope in future issues to address more specific areas of TMD, chronic pain management, sleep disordered breathing issues and whatever else comes out of these discussions.

The TM joint is a vital joint of our body that is necessary for proper mastication, speech and function of the craniomandibular/stomatognathic system. We would never think to say that a patient suffers from "Knee", another joint of our body that can be the cause of much pain. Therefore, "TMJ" is not a disease but TMDJ (Temporomandibular Joint Dysfunction), Craniomandibular Dysfunction or Orofacial Pain can be classified as diseases. TMDJ is a disease that embraces a number of clinical problems that involve the masticatory musculature, the nervous system, the skeletal structures, the cervical structures (neck, shoulder and back pain), the pharyngeal airway (Obstructive Sleep Apnea, Upper Airway Resistance Syndrome and the associated co-morbidities), the TM joint, the teeth (occlusion) as well as the psychological well being of patients. Craniofacial pain (headache, facial pain/TMD) and sleep disordered breathing are very closely related and in fact at Johns Hopkins University a study they completed and published in *SLEEP.* Vol. 32, No. 6, 2009 demonstrated an 88% connection.



Dr. Charles Carlson (a clinical psychologist) has shown that 28% of OroFacial pain patients suffer from depression, 31% from anxiety disorders and 1% obsessive/compulsive disorders. He has also shown that sleep dysfunction leads to lower pain thresholds (allodynia and hyperalgesia?) as well as sleep deprivation leading to increased glial cell activation (chronic pain mediators).

Numerous studies report that persistent and chronic pain is more prevalent in the head and neck region than in any other part of the body. Furthermore, 22% of the general population experiences Orofacial pain in any given six-month period. It is generally accepted that pain that persists for longer than 6 months is considered chronic. More than 15 percent of Americans suffer from facial pain that is chronic (Canadian data is similar). Having to deal with chronic pain, headaches and facial pain can be very frustrating. Many health care providers get frustrated with these patients and end up telling them "It's all in your head", (really it is, isn't it?).

Clinically it is very simple, it must all start with a diagnosis. Hippocrates stated, "Without diagnosis there can be no treatment." Our professions are very quick to prescribe medications to treat the symptoms without considering the structural cause of these symptoms. As we are all aware, chronic pain is a disease of it's own with many co-morbidities. Our duty is to find the structural problems that have lead to these problems. In recent years our therapy has focused on the mechanical aspects of craniomandibular dysfunction leading us to discover there is dysfunction of the Trigeminal Nerve (CN V). We now use Motor Reflex Testing (MTR) and Applied Kinesiology to assist us in determining where the structural weakness lies with the patient, which leads to a more directed treatment approach leading to a healthier patient.

Our patients often ask us will they be cured of this pain? As well-meaning clinicians we struggle with the patient to find a "cure". The patient often develops iatrogenic problems secondary to multiple destructive interventions (diagnosis is the key). If we can ***C***orrect the ***U***nderlying structural ***R***eason for ***E***rror **(*CURE*),** then we have a chance of making that patient better, get them off their medications and back to the normal activities of daily life.

In future issues of our newsletter, I will attempt to bring to the CAPM what the dentists are doing in the area of craniofacial pain, chronic pain, sleep disordered breathing and headaches. I will be calling upon our members of the Canadian Chapter of the American Academy of Craniofacial Pain to provide these perspectives. I will encourage you to visit the website of the AACP **www.aacfp.org** to find a dentist in your area with the passion for helping this very special and needy group of patients. On a final note, Canadian dentists have an excellent peer reviewed journal, Oral Health. The most recent issue, March 2012, is entirely devoted to sleep, pain and the dentist. Visit **www.oralhealthgroup.com** to view what is current from the dental perspective in these areas.

Dr. Dennis Marangos BSc, DDS
Diplomate, American Board of Craniofacial Pain
Fellow, American Academy of Craniofacial Pain
Immediate Past-President Canadian Chapter of the AACP
Member, American Academy of Dental Sleep Medicine

TMJ DYSFUNCTION: ADDENDUM

By Gloria Gilbert, Newsletter Editor

Health professionals who treat the person with post traumatic neck pain are aware of the often myriad of symptoms compromising 'a diagnosis'. One often overlooked joint is the TMJ. If the cervical spine can be injured at the time of neck trauma, does it not follow that the TMJ can be injured as well? (review both the anatomy and the mechanism of injury!)

Attached to the newsletter is a **TMJ Questionnaire (Q)** that is used in our physiotherapy clinic . Although the Q cannot provide a conclusive diagnosis, it does assist us in looking at other symptoms and structures that may be contributing to a person's 'delayed recovery'.

Ensuring good alignment of the TMJ often assists in a reduction of ear pain (? Is it really tinnitus), headaches, and improves a person's quality of sleep (by ensuring airways are unobstructed. In 1982, I took a Roccabado course on 'The Cervical Spine and the TMJ'. The Roccabados were a brother, dentist and sister, physiotherapist team who were doing early investigation in this area. We must be careful not to miss the more obvious STRUCTURAL changes that can occur at trauma.

UPCOMING MEETINGS

May 23-26, 2012
Canadian Pain Society
Annual Conference
Whistler, BC
www.canadianpainsociety.ca/meetings

May 23—25, 2012
Canadian Physiotherapy Association Congress
Saskatoon, Saskatchewan
www.physiotherapy.ca

August 27-31, 2012
IASP 14th Congress on Pain
Milan, Italy
www.iasp-pain.org/Milan

June 14-26, 2012
Canadian Psychological Association
73rd annual conference
Halifax, Nova Scotia
www,cpa.ca

September 20-12, 2012
23rd Annual Meeting, American Academy of Pain Management
Phoenix, Arizona
www.aapainmanage.org

October 2-6, 2012
14th World Congreve on Pain
Tokyo, Japan
www. iasp-pain.org

May 23-26, 2013
4th International Congress on Neuropathic Pain
Toronto, Ontario

June 10-14, 2013
9th International Symposium on Pediatric Pain
Stockholm

June 12—15, 2013
Canadian Pain Society
Annual Conference
Winnipeg, Manitoba

HAVE YOU CONSIDERED TOPICAL ANALGESICS?

By, Patricia Morley-Forster
Professor, Department of Anesthesiology and Perioperative Medicine, Schulich School of Medicine, Western University, London, Ontario, Canada

Topical analgesics form a growing share of the North American pharmaceutical market for pain products. Yet only a minority of clinicians prescribe them due to lack of knowledge about indications and efficacy. (1) This update summarizes the pharmacokinetics, mechanism of action and efficacy data of a variety of topical agents,

There is a difference between a "topical" and a "transdermal" method of delivery. Topical analgesics act on peripheral nociceptors in the dermis with minimal vascular uptake. Transdermal methods deliver analgesia to the bloodstream via percutaneous absorption with the intended site of action being on the central nervous system.

The main benefit of a topical analgesic is that it minimizes serum concentration thus reducing side effects and drug interactions, especially important in the elderly. Other advantages are avoidance of first-pass metabolism, direct access to the target site, applicable on a PRN basis and useful when oral intake is impossible. The disadvantages are that the penetration of intact skin requires a specialized carrier vehicle, there is a great deal of inter-individual variability in uptake of a topical depending on skin characteristics (e.g. gender, age, race, temperature), dermal enzymes may metabolize the drugs, and there is always the potential for skin irritation.

The carrier vehicle is just as important as the active drug. It must be both lipid-soluble to penetrate the stratum corneum and hydrophilic to be able to diffuse through the more aqueous epidermis. Plurionic—lecithin—organogel, or PLO gel, is the vehicle most commonly-used by compounding pharmacists. DMSO (propylene glycol, glycerin, ethanol and water) is also utilized. Occlusion, electrical iontophoresis and ultra-sound application all have been shown to improve penetration.

Animal and human studies demonstrate efficacy of peripheral application of drugs for both nociceptive, and neuropathic pain. Based on knowledge of the diverse chemical mediators of peripheral nociception, clinical trials have been conducted on the following drug classes: NSAIDS, local anesthetics, tricyclic antidepressants, capsaicin, and glutamate antagonists (ketamine) .

The primary mechanism of action of a topical NSAID is inhibition of prostaglandin synthesis, as well as of other inflammatory mediators. Total systemic absorption is only 3-5% of the oral route so that adverse side effects, including GI bleeding, renal toxicity and airway irritability are very unlikely. Local skin reactions are also rare. Topical NSAIDs achieve steady-state concentrations within 2-5 days. The most commonly studied drugs have been ketoprofen, diclofenac, indomethacin, ibuprofen, piroxicam and salicylate. They have been used for acutely painful conditions such as soft tissue trauma, sprains, as well as chronic pain of osteoarthritis and rheumatoid arthritis.

Randomized placebo-controlled trials in North America of topical diclofenac for knee osteoarthritis have reported benefits on pain and function scores after 4 and 12 weeks.(2) Diclofenac in DMSO vehicle is available in Canada by prescription as *Pennsaid 1.5% solution*. (see Appendix). Despite its suitability for the elderly, it is not covered by provincial drug benefits in Ontario, though may be in other provinces. It is also available in an over-the-counter preparation, Voltaren emulgel, (Diclofenac 1.16%.). Longer-acting patch formulations of ketoprofen and diclofenac are available throughout Europe where they are widely-used as first-line pain therapy for acute back and ligament strains.

Lidocaine a sodium-channel blocker, has been formulated in a 5% slow-release patch with excellent penetrance. Although Lidoderm has been available in the US for over 12 years, it is still unavailable in Canada. In the guidelines for neuropathic pain treatment endorsed by the Canadian Pain Society, Lidoderm is recommended as second–line therapy, and has also shown efficacy for pain from knee osteoarthritis.

In clinical trials of neuropathic pain, reductions in pain scores of over 50% have been reported in one-quarter to one-third of patients with a NNT of 4.4 (3) Even if 4 patches are applied daily, systemic lidocaine concentrations are much lower than those required to trigger cardiovascular toxicity.

Topical tricyclic antidepressants, the prototype being amitriptyline work primarily by inhibiting peripheral histamine, serotonin and sodium channels. Concentrations studied have ranged from 1 to 4%, but have not shown superiority to placebo gels. (4) They seem to be most useful when combined with other agents such as NSAIDs, Lidocaine and Ketamine. At St Joseph's Health Care, we use a preparation of amitriptyline, lidocaine, and ketoprofen in PLO gel (See Appendix).

Capsaicin is available in 0.025%, 0.075% , and most recently in an 8% patch marketed as Qutenza. It works by desensitizing TRPV1 channels of nerve fibers which are crucial in initiating pain transmission. The lower concentration is usually prescribed for arthritis while the .075% is preferred for neuropathic pain . The NNT is 8.1 for osteoarthritis and 5.7 for diabetic neuropathy/postherpetic neuralgia. (5) The major drawback to its clinical use is that it causes intense burning on application for the first few days.

A randomised double-blind study in patients with PHN showed that a 60 minute application of the 8% Capsaicin patch resulted in sustained relief significantly great than placebo (0.025% capsaicin) for up to 12 weeks.(7)

The effect of topical Ketamine on neuropathic pain has been studied alone, and in combination, with concentrations ranging from 1% to 10%. In 2009, a Finnish group found that topical 5% ketamine reduced the hyperalgesia produced after intradermal application of capsaicin.(8) Most recently, a study from Australia found a reduction in the allodynia (sensitivity) in 20 patients with complex regional pain syndrome after application of 10% topical ketamine.(9) Serum levels of ketamine and its active metabolites norketamine were measured but barely detectable.

There are a variety of over the counter topical agents whose active ingredient is a counterirritant. Common examples are garlic, camphor, marsh tea, peppermint oil, and menthol. Patients report generally favourable, though modest results with them. They have not been rigorously tested against placebo preparations. One of the problems in assessing the efficacy of topicals is that there is invariably a high placebo response rate suggesting that merely rubbing the area gently may relieve pain by physical methods.

In summary, topical agents are useful when there is a circumscribed focal area of pain whether neuropathic or nociceptive. They may also be useful in multimodal treatment of myofascial trigger points. Use your imagination. Your patients will be grateful.

APPENDIX:
Diclofenac 1.5% (Pennsaid). Apply 40 gtts Q 6H
Capsaicin 0.075% or 0.025% gel. Apply QID to painful area.
Lidoderm 5% Patch Apply one patch Q 12H to painful area.
Amitryptiline 5%/Lidocaine 5%//Ketoprofen 5% in PLO gel
Ketamine 2% +Amitriptyline 5% in PLO gel

TOPICAL ANALGESICS ADDENDUM

By Gloria Gilbert, Newsletter Editor

As noted in the important article authorized by Dr. Morley-Forster, many of the people we treat use over the counter pain analgesics. Many others have family and friends who provide them with special remedies and products available from other countries (i.e. Europe). Although most of these products may not be 'dangerous', some instruction would be provided to people about how, when and why to use these products.

There are also an increasingly a number of topical analgesics that can 'only' be dispensed through health professionals offices and who are licensed to practice under the RHPA—The Regulated Health Professions' Act. (physiotherapists, chiropractors, massage therapists etc.).

It remains important for us as clinicians to scrutinize the ingredients as well as the mode of transmission. What is the difference between biofreeze, cryoderm and pharmax relief (Seroyal). These products may indeed be helpful in developing a pain management program for our clients when there are localized areas of discomfort.

It does not negate the fact that an appropriate pain/symptom management program must be individualized and adhered to 24/7. Pharmaceutical management may be needed initially and/or to control certain types of pain (neuropathic) but each health provider should also consider that over time and as your client gains better 'control' of their symptoms, conservative means of treatment (electrical current, thermal devices, exercises, assistive devices are important.

Most family physicians UNDER treat their patient's pain symptoms. Most patients want to be able to participate in their daily activities, tasks—with as little prescription medication as possible . . .

How do we balance both goals?

ATTACHMENTS WITH THIS NEWSLETTER

Attached to this Newsletter, are the following two documents. Please feel free to distribute the CPC Newsletter to others and also to use the TMJ Questionnaire for your assessment practices.

1. **Canadian Pain Coalition Spring, 2012 Newsletter**
2. **TMJ Questionnaire**

CAPM CALL FOR NEWSLETTER ARTICLES

This Newsletter attempts to be published 4 times per year. We would like this publication to be useful to our members and to others reading the information. If you have any interesting articles, information or know about any upcoming meetings, workshops, one-day seminars, let us know and we can publish your entry. Through publications such as this, we are able to share information, findings and noteworthy items amongst us. I encourage you to participate and send in anything that you would like to share.

Thank you.
Gloria Gilbert, Newsletter Editor