CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 1 VOLUME 7, APRIL 2015

EDITORIAL

BY GLORIA GILBERT, PT, MSC, CAPM EDITOR

The CAPM Executive Committee has been hard at work on many fronts. Spear-headed by our President Dr. Eldon Tunks - new credentialing and advanced credentialing pathways have been developed.

Credentialing is a mark of approval by the professional association CAPM that the member has achieved recommended standards of professional development and experiences in pain management. **CAPM members now have three options for credentialing**:

1. Through the American Academy of Pain Management (AAPM) –must be a current CAPM member in the credentialing stream.
2. Through CAPM Credentialing courses.
3. Advanced credentialing through CAPM.

Launched in 2014, CAPM now offers Credentialing through a 3-day course plus exam. Advanced Credentialing in Pain Management (for specific competencies) is offered for specific professional competencies in Pain management is also offered and is restricted to specific professional groups and individuals with specialized skills and procedures.

Please refer to the website of CAPM http://www.canadianapm.com click on CREDENTIALING to review in detail the different processes, the requirements for credentialing and the course outline of the CAPM-based initiative.

Elections for your new Executive Committee have been held and we are pleased to welcome John P. Crawford, DC., PhD and Chis Giorshev,MD who joins Eldon Tunks, Kevin Rod, Lisa Goldstein, Eleni Hapidou, Martha Bauer and Gloria Gilbert for the 2015-2017 term of office.

Featured in this edition of the newsletter is an INDEX of past articles , educational initiatives, topical issues etc. that have been published in the CAPM newsletter since 2008. These articles are all posted on the Website and can be accessed by clicking the ***newsletters and communication icon.*** Members are encouraged to read /review each newsletter in its entirety. Along with the lead and topical articles, much insight and information about CAPM and especially its multi-disciplinary orientation will be obtained by reviewing the editorials and Executive summaries posted in each edition.

Starting in 2008, members will note that the information and science about the 'patient with chronic pain' has evolved into topics such as 'delayed recovery post persistent traumatic pain' and the possibility of a head injury affecting recovery. Our members have ensured that we are current with real clinical concerns and challenges.

Howard Vernon DC, PhD, FCCS (Canadian Memorial Chiropractic College in Toronto) has written an article entitled ***Concussion and Neck Injury***: long-lost cousins finally meet. Noting that in the concussion literature, the role of the neck injury is often overlooked. It is interesting to recall that in previous articles in the newsletter about post traumatic injuries, it is the concussion that is often overlooked. Maybe we are finally realizing that delayed recovery happens along a 'continuum' with many different factors influencing the outcomes. Until such time as we can come up with a comprehensive intake for the person who may or may not have sustained a concussion at the time of trauma, your Editor is also including the SCAT Sport Concussion Assessment Tool- 2 pages for review. (An attachment to this Newsletter). Dr Charles Tator, eminent neurosurgeon and sports researcher has stated many times that symptoms caused by a sports injury can also be attributable to any type of traumatic event. Clinicians, may find that the SCAT provides some useful and simple ways of assessing a possible concussion.

It is possible that educational initiatives for CAPM members may change over time. The newsletter format may evolve into one that is more 'experiential'. Consideration is being given to having 'graduates' of the CAPM courses provide educational opportunities (mini workshops) for Academy mummers. Stay tuned!

Our newsletter however is the main vehicle for communication with all CAPM members. Please continue to submit articles, subjects for discussion, meeting notices and your comments to CAPM.

Respectfully Submitted
Gloria Gilbert, PT; Fellow, CAPM; Newsletter Editor

For those of us who treat people who have sustained injuries in motor vehicle accidents (MVA), we are often faced with OPINIONS of other health professionals who may not agree with an ongoing treatment approach. This newsletter will NOT address that other 'clinical problem' at this time. Information is in this newsletter is based on published peer-reviewed journals and documents, as well as some clinical questions.

INSIDE THIS ISSUE:

CONCUSSION AND NECK INJURY: LONG-LOST COUSINS FINALLY MEET

BY HOWARD VERNON, DC, PHD, FCCS, CANADIAN MEMORIAL CHIROPRACTIC COLLEGE, TORONTO, ONTARIO

Practitioners of manual therapy have long observed that patients sustaining concussion/mild traumatic brain injury, whether from sports injuries or car accident-related whiplash, also have symptoms and dysfunction in the cervical spine, especially the upper cervical spine. There is an archive of literature on the topic of cervicogenic headache and cervicogenic vertigo; however this has remained limited in most people's minds to circumstances that clearly implicate neck injury, such as whiplash. Indeed, the revision of the term whiplash to Whiplash Associated Disorder, by the Quebec Task Force on Neck Pain (1) was motived by the consensus opinion that headache, dizziness, disturbance of concentration and sleep and mood disorders were common complaints of whiplash-injured patients.

What has received much less attention is the role of neck injury and neck-related symptoms in the circumstance where concussion has clearly been sustained and diagnosed. Once the label of "concussion" is attached to the complaint (and this may be obvious even immediately, such as on a field or rink of sports play), then it appears that all the subsequent symptomatology, including in the short-term (as concussion-related) and in the longer-term (as post-concussion syndrome) is attributed to mild brain injury. The role of the neck has been largely ignored.

The first study to directly address this issue was published in 1994 by Treleaven et al. (2) in which 12 post-concussion headache patients were compared to 12 controls. The PCH group was distinguished from the control group by the presence of painful upper cervical segmental joint dysfunction, less endurance in the neck flexor muscles and a higher incidence of moderately tight neck musculature.

Recently, two papers have extended the literature supporting the role of the neck in post-concussion syndrome. Schneider et al. (3) report the results of a small clinical trial of usual treatment vs treatment including cervical physiotherapy (including manual therapy) and vestibular exercises. In the treatment group, 73% (11/15) of the participants were medically cleared within 8 weeks of initiation of treatment, compared with 7% (1/14) in the control group. Subjects in the treatment group were 3.91 (95% Cl 1.34 to 11.34) times more likely to be medically cleared by 8 weeks.

Leddy et al (4) report on 128 patients who had symptoms after head injury for more than 3 weeks and who had provocative treadmill exercise testing. These subjects were divided into a group with what they called "physiologic post-concussion disorder" (i.e. usual head trauma; N = 36) and cervical/vestibular PCD" (N = 92). There was no statistically significant difference in the kind or number of symptoms expressed by both groups. My colleagues Drs. Cam Marshall and Jay Triano and I have worked with this group and came to the same independent conclusion based on subjects in both groups completing the Quebec Task Force Neck Pain Questionnaire as well as the Neck Disability Index. There was no difference in the scores of both groups on these measures (unpublished work).

In Leddy et al., "concussion" and neck-injured patients appear similar in the clinic on the basis of their symptomatology alone. In Schneider et al., treatment of neck dysfunction results in faster recovery from "concussion". Leddy et al. ask "Brain or Strain?". I would add "Head or Neck?". Both groups, as well as others, strongly encourage inclusion of a thorough assessment of the cervical spine in every case of "concussion" or mild traumatic brain injury. Another of my mottos is, "you can injure the neck without injuring the brain, but you can't injure the brain without injuring the neck". We are finally getting good clinical studies which are bringing this issue out of the closet and into the clinic. Our patients will be the beneficiaries of this welcome development.

1. Spitzer WO, Skovron ML, Salmi LR, Cassidy JD, Duranceau J, Suissa S, Zeis E. Scientific monograph of the Quebec Task Force on Whiplash-Associated Disorders: redefining "whiplash" and its management. Spine 1995;20(8 Suppl):1S-73S

2. Treleaven J, Jull G, Atkinson L. Cervical musculoskeletal dysfunction in post-concessional headache. Cephalagia 1994; 14:273-279.

3. Schneider KJ, Meeuwisse WH, Nettel-Aquirre A, Barlow K, Boyd L, Kang J, Emery CA. Cervicovestibular rehabilitation in sport-related concussion: a randomized controlled trial. Br J Sports Med. 2014 May 22. [Epub ahead of print].

4. Leddy JJ, Baker JG, Merchant A, Picano J., Faile D, Matuszak J, Willer B. Brain or Strain? Symptoms alne do not distinguish physiologic concussion from cervical/vestibular injury. Clin J Sport Med 2014, July [Epub ahead of print}.

REPORT FROM THE CAPM EXECUTIVE

DR. ELDON TUNKS, PRESIDENT

Since last year the CAPM has now been credentialing on-site in Canada for some members using a course and exam currently in Hamilton Ontario, which makes it more economical and relevant for some members. (Joint membership and credentialing with CAPM and AAPM is however still encouraged for members who are able.) Since last year with the course and examination in Hamilton Ontario we have credentialed 15 of our members as Diplomate of Canadian Academy. We have also instituted Advanced Credentialing in pain management for specific competencies including Interventional Pain Treatment and we've begun the process for advanced credentialing for chiropractic fellows with special expertise and academic commitments in Pain Management. We will continue to follow the model of the AAPM requiring for all credentialing three letters of reference, demonstrated two years in practice, proof of the highest academic degree, proof of registration with the healthcare regulatory body, and membership in the credentialing stream of CAPM. We are looking now to make the credentialing more generally accessible by creating for our members in the rest of Canada alternatives to the Ontario-based 72 hour course and examination. We should have an announcement on this in the next couple of months.

We have begun an outreach also with other Canadian regulated professional bodies to make CAPM membership comprehensive for regulated healthcare professionals who work with acute and chronic pain patients.

Our directors in the executive for the coming two years are Martha Bauer, John Crawford, Gloria Gilbert, Chris Giorshev, Lisa Goldstein, Eleni Hapidou, Kevin Rod, and Eldon Tunks. We thank the membership for faithful support, commitment and loyalty to CAPM.

ELDON TUNKS, MD, FRCP C, PRESIDENT

COMPLEX REGIONAL PAIN SYNDROME

DR. ELDON TUNKS, MD, FRCP C

- 30-year-old man is struck by a hockey stick just below the right knee lateral peroneal nerve, develops pain and tingling in the dorsal aspect of right ankle and foot.
- Within a few days, going on to swelling, sweating, redness, coldness, spontaneous burning and oversensitivity of the right foot, which over two weeks spreads to the entire right lower extremity and still persists at 6 months
- He reports jabbing pains in the lateral right shin and dorsum of the foot, and constant oversensitivity from hip down to foot, and he cannot tolerate shoe on foot

EARLY VERSIONS OF THE CONCEPT

- American Civil War, observation of firearm wounds inducing burning pain and autonomic reactions – "causalgia" meaning burning pain (Weir-Mitchell, 1872)
- In this century the World Wars contributed further observations of the syndrome
- Clinical observations were that immobilization could contribute to it

- This century it was observed that sympathetic blocks could relieve it in some cases. This led to a concept that it was due to sympathetic dysregulation
- Bonica, "the Management of Pain" in 1953 coined the term "reflex sympathetic dystrophy". At that time sympathetic disturbance was believed to be fundamental and the acid test of diagnosis was pain relief from sympathetic block

- In time both research and clinical experience put in doubt the unitary role of sympathetic dysregulation and the diagnostic value or curative potential of sympathetic block

- Any treatment (except immobilization) has about 30% efficacy in first half year, whether blocks or physical therapy (Sympathetic block. massage, TENS, contrast bath, parrafin bath, pneumatic pump), and 75% have good to fair recovery
- Subbarao & Stillwell: Arch Phys Med Rehabil 62 (1981) 549-54
- In RSD (CRPS), sympathetic activity is depressed in the affected limb, while sympathetic receptors are up-regulated. There is no logical reason to restrict treatment of CRPS to sympathetic blocks

- Two decades ago, researchers recognized there was no reflex, variably response to sympathetic blocks, and usually not progressing to dystrophy. Multiple pain mechanisms including autonomic, neuropathic, myofascial, central (e.g. dystonia, neglect)
- Proposed term "complex regional pain syndrome"

CHANGING CONCEPT FROM RSD TO CRPS

- Now called "complex regional pain syndrome";
  - **Type I (no discernible nerve injury)**
  - **Type II (associated with discernible nerve injury)**

- Essentially a clinical diagnosis.
- Stanton-Hicks, Janig, et al (PAIN,1995)

Three phase bone scan may be supportive of diagnosis, but not sufficient for diagnosis.

IASP CRITERIA: COMPLEX REGIONAL PAIN SYNDROME TYPE I

- Presence of an initiating noxious event or immobilization
- Continuing pain, allodynia, or hyperalgesia with pain disproportionate to the inciting event
- Evidence at some time of edema, change in skin blood flow such as color change, temperature change more than 1.1 C^{o} difference from homologous part, or abnormal sudomotor activity in the region of pain
- Diagnosis is excluded by existence of conditions that would otherwise explain the pain and dysfunction

IASP CRITERIA: COMPLEX REGIONAL PAIN SYNDROME TYPE II

- Nerve injury: pain in but not necessarily limited to the distribution of injured nerve
- continuing allodynia or hyperalgesia after nerve injury
- evidence at some time of edema, changes in skin blood flow or abnormal sudomotor activity
- diagnosis is excluded by the existence of conditions that would otherwise explain pain and dysfunction.

COMPLEX REGIONAL PAIN SYNDROME, *Continued*

DR. ELDON TUNKS, MD, FRCP C

- Research showed a lack of precision of these criteria, lacking specificity in distinguishing it from other neuropathic conditions, and with undue reliance on sympathetic dysregulation or response to sympathetic block
- Emphasis on patient history of vasomotor/sudomotor symptoms without observed signs at time of diagnosis makes room for false positives

EMPIRICALLY DERIVED CRITERIA

- Harden, Bruehl (Budapest criteria), 2005
- Derived from factor analysis of observation over large patient sample
- Validated (Harden, Bruehl et al, PAIN 2010)

BUDAPEST CRITERIA

- Continuing pain disproportionate to injury
- Included 3 out of 4 clusters of symptoms – sensory, vasomotor, sudomotor, motor/trophic
- Required 2 clinical signs – hyperalgesia or allodynia, vasomotor, sudomotor/edema, motor/trophic
- No other diagnosis better explains findings

DETAILS OF DIAGNOSTIC SYMPTOMS

- Sensory: hyperalgesia/allodynia
- Vasomotor: temperature /color asymmetry
- Sudomotor/edema: changes or asymmetry
- Motor/trophic: decreased ROM or dysfunction (weakness, tremor, dystonia), trophic changes

DETAILS OF DIAGNOSTIC SIGNS

- At time of the evaluation must have one sign in two or more –
- Sensory: hyperalgesia, allodynia (light touch and pressure or joint movement)
- Vasomotor: temperature, color
- Sudomotor/edema: changes or asymmetry
- Motor/trophic: motor dysfunction or trophic changes
- Harden and Bruehl recognized that the new research criteria have better specificity but do not necessarily include all areas of relevance to etiology of CRPS: for example sensory or apparent motor neglect, skin ulceration, aggravation by motor activity, possible central plasticity changes (for example evidence from transcranial magnetic stimulation) etc.

VISUAL-SPATIAL "NEGLECT"

- Not really neglect in the sense in which it is found in stroke patients. Affects just the limb and not whole side. Patient may be more rather than less aware of discomfort in limb
- Vision: impaired recognition, size, position of limb
- Imagery: distorted mental image of limb
- Proprioception: limb position outside visual field

MOTOR SIGNS

- Not like neglect in stroke patients
- Hypokinesia: amplitude reduced and taking more effort, sometimes hanging passively
- Movement suppressed in anticipation of pain, fear-avoidance, and learned non-use, but leading to modified cortical representation (eg. impaired limb had to be stimulated >25 ms before normal limb for stimuli to be considered "simultaneous")

EVIDENCE FOR CENTRAL MECHANISMS

- Dystonic and other motor signs: tremors common, and sometimes myoclonus, or dystonia of distal hand/foot
- Response to transcranial magnetic stimulation and mirror therapy suggests central plasticity and distorted representation of injured limb

COMPLEX REGIONAL PAIN SYNDROME, *Continued*

DR. ELDON TUNKS, MD, FRCP C

TREATMENT OF CRPS (RSD)

- Avoid immobilization
- Treat pain of CRPS: opioids, cortisone pulse, anti-inflammatory treatment early on, trial of at least one sympathetic block
- Treat other sources of non-CRPS pain coexisting in the same location
- Pain management: pacing techniques, anxiety control, behavioral management, and aids (eg. walker, scooter, orthotics)
- Anti-inflammatory: (NSAID), prednisone pulse, topical DMSO as free radical scavenger in acute CRPS
- Immunity modifying treatment (eg. Prednisone pulse)
- Anticonvulsants: gabapentin, carbamazepine
- Antidepressants: amitriptyline, imipramine, doxepin, (less likely desipramine)
- SNRI: duloxetine, venlafaxine
- Opioids: tramadol due to combined serotonergic and mu agonist effect, methadone due to mu and NMDA effect, buprenorphine, but concern that strong opioids may also sometimes elicit allodynia and hyperpathia
- Antihypertensives: clonidine, nifedipine
- Topical lidocaine or clonidine
- Ketamine (but toxic)
- Calcitonin: conflicting results
- Bisphosphonates: evidence for alendronate, pamidronate

INTERVENTIONAL TREATMENT

- If there is dystonia, intrathecal baclofen
- Trial of at least one sympathetic block and a series if effective, but sympathectomy is not supported
- anecdotal response to IV regional clonidine block or lidocaine with ketorolac
- Continuous brachial plexus or spinal infusions
- Epidural infusion with PRN boluses (regional anesthetic or clonidine), or intermittent blocks
- Neurolytic blocks risk of post-sympathectomy pain from 25% to 44%
- Percutaneous radiofrequency lesioning of sympathetics unknown efficacy
- Neurostimulation: spinal cord stimulation reduces pain and improves quality of life, but so far no evidence of improved function
- Peripheral nerve stimulation uncertain efficacy

COGNITIVE-BEHAVIORAL

- Graded motor imagery including mirror therapy. Therapy inducing patients to move the painful extremity can aggravate the pain so it is usually initiated with right/left recognition training, followed by imagined limb movement, followed by mirror therapy beginning at very low amplitude and gradually increasing (Moseley, 2004)
- Transcranial magnetic stimulation over the M1 motor cortex. 23 patients randomized, with the control group later crossed over to the experimental treatment. A series of 10 trials of TCMS was found to be significantly more effective for pain control than sham procedure
- (Picarelli 2010)

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Legrain V, et al. Pain, body, and space: what do patients with complex regional pain syndrome really neglect? PAIN 153 (2012) 948-951

Mailis-Gagnon A, and Furlan A. Sympathectomy for neuropathic pain (review). Cochrane Database of Systematic Reviews 2002, issue 1, DOI: 10. 1002/14651858. CD 002918

Moseley GL. Graded motor imagery is effective for long-standing conflict regional pain syndrome: a randomized controlled trial. PAIN 108 (2004) 192-198

Perez RSGM et al. The treatment of complex regional pain syndrome type I with free radical scavengers: a randomized controlled study. PAIN 102 (2003) 297-307

Picarelli H et al. repetitive transcranial magnetic stimulation is efficacious as an add-on to pharmacological therapy in complex regional pain syndrome type I. J Pain 11 (2010) 1203-1210

Punt TD, et al. Neglect-like symptoms and complex regional pain syndrome: learned nonuse by another name? PAIN 154 (2013) 200-203

Stanton-Hicks M, Janig W, Hassenbusch S, et al. Reflex sympathetic dystrophy: changing concepts and taxonomy. PAIN 63 (1995) 127-133

Van Rijn M, et al. Onset and progression of dystonia in complex regional pain syndrome. Pain 130 (2007) 287-293

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DENOTES LEAD ARTICLE *

Update from the Professions

Physiotherapy: Gloria Gilbert: February 2009
Chiropractic (neck pain task force): Howie Vernon: June 2009

Chronic Pain Assessment & Management:

Case Study: Assessment of a person with chronic pain by a community-based Physiotherapist (the challenge of developing a team) Gloria Gilbert: Fall 2009
Case Study - follow-up: Suggestions for better co-ordination of services: Winter 2010

***Assessment & Treatment of the patient with chronic pain in the community:** Gloria Gilbert, Eleni Hapidou, Howie Vernon: Spring 2010

***Completing the Assessment Process and Developing short and long term treatment goals: In-home OT Assessment and Psychological Assessment:** Bauer and Hapidou: Fall 2010

***Talking to Your Patient about Pain: Developing a Pain Vocabulary:** Gloria Gilbert: June 2009
Developing a vocabulary to Talk to your Patient about Pain (and their Feelings) - A mini review: June 2013
Words to Avoid- when developing a vocabulary to talk to your patient about pain - Part Two: December 2013

***Using scales in the assessment & treatment of chronic pain:** Kevin Rod: June 2009

***Current Patterns in Chronic Non-Cancer Pain Management in Primary Care:** Kevin Rod: October 2012
Improving Pain Control: by Non-Medicinal Methods (with reference to article by Dr. Patricia Morley-Forster Spring 2012):* Gloria Gilbert: February 2013
Assessment Tools in Pain Management: Howard Vernon: June 2013
***Low Back Pain Management: Goals to Resolve Pain and/ or Prevent Disability:** Eldon Tunks: December 2013

Pain Management Programs (PMP): several reviews, including Effects of Cognitive-Behavioural programs, Acceptance-Based intervention, the use of the Canadian Occupational Performance measure: May 2014
***The Relationship Between Patient Satisfaction & Treatment Outcomes in a Chronic Pain Community Clinic:** Kevin Rod: September 2013

Interventional Management:

***Interventional Management for Chronic Non-Malignant Pain:** Dr. G.D. Gale: February 2009
***Non-Radiologically Guided Nerve Blocks for Chronic Non-Malignant Pain:** Gale, Rothbart, & Jacobs: August 2011

Delayed Recovery Post Trauma:

Pre-Amble and Disclosures- Delayed Recovery Post (Neck) Trauma – editorial Part One: Gloria Gilbert: June 2013
Persistent Post-Trauma Neck Pain: June 2013
Mild Traumatic Brain Injury: June 2013
Ontario Neurotrauma Foundation: June 2013
Delayed Recovery Post (neck Trauma)- Part Two: Gloria Gilbert: December 2013
***The Role of the Occupational Therapist in the Management of the Client with Post traumatic chronic pain:** Martha Bauer: December 2013
Concussions and Their Consequences: Current Diagnosis, Management & Prevention: December 2013 (from information provided by Dr. Charles Tator)
Post-concussive syndrome and TBI: Gloria Gilbert: February 2014
****Understanding Visual Dysfunction Following a TBI***: William Padula, OD. Post Trauma Vision Syndrome: February 2014
***Behavioral Optometry References*:** Maciej Suwala, OD May 2014. Post Trauma Vision Syndrome
Chronic Pain and TBI- An Integrative Approach: Richard Nahas, MD: February 2013
Scalp Acupuncture for Acquired Brain Injury: Richard Nahas: May 2014

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DENOTES LEAD ARTICLE *

Post Traumatic Stress Disorder:

Post-Traumatic Stress Disorder (PTSD): Overview of Diagnosis and Treatment: Eleni Hapidou, PhD, C.Psych: June 2013
PTSD and Chronic Pain in Veterans: Eleni Hapidou: February 2014

Specific Topics:

IMMPACT: Recommendations: J.Pain.Vol.2 pp.105-121.www.sciencedirect.com. Interpreting the clinical importance of treatment outcomes in chronic pain clinical trials: Spring 2009

***Pain Analgesia During Pregnancy and Breast-Feeding:** David Rosenbloom: March 2011

***The Sunshine Vitamin (Vitamin D):** Linda Rapson: February 2013

***Central Pain Mechanisms Underlie Many clinical pain Syndromes:** Eldon Tunks: June 2013

***Readiness to Change**: Eldon Tunks: January 2010

***Proving Chronic Pain - a Lawyer's Perspective**- from workshop on Pain Management Across the Continuum: Devry Smith Frank LLP Personal Injury Group: February 2012
Disability Tax Credit: February 2012

***Physician Risk and Responsibility in Prescribing Cannabis for Pain:** Eldon Tunks: October 2012
Craniosacral Therapy: Nina Chernick: June 2013

***Mindfulness Meditation & Managing Pain:** Kate Partridge, PhD, C.Psych: May 2014
PGAP- Progressive Goal Attainment Program: May 2014
NORA: The Neuro-Optometric Rehabilitation Association: Winter 2011

Educational Websites & Materials:

Arthritis Society, WebMD.com, myfavouritemedicine.com: Dr. Mike Evans: February 2014
nepknowmore.ca, painexplained.ca, WebMD.com/ chronic: September 2010
Pain assessment tool (Purdue Pharma) ,Opioid risk tool, FM Practical Assessment Tools (Pfizer), Canadian Pain Coalition brochure, FIbrocentres.ca.: Fall 2010

Arthritis and related topics:

Osteoarthritis pain-New Understanding and Revised Guidelines on Management: Philip A. Baer, Rheumatologist: May 2014
'I Can Feel it in my Bones"- Do Weather Changes Really Affect Pain Complaints?: May 2014

Fibromyalgia:

Fibromyalgia, The Orphan Syndrome: David Saul: February 2009
***2012 Canadian Guidelines for the Diagnosis & Management of FM Syndrome:** Gloria Gilbert : December 2013
FM Consensus Report-an Update: February 2014

Book Reviews:

Breaking Thru the Fibro Fog: K White and J Russell: February 2012
Cannabis Chassidism-The Ancient & Emerging Torah of Drugs: February 2013
Grouch: Summer 2011 and June 2013
Coping with Mild Traumatic Brain Injury: Stoler and Hill: June 2013
On Suffering: Pathways to Healing and Health: Beverly Clarke PT: December 2013

Highlighting Our CAPM Members:

Tribute to Dr Ronald Melzack: September 2010
Lifetime Achievement Award, Physiotherapy Gloria Gilbert: August 2011
Dr. Don Ranney: Winter 2011
Ruth Dubin and Patricia Morley-Forster: February 2012
Norman Buckley and Judith Hunter: May 2012
Members in the News: Norman Buckley, Eleni Hapidou, Pam Squire: October 2012
Reminiscences of a Pain Expert- Dr Harold Merskey: June 2013
Kevin Rod-New Teachers' Award: June 2013

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DENOTES LEAD ARTICLE *

Temporomandibular Joint Dysfunction (TMJD)

***How Do (Should) Dentists Approach the Patient with TMJD**: Dennis Marangos, DDS: May 2012

TMJ Dysfunction Addendum: Gloria Gilbert: May 2012

***TMJD Pain After Whiplash Trauma:** A Systemic View by Haggman-Henrikson, precied by Dr. Dennis Marangos, DDS: May 2014

Topical Analgesics:

***Have You Considered Topical Analgesics?:** Patricia Morley-Forster: May 2012

Topical Analgesics- Addendum: Gloria Gilbert: May 2012

Attachments to the Newsletter:

TMJ Questionnaire: May 2012

How to Adjust Your Workstation-Hamilton Health Sciences: February 2012

Physician Risk & Responsibility in Prescribing Cannabis for Pain: Eldon Tunks: October 2012

Coping Strategies Questionnaire: February 2013

Also posted to the website:

Chronic Pain in Context: Some observations from 25 years in the field: Michael MacDonald, PhD, C.Psych in J.Clinic.Psychol. Practice 2011(2) 22-32

UPCOMING EVENTS

Practical Strategies Webinar- Auto Insurance Open Forum for Health Professionals
Free webinar—asking for questions & concerns before webinar
April 28, 2015: 9:00 am—10:30 am
To register http://www.pialaw.ca

Registered Massage Therapists Association of Ontario
Education Conference
May 8—May 10, 2015: Sheraton Toronto Airport Hotel, Toronto, Ontario
http://www.rmtao.com

Canadian Pain Society Annual Conference
May 20—May 23, 2015: Charlottetown, PEI
http://www.canadianpainsociety.ca

Canadian Association of Occupational Therapists
Annual Conference
May 27—May 30, 2015
http://www.caot.ca

Practical Strategies: A One-Day Conference for Health Care Professionals: Rehabilitation Challenges of the Invisible Injury
June 11, 2014: Toronto, Ontario
http:// www.pialaw.ca

Canadian Physiotherapy Association Congress
June 18—June 21, 2015: Halifax, Nova Scotia
http://www.physiotherapy.ca

CAPM Credentialing Course, 2015
August 29, September 26, November 8: Three-day course including Exam
CAPM Office: 905-404-9545
office@canadianapm.com: http://www.canadianapm.com

CALL FOR ARTICLES

CAPM members are encouraged to email me interesting articles—new and old, important information about new programs or products for people in pain.

Please contact the office for article submission details.
Tel: 905-404-9545; office@canadianapm.com

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