CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

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Pain Management Clinics . . . The good news and the concerned news

Living in a relatively small (but terrific) city like I do in London, Ontario, one can readily see all the new pain management initiatives at a glance. It seems that almost 'everyone' and anyone can own and operate a Pain Management Clinic! It is true that most hospital-based pain clinics, like the one at St. Joseph's Health Centre (under the auspices of UWO-The University of Western Ontario) have long waiting lists. Perhaps the public is becoming frustrated and demanding improved access.

Anesthesiologists, other physicians as well as a variety of health providers are making the move into the community providing 'pain management centres'. But what are they really doing? Is this only a good business venture (the public is waiting) or is this truly a professional aspiration?

It is well acknowledged in the literature that effective pain management services must be provided in an inter-disciplinary environment. Many of these new clinics do the intervention and or prescribe the medication. Some even provide a hodge podge of services (You can pick and choose acupuncture, massage therapy, chiropractic, orthotics, physiotherapy etc.). Only a few however, are able to truly offer a comprehensive treatment program for their clients- a program which addresses the physical, psychological, emotional, social and vocational aspects of a person's life.

To be truly inter-disciplinary, a health provider (a previous CAPM newsletter emphasized the importance of the involvement of the primary care physician) or clinical case manager, must co-ordinate services and assess treatment outcomes within the team environment… a process that is essential for an effective patient centered program.

It is also interesting to note that some clinics are 'stand alone', i.e. they have no ongoing relationship to any other treatment provider.

So- the good news is- Pain is in!

Patients are becoming more knowledgeable (thanks to organizations like the Canadian Pain Coalition) and are beginning to demand improved pain management services. Health providers are more readily acknowledging and providing needed services. But we must be cautious! Health providers who work in a truly inter-professional environment of pain management know that medication and interventional techniques are only 2 of the important components of a much larger puzzle.

Involving the patient, their family, their employer, their insurer (etc.) in the process of

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INSIDE THIS ISSUE:

BRONZE LEVEL CORPORATE MEMBER

PURDUE

Editor's Letter, continued

rehabilitation or recovery takes time, patience (***with a ce***) and is at times (usually) very complex. Good pain management is also a life-long process- involving accommodation, a possibly changed life plan, as well as acceptance – all the while diligently continuing to attain and maintain independence.

Another reason why every provider involved in the arena of pain management MUST become a member of the Canadian Academy of Pain Management (canadianapm.com)!! We instantly become a team with similar goals and objectives to better care for our patients/clients. This issue of the newsletter highlights the Annual Meeting of CAPM held in the Spring at the Canadian Pain Society Meeting in Niagara. It also contains 2 important articles- one related to the long term experience of a community-based clinical psychologist and the other on interventional techniques for the cervical zygopophyseal joints co-authored by several members of the CAPM family. These articles have been
printed in full as attachments to the newsletter. Also attached are the 2011-2012 Board Members of the CAPM.

All members of CAPM are 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, presenting your own article for publication in this newsletter or comment on an important meeting/conference to have attended.

Respectfully submitted,

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

Update from the Executive

The many accomplishments and goals of the CAPM have been posted to the Website. Of particular note is the following:

- CAPM, the president of the Canadian Pain Society and several Academic Directors in Anaesthesiology have applied to the (RCPS) Royal College of Physicians and Surgeons of Canada Anaesthesiology Section to recognize a Fellowship in Pain Management. This document is currently working its way through the RCPS and in 3-4 years will be approved as a recognized sub-speciality open to anaesthetists physiatrists, neurologists and psychiatrists.
- CAPM has a formal agreement with the American Academy of Pain Management (AAPM) to use their examination process to qualify our Canadian physicians and health professionals for credentialing. The AAPM process uses a robust screening to determine eligibility, and a validated examination with invigilators.
- CAPM has arrived at a consensus with the College of Physicians and Surgeons of Ontario regarding the ethics of proper representation on business cards or letterheads for individuals qualified and licensed in a given area that are practicing in pain management.
- CAPM has had a very cordial and encouraging meeting in support of OMA Pain Physicians. Section Chair Dr. Howard Jacobs meeting with officials of the Ontario Ministry of Health and of OHIP to address and resolve the problem of negotiation of fees when primary care physician refer their patients to pain clinics staffed by other primary care physicians who have interventional pain management expertise.

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- CAPM and the chiropractic educators are discussing pain education and credentialing within the chiropractic post graduate education.
- In process is the planning of our second Inter-disciplinary Clinical Skills Day which will be held in Toronto in November 2011. Further information is provided within this newsletter.

Yours sincerely,

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

Annual Meeting of the CAPM, May 2011

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Photo of Eleni and Martha at the CAPM Annual Meeting

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Highlights of the AGM (posted on website as Accomplishments and Goals)
Since 2005, the CAPM has publicized the vision and mission statement of the organization which are 3-fold
(i) excellence in care of patients and their families suffering pain
(ii) high standards of interdisciplinary pain care and
(iii) evidence –based practice.

- The website identifies members of the CAPM and credentialed members who have demonstrated the experience and knowledge recommended by CAPM and AAPM. In order to fulfill the mandate to provide evidence-based standards of care with an interdisciplinary pain focus, CAPM offered a 2 day course open to all health professionals in January 2011. A subcommittee of CAPM is developing another course which will be held in Ontario but will serve a template for other courses that can be provided across the county.

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- The newsletter has been re-launched offering both information and educational initiatives from all health disciplines working in the area of pain.
- Membership numbers stand at 100+ with numbers increasing as the mandate and reputation of CAPM becomes understood.
- CAPM is prepared to work with other health disciplines to offer both pain education and advanced credentialing.
- Members of the Board represent an increasing number of health disciplines; CAPM is also beginning collaboration with the Canadian Chapter of the American Academy of Craniofacial Pain to support credentialing of craniofacial experts in Canada.

Save The Date!

CAPM Course November 19-20, 2011
A two day course on 'Clinical Problem Solving in Pain' will be held at the Four Points Sheraton at the Toronto Airport location. This course will combine theory, discussion and case study presentations. More information will be circulated in a separate document.

Life-Time Achievement Award- Update from the Physiotherapy Profession:

At the Canadian Physiotherapy Association Congress held recently in Whistler, B.C. Gloria Gilbert, was awarded a Life Membership Achievement Award. Gloria joins other physiotherapists who have demonstrated outstanding service to CPA for at least 25 years. Gloria's volunteer work in London (Scientific Advisory Board of Pain Program, UWO), her work with the re-vitalization of CAPM and her mentoring to her physiotherapy colleagues in the area of chronic pain management were noted. Of particular note is that The Pain Sciences Division of CPA is now a thriving and important Division of the organization.

New Publication "Grouch!!"

Cathryn Morgan, a patient and educator has written an informative and beautifully illustrated book (Crystal Beshara) entitled GrrrOUCH! Pain is Like a grouch bear.
Although Cathryn suggests that it was written for children, it is suitable for all ages…feelings are difficult to express! Cathryn earned the Pain Awareness Award from the Canadian Pain Society and the Canadian Pain Coalition in 2011.
Check out more information at www.painislikeagrouchybear.com or www.cathrynmorgan.com
(613-828-7482)

Upcoming Meeting Notices

PAINWeek 2011. September 7-10, 2011
Las Vegas, Nevada
www.painweek.org

American Academy of Pain Management, 22nd Annual Clinical meeting
September 20-23, 2011
Las Vegas, Nevada
www.aapainmanage.org

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Canadian Arthritis Network 2011 Annual Scientific Conference
October 27-29, 2011
Quebec, Quebec
www.arthritisnetwork.ca

Canadian Pain Society (CPS)
May 23-26, 2012
Whistler, BC
Currently call for papers and workshops, deadline October 15, 2011 and November 30, 2011 for regular research posters
www.canadianpainsociety.com

4th International Congress on Neuropathic Pain
Toronto, Ontario
May 23-26, 2012
www.kenes.com

International Association for the Study of Pain (IASP)
14th Congress on Pain
August 27-31, 2012
Milan Italy
www.iasp-pain.org/Milan

Non Radiologically Guided Nerve Blocks for Chronic Non-Malignant Spinal Pain with a Discussion of Para-vertebral Nerve Blocks

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Peter J. Rothbart, MD, FRCP(C), DABPM
Howard P. Jacobs, MD, DAAPM, LRCP&SI, MICGP

INTRODUCTION

There is controversy and confusion about, “blind techniques” (techniques by palpation of landmarks) for therapeutic cervical paravertebral blocks and lumbar paravertebral blocks. Such blocks are also used in the thoracic region.

The OHIP fee schedule does not give any information or definition on techniques of these nerve blocks.

However, Taber’s Cyclopedic dictionary 18th Edition (1997) defined paravertebral as “alongside or near the vertebral column”, and Dorland’s Medical Dictionary, 27th Edition (1985) defined it as “beside the vertebral column”, and Miller-Kean’s Encyclopedia, 5th Edition (1972), simply stated that it meant “near the vertebrae”.

In the past few years some anaesthetists in Ontario have been performing these procedures under x-ray control, whereas previously it was routinely carried out as a “blind procedure”. This procedure involves a local anaesthetic blockade of the medial branch of the dorsal ramus of the nerve root. The physicians using x-ray control are billing this procedure as a paravertebral block. On the other hand, physicians who are performing the blocks by “blind technique” are bathing the area of the dorsal ramus and they too are billing this as a paravertebral block.

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To bring some clarity to the issue, some of the early history of these procedures is useful.

Until approximately 1990, the facet joints were thought to have no innervation, and so nerve blocks of the facet joints were considered to be of no value in pain relief. However, research by Bogduk and colleagues showed through peer review publications that facet joints were highly innervated with microscopic nerves. Barnsley, *et al* (1993), also confirmed that local anaesthetic of the medial branch of the nerve at the appropriate facet level would result in blockade of pain from damage of that joint (diagnostic block). If the diagnostic blocks were successful in providing pain relief, then thermocoagulation of that medial branch could relieve the facet pain for several months.

Bogduk insisted that the diagnostic block must use 0.5cc of local anaesthetic or less and must decrease the neck pain to 0-1 on a VAS scale, otherwise the diagnostic block was considered a failure, and the patient was not eligible for thermocoagulation of the nerves. This technique was published in New England Journal of Medicine, May 1996. On discussions with Bogduk about rhizolysis for facet pain, it was clear that <10% of patients with neck pain fulfilled the criteria to be considered for rhizolysis of the median branch nerve. A significant number of patients have negative diagnostic nerve blocks using Dr. Bogduk's criteria presumably due to pain generators other than the facets. The strictness of Bogduk's criteria leaves many patients who do not qualify for rhizolysis. For the last several years we have found that sensory blockade in the paravertebral area around the facet joints provides good pain relief in cervical areas and also thoracic and lumbar regions.

Nevertheless, the techniques of diagnostic blocks and rhizolysis were quickly popularized in the US pain clinics. Physicians loosened the criteria so that a drop of 50% for over six hours with Marcaine, on the VAS scale was generally considered an indication for rhizolysis. In Canada most pain specialists performed the paravertebral therapeutic blocks using the blind technique and found this was effective in relieving the pain at that level. These blocks were also of some prognostic value. We now know that the whole vertebral column is highly innervated. This has confirmed the value of techniques to block nociceptors in the area of the pain and to move away from pure facet joint blocks.

TERMINOLOGY

One of the authors (GDG) has reviewed interventional management for Chronic Non-Malignant Pain (CNMP) including the use of palliative and therapeutic nerve blocks (Gale, 2009) and two of the authors discussed the place of non-radiologically-guided nerve blocks in the treatment of CNMP (Rothbart and Gale, 2001). Therapeutic nerve blocks are discussed in the Guidelines of the Wisconsin Medical Society (2004).

Rovenstein and Wertheim (1941) and Bonica (1951) described nerve block therapy in the management of CNMP as diagnostic, prognostic, and therapeutic. In later years, since the advent of diagnostic nerve blocks with x-ray control (Barnsley, *et al*, 1993), it would be a reasonable decision to restrict the term "diagnostic" to that use but the terms prognostic, therapeutic, or even palliative would still reasonably be appropriate for the non-radiologically guided nerve blocks for CNMP.

Since it is now ninety years since the first therapeutic nerve blocks were performed by Scholl (1921, 1922) who reported lesser occipital nerve blocks with Procaine, many regional anaesthesia blocks have been used for treating CNMP. The rationale for the practice was provided by Arner, *et al* (1990) who found prolonged

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pain relief of neuralgia after regional anaesthesia nerve blocks. The demand for the treatment of CNMP has increased in recent years because of an increasing awareness of the distress and harm caused by unremitting CNMP, the incidence of which Moulin, *et al* (2002) found to be 29% in Canada.

It is therefore proposed to use the terms therapeutic or palliative for the non-radiologically-guided nerve blocks for CNMP. Terms which may also be suggested are prognostic in determining where the blocks may suggest future benefit or the presence of pain generators.

One Guideline has suggested that therapeutic blocks may be useful diagnostically (Wisconsin Medical Society, 2004). Several observers have found clinically that non-radiologically-guided paravertebral blocks (see below) have provided better pain relief than the radiologically guided medical branch blocks because the more widespread distribution of the anaesthetic blocks affect more pain generators than just the zygapophyseal joints (GDG, PJR). The focus of this paper is to discuss non-radiologically-guided nerve blocks for the treatment of CNMP of spinal origin. These techniques have been developed over many years without the use of radiological guidance to provide safe reproducible and effective pain relief. The nerve blocks used are usually termed paravertebral.

THE ANATOMY OF THE VERTEBRAL COLUMN

The vertebral column provides a partly rigid and partly flexible axis for the body and a pivot for the head. Consequently, it has important roles in posture, support of body weight, locomotion, and protection of the spinal cord and nerve roots.

The spine or axial skeleton consists of 33 vertebrae which articulate at anterior and posterior intervertebral joints.

THE ANTERIOR INTERVERTEBRAL JOINTS

The anterior intervertebral joints, designed for strength and weight-bearing, contain intervertebral discs. These intervertebral discs are innervated by the anterior primary ramus (APR) of adjacent spinal nerves with additional autonomic connections. Consequently, discogenic spinal pain may be referred over several spinal segments. These structures are innervated by branches derived from the anterior primary rami of spinal nerves and their blockade is best achieved using epidural anaesthesia.

THE ZYGAPOPHYSEAL JOINTS

From C2 to S1, the zygapophyseal joints are between the inferior articular process of a superior vertebra and the superior articular process of an inferior vertebra. Each joint has a fibrous capsule lined with synovial membrane, which permits gliding movements between facets of the vertebrae.

THE NERVE SUPPLY FOR ZYGAPOPHYSEAL JOINTS

This is for proprioception for movement and position, and for pain there are nerve endings in the articular capsule. Hilton's Law states that the nerves supplying a joint also supply the muscles moving the joints and the skin covering the attachments of these muscles. This may help to explain the referral pattern of some joint pain (pain is always referred to structures in the same spinal segment).

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THE SPINAL NERVES (from K.L. Moore Anatomy, 1985)

There are 31 pairs of spinal nerves attached to the spinal cord by dorsal and ventral roots. The ventral roots leaving the cord contain efferent or motion fibres, which are distributed to muscles and glands. The dorsal roots entering the cord contain afferent or sensory fibres, which convey sensation from sensory nerve endings. The cell bodies making up the ventral roots are in the ventral gray horn of the spinal cord, whereas the cell bodies of axons making up the dorsal roots are outside the spinal cord in the spinal ganglia (dorsal root ganglia). These ganglia are located in the intervertebral foramina where they rest on the pedicles of the vertebral arches.

Distal to the spinal ganglia, just outside the intervertebral foramina, the dorsal and ventral roots unite to form a spinal nerve. Each spinal nerve divides almost immediately into a ventral primary ramus and a dorsal primary ramus.

THE DORSAL PRIMARY RAMUS

This supplies nerve fibres to the back, the zygapophyseal joints, muscles, ligaments, and skin.

THE VENTRAL PRIMARY RAMUS

This supplies nerve fibres to the limbs and the anterolateral regions of the trunk. The dorsal and ventral primary rami of the spinal nerves contain:

- Motor or efferent fibres from the ventral horn cells of the spinal cord
- Sensory of afferent fibres of spinal ganglion cells
- Autonomic fibres

SURFACE LANDMARKS FOR PARAVERTEBRAL BLOCKS

In the cervical region, transverse processes, and spinous processes, notably C2 and C7, may be palpated.

In the lumbar region, the spine of L4 is level with the pelvic brim.

In the thoracic region, the tip of the spinous process of T8 lies in line with the transverse processes of T9 (Moore, 1981).

The long downward slope of the thoracic spinous processes tends to decrease caudally as the spinous process become heavier, so the spinous process of T11 is in line with the space between the transverse processes of the 11^{th} and 12^{th} thoracic vertebrae, and the spinous process of the 12^{th} thoracic vertebra lies in line with the space between the transverse processes of the 12^{th} thoracic and 1^{st} lumbar vertebrae.

PARAVERTEBRAL BLOCKADE OF SPINAL NERVES

Outside the spinal canal spinal nerves may be blocked in the paravertebral region or at certain points along their subsequent course. (Wall and Melzack, 1994).

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THE CERVICAL REGION

Two equally valid techniques have been described to block cervical spinal nerves.

The oblique lateral approach (Wall and Melzak, 1994 from Bonica 1959)

The head is placed obliquely on a pillow and the transverse processes palpated. The C2-3 transverse process is palpated 1.5cm caudad to the mastoid process. The needle is inserted medially and slightly caudad to avoid unintentional insertion into the intervertebral foramen and is advanced to touch the transverse process before injection is performed. The process is repeated at intervals more caudally for the lower cervical joints.

THE POSTERIOR APPROACH TO CERVICAL ZYGAPOPHYSEAL JOINTS

This was described by Saunders and Longworth (2006). These authors described a posterior parasagittal approach, in which the needle always lies parallel to the spinous process and never angles medially and then touches bone before injection into the joint capsule. This technique has the advantage that the needle is not directed towards the spinal cord with its risks of a misplaced intraneural injection. The risks of aiming a needle at the spinal cord was described by Parker EO (2005). The approach of Saunders and Longworth may be used to inject close to the joint and still achieve blockade of facet pain. These authors also described a similar technique for lumbar joint blockade.

THE THORACIC AND LUMBAR REGIONS

The posterior approach described by Saunders and Longworth (2006) for the cervical and lumbar regions may also be used in the thoracic region. This technique is appropriate for anaesthesia of posterior vertebral structures, principally the zygapophyseal joints. It avoids the risks of the deeper paravertebral injection with consequent risk of pneumothorax in the thoracic region and leg weakness caused by nerve root anaesthesia caused by paravertebral injection deep to the transverse process in the lumbar region. (A. Lee in Wildsmith, *et al,* 2003; Mulroy 1995; Davies and Cashman in Lee's Synopsis 2005; Finucane 1999; Richardson, *et al* 1999; Greengrass and Buckenmaier 2002 and Moore 1981).

CONCLUSION

It is concluded that when analgesia for posterior structures is required in the thoracic and lumbar regions, it is best achieved by a technique that does not advance the needle deep to the transverse processes. This will ensure adequate anaesthesia of the zygapophyseal joints and other posterior structures using a technique the same or similar to that of Saunders and Longworth (2006). Two techniques for anaesthesia of cervical zygapophyseal joints are described above.

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Journal of Clinical Psychology Practice

Chronic Pain In Context: Some Observations from 25 Years in the Field
Michael R. MacDonald
MacDonald & Bryant
London ON

It is not easy coming to see a psychologist when you have physical injuries and pain. Most people do not know why they were referred to us. Most people are not sure there is even any point to showing up. To help them feel comfortable, I usually start with a simple overview. First, I explain that if you have short-term pain, you would never end up coming to see a psychologist like me.

If your pain settles down within a few months, you can return to work, return to your normal life. Not much stress is involved. If your pain and injuries continue, month after month, with little improvement, then the stresses start to build. Maybe your work is disrupted and you are) having trouble getting income replacement benefits. Maybe your pain and limitations interfere with your family life, and your spouse and children are having difficulties coping with the extra load on them. At this point, people start tearing up. They can see that I am speaking about their struggles and

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everyday experience. We are on the same page. This is where treatment starts -- within the first few minutes of meeting each other. and children are having difficulties coping with the extra load on them. At this point, people start tearing up. They can see that I am speaking about their struggles and everyday experience. We are on the same page. This is where treatment starts -- within the first few minutes of meeting each other.
(For the entire article please see the attachment that was sent with the Newsletter issue)

Articles Needed

If you have any articles, notes of interest or any other piece you think would be beneficial to CAPM members, please send to Gloria Gilbert, Newsletter Editor gloriagilbert@sympatico.ca; Gloria@downtownclinic.ca

Thank you