CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

ISSUE 3 VOLUME 6, WINTER 2013

DELAYED RECOVERY POST (NECK) TRAUMA PART TWO

BY GLORIA GILBERT, PT, MSC, CAPM EDITOR

The Spring-Summer 2013 edition of the CAPM Newsletter began a discussion about Persistent Post Traumatic Pain. The only extensive review on this subject is found in the Whiplash (MVA) literature. The review does report that in addition to neck pain and headaches, there may be possible 'other physical reasons' for delayed recovery.

It is evident that the long term squealae of 'post traumatic neck pain and headaches' as well as the possible association with Traumatic Brain Injury (TBI) needs to be studied more extensively.

We should all be familiar with the psycho-social, cultural and personality factors which may be influencing a person's recovery/rehabilitation.

However, it may be helpful to ask whether both the 'other physical factors' (not yet diagnosed) as well as all the psycho-social influences make the rehabilitation of the post trauma neck patient even more complicated than it is already.

It may be helpful to review the content of the last newsletter (Part 1) as a pre-amble to this edition-Part Two.

One Academy member has emailed a concern he has about problems such as visual distortion, vestibular disturbance etc. associated with a TBI.

He continues that '*although no one should doubt the credibility of these complaints, many of these issues resolve or improve with the passage of time, independent of any specific treatment. Because there are no controlled trials of treatments for these sensory disturbances we never know when someone gets better (because of the treatment) or if we are observing the natural history of the problem."*

Your editor would comment however that her client-base is by definition 'the person with post-traumatic chronic/persistent neck pain (primarily) …and that she usually is referred patients who are 9 months to 3 years post event.

It is likely therefore that the 'natural history of visual, vestibular and other sensory symptoms' has resolved. Yet many of these people continue to experience these sensory problems. The management of these symptoms must be distinct from the treatment of musculoskeletal/spinal pain problems. The treatment challenge then continues over time to integrate the 2 areas of dysfunction (i.e. balance may be affected because of changes to the vestibular and visual system; memory and concentration concerns may impact on a person's ability to 'remember' their exercise routine and/or daily schedule'.

The growing literature base on concussion…and especially Mild TBI will assist us in better assessing and treating these challenging patients. At the same time, these problems provide an opportunity to discuss 'Delayed Recovery Post (neck) Trauma- Part Three 'in our next newsletter.

The next newsletter will review the current literature and the rationale for the assessment and management of 'sensory' problems (vision, vestibular, memory, concentration, proprioception) ….associated with many patients experiencing post traumatic neck pain/headaches.

Academy members who are dentists, optometrists, ophthalmologists, and ENT specialists' in particular are asked to contribute to this newsletter.

<u>If possible, please also send this newsletter with these questions/concerns to your other 'health provider' associates who may be able to contribute to this discussion.</u>

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:

DELAYED RECOVERY POST (NECK) TRAUMA PART TWO

CONTINUED…

The current newsletter will continue the 'development of a pain vocabulary' emphasizing words that we 'should' try not to use. A 2 page attachment to this newsletter, written by your editor, can be used as hand-out for your patients (no permission required).

Dr Eldon Tunks, our Academy president has written an article on Low Back Pain and Disability. Pain resolution may not be as essential to good recovery as is a person's ability to resume their usual pre-pain activities.

The Role of Occupational Therapy in the rehabilitation of the post trauma patient has been written by O.T. Martha Bauer. It will assist us to better understand and appreciate the role that the OT can play in successful treatment planning.

The results of a study on 'The Relationship Between Patient Satisfaction and Treatment Outcome in Chronic Pain Community Clinics' has been submitted by Kim Rod. It would serve us all well to survey our patients to improve our own clinical practice.

The transition from acute to chronic pain and the challenges with both treatment and management have been the subject of many reviews, discussions (and articles). This topic will also be highlighted in the next edition of the newsletter.

Questions remain as to whether this 'transition time' is the same for patients with traumatic injuries. ***(Another good research question!)***

At the end of this newsletter, members will be provided with "A patient-centered Exercise".

On September 8, 2013, an Education workshop was held in conjunction with the CAPM Annual Meeting in Hamilton. Your editor presented on 'Delayed Recovery Post Neck Trauma'. The patient was a 22 year old young man who was assessed by this therapist 19 months after the MVA. The trauma.

The difficulties in providing a treatment program for patients with delayed recovery are evident.
The 'exercise- has been developed to consider what kind of treatment/ management SHOULD have been implemented from the time of the accident…to lessen the long term functional effects of this trauma.

Please respond to this 'exercise' question as soon as possible.

DEVELOPING A VOCABULARY TO TALK TO YOUR PATIENT'S ABOUT PAIN—PART TWO

GLORIA GILBERT, PT, MSC

The reader is again reminded to refer to part 1 of this discussion, published on Page 5 of the last newsletter.

Patients who 'do not recover/get back' to 'normal' in a certain period of time often feel guilty about 'Not being a good patient, mother, friend, spouse etc.'

Often relatives, friends and at times health professionals suggest that the patient SHOULD be better by now!

It is evident that each person and each condition must be managed individually. There are no 'rules' about recovery time. Many factors (extent of injury or disease, psycho-social issues including work situations) can impact on a person's recovery and resumption of a more 'normal' lifestyle (for them).

It remains important to state again that chronic/persistent pain is NOT a diagnosis. It We must link the persistence of pain to the myriad of reasons as to why this could be occurring - and provide appropriate treatment and direction.

It may be helpful to ask your patient to **" Try and explain to me HOW and WHAT you are feeling (experiencing) without using the word PAIN."**

While you are also assisting them in separating physical from emotional from 'other' words, remind them to try NOT to use the following words (when talking to themselves or someone else)

- Should
- Supposed to
- Ought to
- It's only
- It's just
- But
- Use to
- Etc.

You may find that the inter-action with your patient becomes more helpful…

THE ROLE OF OCCUPATIONAL THERAPY IN THE MANAGEMENT OF THE CLIENT WITH POST-TRAUMATIC PERSISTENT PAIN

MARTHA BAUER

Occupational Therapists (OT'S) work with clients with post-traumatic injuries to help them learn and/or integrate pain management strategies into their daily activities. No matter the reason or the source of the pain (and whether traumatic or not) OT's are able to consider the physical, cognitive, emotional, environmental and occupational factors that impact on successful function. (home, work, leisure activities)

OT's work with the other team members in establishing a coordinated approach to care. This can involve communication by phone, brief letters, and team meetings when possible. Team communication is very important to ensure that the client, family and team members fully understand when it is safe to function (move!) and when it is important to limit activity. Ensuring that there are consistent messages from all team members is important for successful recovery.

OT's can perform an assessment in the clinic or in the clients' home. The O.T. notes any physical, cognitive, emotional and environmental concerns – usually when clients are performing various functional tasks. (navigating the home, working in the kitchen, personal care etc.)
The OT report then includes a review of the individual functional goals with a focus on what is important and meaningful in each person's life. These activity goals become the modality of treatment.
When discussing the concerns about pain management with the team, the OT can label and address barriers to function and barriers to change.

As an example: if someone wants to be able to complete kitchen chores (wash and dry dishes), grocery shopping, take children to the park or return to work, an OT might practice with the client in the home environment making "in vivo" adaptations.
Adaptations could be:

- the method itself (including pacing the activity)
- devices/strategies used (e.g. a stool, alternate type of devices, brief practical relaxation strategies, stretches)
- the postures/positions (elevating the task, alternating hand use, watching for over-gripping)
- and observing the cognitive distortions around pain itself or activity management that might impede successful task completion.

Integrating strategies developed in other therapies (physiotherapy, psychology) can also become another key element of the process.

OT's most often use a cognitive behavioural approach to develop and implement graduated re-activation programs.

OT's are often involved in designing and implementing return to work plans and advocating and negotiating with employers about what is appropriate for people living with persistent pain. OT's might simulate a work activity and practice a simulation in clinic or at home.

In summary, the goal of the occupational therapy working with the client with persistent pain is to help people learn and integrate successful approaches to activity management. By applying these principles, clients can participate more meaningfully in their important daily activities.

Happy Occupational Therapy Month (October 2013)

Martha Bauer, BSc., OT, Reg. (Ont)
OT: Skills For The Job Of Living

REPORT FROM THE CAPM EXECUTIVE, OCTOBER 2013

DR. ELDON TUNKS, PRESIDENT CAPM

Many members of CAPM have availed themselves of the provisions for credentialing. This is presently done either online, through CAPM collaboration with our partners and counterparts the American Academy of Pain Management (AAPM), using their screening and validated multiple choice examination, or at the time of AAPM annual meetings, the latest being September 26-29 2013. This credentialing as Diplomate for PhD and Doctors and equivalent, Fellow for Masters degree equivalent, and Clinical Associate for Baccalaureate and equivalent, is a "seal of approval" that that member has submitted evidence of appropriate academic training and good standing with the regulatory authority, endorsement by peers, practice in pain management for at least two years, and knowledge of the pain field as supported by success at the standardized examination.

While at that AAPM annual meeting we discussed with AAPM colleagues our plans, and their plans, for implementing Advanced Credentialing. AAPM is about to introduce Advanced Credentialing for MDs and DO physicians. The difference is that while credentialing as it stands now endorses the member's commitment to ethical and knowledgeable pain practice according to verifiable standards, Advanced Credentialing evaluates procedural and clinical skills-based indicators in specialized areas of pain expertise. Within this coming year we expect to introduce Advanced Credentialing for Interventional Pain practice for MDs. A committee struck by CAPM last year resulted in a set of training and professional formation recommendations for Advanced Credentialing. Chronologically it would be available first for Change-of-Scope Interventional Practice in Out-of-hospital-premises clinics, and later using the analogous criteria for interventional physicians in academic centers, and in other provinces where the regulatory system may vary. We have also had several months of discussion with another non-MD professional regarding Advanced Credentialing in that clinical discipline – details to be announced when we get feedback from their regulatory body. We have developed a template for this that would be applicable to any discipline that has members practicing in pain management. We invite our members from any of the clinical disciplines to discuss with our executive if you would like to see Advanced Credentialing applied to your professional skill-based professional discipline.

We thank all of you, our members, for your steady support of our efforts to raise the profile of all clinicians committed to managing pain with a comprehensive and multidisciplinary focus.

Dr. Eldon Tunks, President CAPM

LOW BACK PAIN MANAGEMENT: GOALS TO RESOLVE PAIN AND/OR PREVENT DISABILITY

DR. ELDON TUNKS, PRESIDENT CAPM

CAPM recommends a comprehensive approach to pain relief. Here is one of the ways that comprehensive pain management is carried out. We who deal with clinical problems of pain management, encounter this question daily. Among those who seek our help most are concerned about the most immediate problem of pain and discomfort, but many also want a solution to impairments or disability associated with pain, as it intrudes on quality of life and financial security.

Certainly in most of our experience, acute injuries such as fractures and sprains cause pain and inhibit our activity to some extent and in a few days or weeks the pain and activity impairment are both gone, so intuitively it is natural to focus just on the pain relief and assume that the impairments will resolve with the pain. However the acute injury model does not reflect the majority of painful conditions in all of our experience. For example, Crook et al. showed that the prevalence of persistent pain is in the order of 4 times greater than prevalence of acute pain; 5% vs. 10 - 40% (depending on age). [1] A prospective study by Henschke et al.[2] of the course and prognosis of men and women with acute low back pain in primary care clinics found that Complete recovery % (i.e. no pain or disability and RTW)

-- 4-8 weeks	39%
-- 3-6 months	57%
-- 12 months	72%
Non-recovery	28%*

*Non-recovery predicted by older age, depression, compensation, higher pain and longer duration at time of first assessment, and more days reduced activity before first assessment.

The same study found that return to previous work status

-- 2 weeks	50%
-- 6 weeks	74.6%
-- 12 weeks	83.2%
-- 1 year	89.5%

LOW BACK PAIN MANAGEMENT: GOALS TO RESOLVE PAIN AND/OR PREVENT DISABILITY

Continued...

But those still reporting Pain

-- 6 weeks 60.1%
-- 3 months 48.5%
-- 12 months 42.6%

And those still reporting Disability

-- 6 weeks 39.7%
-- 3 months 28.6%
-- 6 months 25.2%

From this it is evident that disability defined as non-return to previous productive roles/work resolves in many patients before their pain resolves: in this study, 40% of those who have returned to their jobs still report pain.

Pengel et al. conducted a systematic review of prospective follow-up studies of acute low back/sciatica.[3] Over 9 studies they found that pain decreased rapidly in first month – mean reduction 50 % (12%-84%). Pain still decreased slowly until three months, and then remained nearly constant until 12 months. Disability decreased during first month -- mean reduction 58% (33%-83%). Of those initially off work – pooled estimate 82% (73%-91%) returned by one month, and 93% returned by three to six months (91%-96%).
The advice arising from these studies is to not neglect appropriate methods of pain relief but to keep a focus from the beginning on preventing or shortening disability: this requires discussion with the patients that maintaining or restoring function should not wait for all pain to be resolved. This may require early discussion with the patient's occupational health office arrangements for modified or gradual work return while supporting recommended pain relief strategies in the workplace.

Another aspect to consider is the risk of pain recurrence – in Pengel et al. review pain recurrence within three months was mean of 26 % (19%-34%). Risk of pain recurrence within 12 months – 73% (59%-88%).

This evidence shows that people with acute low back pain and associated disability usually improve rapidly within a few weeks. However, pain and disability are typically ongoing in some, and recurrences are common. Estimates of recovery based on initial pain improvement or initial work re-entry may significantly underestimate future morbidity and prognosis. Since musculoskeletal (neck and back) pain often tends to be recurrent but improve with pattern of diminishing episodes of recurrences, it is appropriate early on to discuss with the patient that improvement in disability and pain are more likely than not to proceed favorably and that the pain/disability management will improve the likelihood of good pain and functional recovery, but that the patient should have a contingency plan how to handle pain episode recurrences, using the techniques learned in the pain clinic, so that possible pain recurrences will not lead to further disability setbacks: for example, in the event of pain recurrences the patient may have a contingency plan for temporarily modifying work, and use pain relief and coping strategies to deal with the pain/discomfort interference on function.

Dr. Eldon Tunks, President CAPM

References:

Crook J, et al: Arch Phys Med Rehab 1986;67:451)
Henschke N, et al: BMJ July 7 2008; 337:171
Pengel et al. BMJ. 2003;327:323

THE RELATIONSHIP BETWEEN PATIENT SATISFACTION AND TREATMENT OUTCOMES IN CHRONIC PAIN COMMUNITY CLINICS

Kim Rod

Abstract

Chronic pain is among a host of chronic disorders that affects many different aspects of patients' lives and requires a multi-disciplinary treatment approach for maximum effectiveness. ***Although there is evidence that multi-disciplinary treatments for chronic pain in community pain clinics is effective, the question remains as to whether there is a correlation between treatment satisfaction and treatment outcome.***

To review: Interventions such as individualized exercise programs, learning relaxation techniques, group therapy, patient education sessions, physiotherapy treatments, medical training therapy, and neurophysiology information has been shown to be more effective than medical treatment and better than non-multidisciplinary treatments (Scascighini 2008) This was noted in an earlier study in which 48% of patients who participated in a multi-disciplinary chronic pain management program had returned to work, and 28% were in vocational training 10 months after completion of the treatment program, whereas none of the patients who did not participate in the program were back to work or in vocational training. (Deardorff 1991)

It has also been shown that following multi-disciplinary treatment, there is a significant increase in the proportion of patients who returned to work as well as a reduction in the use of health care and medication. (Cutler 1994).

Flor (1992) has also reported that return to work was less successful with medical vs. multi-disciplinary management.

Given the explosion and success of rehabilitation-oriented multidisciplinary pain centers, is it worth exploring whether there may be a relationship between patient satisfaction and the treatment outcomes in such settings?

Survey Methods

This case study was conducted in a community pain clinic where patients went through an eight-week multidisciplinary pain program. Patients (N=62) completed questionnaires both before and after treatment to evaluate their level of satisfaction with the program with respect to the severity of their symptoms (scales ranged according to question).

Some of the items studied included

- Helpfulness of different parts of the program
- *Level of change (improvement in functional ability* (e.g. Work (3.57% and family life (3.28%).
- Pain perception
- Coping perception
- Psychological/emotion adjustment

Results and Conclusion

In this survey, there appears to be a relationship between patient satisfaction and treatment outcome; 52.54% of patients felt the treatment program was very helpful, and all the patients reported that they would recommend the program to friends. This relationship is worth investigations by well-organized studies.

To receive a full copy of this study with references
Email: Kim Rod, rodk@mcmaster.ca or the
CAPM newsletter editor (gloria@downtownclinic.ca)

CONCUSSIONS AND THEIR CONSEQUENCES: CURRENT DIAGNOSIS, MANAGEMENT AND PREVENTION

GLORIA GILBERT, PT, MSC

Recently published in the journal of the Canadian Medicine Association is an important article by Dr Charles Tator on Concussion (see pages 4 and 5 of CAPM newsletter Spring-Summer 2013)

Available at www.cmaj.ca/content/185/11/1975.full- (August 6, 2013) you may need to either be the recipient of this journal or know a medical practitioner who can download the material directly from this site.

For many years, Dr Tator has been a researcher and medical practitioner working with injured sports-people; including those who have sustained a concussion. Often concussions have been poorly managed (until more recently). Returning the sports person to the field (or ring) prematurely has often resulted in devastating long term effects.

Working with other specialists, Dr Tator continues to develop guidelines about both resources and return to play that are also appropriate for 'anyone' who has sustained a concussion- i.e. not only sports related.

A bad fall, a serious neck injury, a heavy article landing on your head and many other types of trauma can result in a concussion that is often overlooked- and therefore often inappropriately managed.

In Practice, the cover to the main concussion article, Drs. Laura Purcell, Jamie Kissick and John Rizos (the Canadian Concussion Collaborative) ….highlight " Five things to know about….Concussion."

1. Loss of consciousness is not required to have a concussion.

2. Tools to evaluate concussion include the Sports Concussion Assessment Tool 3 (SCAT 3) and the ChildSCAT 3.

3. Imaging is not necessary to diagnose concussion.

4. The keystone to management is rest.

5. Return to activity should be gradual and follow a medically supervised stepwise exertion protocol.

This health practitioner has attended several workshops on Mild Traumatic Brain Injury where Dr Tator was one of the speakers. Specific questions have been posed to him on whether these 'Concussion Guidelines' also apply to people who have been injured in motor vehicle accidents. Dr Tator has always responded in the affirmative.

Because of the cost of a professional sports-person being injured and side-lined (i.e. hockey player Sydney Crosby) - research dollars are now more readily available from sports-related organizations.

However, it remains essential to apply these same precautions and guidelines to your patients who may demonstrate the following symptoms posts trauma:

- Dizziness, lightheadedness, nausea, headaches that do not resolve (within days to a week)
- Any period (even 1 second!) of loss of consciousness
- Any loss of memory for events immediately before or after the accident
- Any alteration in the mental state at the time of the accident.

Symptoms should be carefully monitored until complete resolution or another diagnosis has been confirmed.
Health professional must therefore be cautious to not dismiss signs and symptoms for which there is no definitive neurological or imaging test

Whatever the reason for the trauma, some additional questions to ask your patient may include:

1. Were you able to get out of the vehicle on your own? Were you able to get up from the floor?

2. What is the first thing you remember after the accident (fall)?

3. Are you experiencing any dizziness, nausea, spinning sensations?

And perhaps we have to caution our rehabilitation health professionals who are working with auto insurers to assess carefully and cautiously, and consider 'return to work' guidelines similarly to those developed for 'return to play'.

- And not recommend that patients return to work /engage in heavy household tasks too soon.
- And ensure that their patients not engage in strenuous exercise (until all symptoms, including pain are better controlled).
- And not be pressured by the auto insurer who suggest that patients should be back to their pre-accident functional status within 6 -8 weeks!

On Suffering: Pathways to Healing and Health

Beverly M. Clarke, PT, PhD
Darmouth College Press ISBN: 9781611680058

Over the last few years, the literature on pain and suffering has attempted to separate these two constructs. I.e. if one is in pain, are they also suffering?

If one is suffering, is it because they are in pain?

In the winter 2000 Physiotherapy Canada journal, I was "heartened' to read an article by Beverley Clarke, PT on the 'Impact of Suffering in Physiotherapy Practice: Cost Containment issues".

Beverley (at that time) summarized two common models of (physiotherapy) practice that demonstrated the failure of physiotherapists to recognize suffering as an entity separate from pain. She summarized that as a result, the practice may result in 1) Incomplete problem identification 2) Ineffective treatment interventions 3) Increased suffering including the escalation of symptomology 4) Inappropriate referrals 5) Increased fiscal expenditures and 6) the inability of some clients to achieve their maximum rehabilitation protocol.

(Finally, we physios were recognizing that successful treatment is not all about doing your exercises- editors' comment)

It was therefore gratifying to know that Dr Clarke has continued her research into this important clinical area. Dr Clarke is currently an Associate Professor in the School of Rehabilitation Science at McMaster University as well as a Neurology Associate, in the Division of Neurology.

On Suffering: Pathways to Healing and Health

Continued...

Her 291 page book (which includes references chapter by chapter), discusses the results of a scientific questionnaire entitled **Measuring and Assessing Suffering Questionnaire** -as well as evidence from and conversations with hundreds of patients.

Dr Clarke discusses the differences between suffering and pain that has universal measureable characteristics. They require suffering-specific treatments that are sensitive to the patient's individual psychology and cultural background.

Many health providers have simplistically stated- Pain is a given, suffering is optional!...This important book on Suffering will expand on the many 'formerly perceived as soft factors' affecting good treatment results.

An important book for all!

2012 CANADIAN GUIDELINES FOR THE DIAGNOSIS AND MANAGEMENT OF FIBROMYALGIA SYNDROME

GLORIA GILBERT, PT, MSC

Fibromyalgia has been acknowledged as a bone fide clinical 'pain' syndrome for more than 20 years- yet controversy continues about the criteria for diagnosis and appropriate management of this condition.

It is acknowledged that subjective concerns and descriptions of symptoms within the patient population are often similar. Although research studies have shown some changes in the neurophysiology of FM sufferers, there is no specific medical test that can 'diagnose' the problem.

A multi-disciplinary panel of medical specialists reviewed the available published evidence. They made recommendations for diagnosis and management of FM based on both the published evidence and ***also the "rational clinical judgment to facilitate the care of patients".***

Guidelines in 1990 (and reviewed in 2010) by the American College of Rheumatology stated that the diagnosis of FM could only be made by a rheumatologist and that a key criteria for diagnosis was based on the number of 'tender-points'. ***These findings were refuted by the panel.***

In fact, the panel felt that the family physician was the most appropriate health professional to both make the diagnosis and assist the patient in becoming actively involved in the self-management of their condition.
The Executive Summary was published in the Journal of the Canadian Pain Society called Pain Research & Management; 18(3): 119-126. (May-June 2013).

The complete documents can be reviewed on the website of the Canadian Pain Society. (www.canadianpainsociety/ca/pdf/Fibromyalgia_Guidelines_2012.pdf)

The diagnosis and treatment recommendations are extensive - but stress the importance of involving the FM person as completely as possible in the self-management of their condition.

Some health providers continue to be concerned that the recommendations include 'pharmaceutical treatment'- and have suggested that this is because some of the reviewers are 'working with the pharmaceutical company'. (to produce this new report and recommendations) I must admit, that as a health provider who has been actively assisting /treating FM patients for many years, I see many more positives than negatives in these new Recommendations. We all need to be reminded that every patient is unique- and required their 'own' self-managed plan (which may include drugs at times).

The following are some of the headings published in the 'Practice Recommendations for FM

- **The clinical evaluation**
- **Testing and confirming the diagnosis**
- **Education and Knowledge**
- **Treatment Overview**
- **Non-pharmacological Overview**
- **Psychological Interventions**
- **Physical Activity**
- **Complementary and Alternative Medicine**
- **Pharmacological Overview**
- **Traditional pain-relieving therapies**
- **Non-traditional pain relieving strategies**
- **Patient follow-up**
- **Outcome Tools**
- **Work Recommendations and Health Care Containment**

These Guidelines should be welcome by both FM sufferers and their health professionals who have diligently strived for years for the better management- and understanding of this condition.

Education and self- management, regular contact with a family physician or other health professional as a 'health coach' may be all that is required to change our approach and management of a condition that affects at least 2 -3 % of the Canadian population.

MEETING DATES

TBI Conference
January 31 2014, Sheraton Hotel Downtown Toronto
Contact *conferences@uhn.ca*

2014 – CPS Pain Refresher Course
February 7-9, Toronto
Contact CPS office at 905-404-9545 or office@canadianpainsociety.ca or www.canadianpainsociety.ca

2014 – Quebec City, Quebec
May 20 to May 23
Contact CPS office at 905-404-9545 or office@canadianpainsociety.ca or www.canadianpainsociety.ca

National Pain Awareness Week
Canadian Pain Coalition – November 2-8, 2014
Contact CPC at 905-404-9545 or office@canadianpaincoalition.ca

National Jeans Day — Canadian Pain Coalition
Thursday November 6, 2014
Contact CPC at 905-404-9545 or office@canadianpaincoalition.ca

2015 – Charlottetown, PEI
May 20 to May 23
Contact CPS office at 905-404-9545 or office@canadianpainsociety.ca or www.canadianpainsociety.ca