FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Newsletter of the Faculty of Pain Medicine AUTUMN 2013

TRANSMITTER

e-Pain

UK Chronic Pain Workforce

Neuromodulation in the UK

Essential Pain Management

Revising for the FFPMRCA Exam

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Kenneth Calman's changes to training are now 17 years old. MMC came into practice 8 years ago. PMETB existed for 5 years before their GMC merger. And now for one of the four home nations, NHS England, HEE and the LETBs are new goliaths on the medical training scene. The Shape of Training report, due out around the time this issue goes to circulation, will herald more changes to the nature of training.

We find ourselves in good hands during these turbulent times and congratulations must go to Kate Grady on her election as the third Dean of the Faculty. Deans bring their own insight and perspective to their Faculties, much as Chairs bring it to their Committees and consultants to their teams, and so are agents of change. As Kate, with the Board, designs her strategy for the future, much will be business as usual (developing a high level exam, protecting Pain Medicine training, promoting standards for Pain Medicine specialists) but important new work streams will come to life over the coming months. Our all Fellow emails, our Regional Advisors, our website and, of course, *Transmitter* will be the founts to go to for further information.

Change is also present in *Transmitter* itself. Karen Simpson stewarded the publication through its first two issues and Kate herself through the next four. John Goddard has kindly agreed to take over this mantle for the next year. Both Karen and Kate brought their own personalities to *Transmitter* and I look forward to John doing the same. For future *Transmitter*s we need to know what you think and what you want to know about. Please let us know!

MANAGING EDITOR
Mr Daniel Waeland

DEAN
Dr Kate Grady

VICE-DEAN
Dr Mark Taylor

CLINICAL EDITOR
Dr Kate Grady

ASSISTANT CLINICAL EDITOR
Dr John Goddard

Sub-Edited by **James Goodwin**

Administered by **Anna Ripley**

Available online at www.fpm.ac.uk

CONTENTS

THE FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists
Churchill House
35 Red Lion Square
London WC1R 4SG

Registered Charity No 1013887
Registered Charity in Scotland No SC037737
VAT Registration No GB 927 2364 18

Message from the Dean

Dr Kate Grady

Dean

This is my first *Transmitter* article as Dean. I am delighted to have been elected to the position, but am mindful of the hard work and responsibility of the role too. I am very well aware of the work that our Fellows, Associate Fellows, Members and others affiliated to us undertake for the Faculty and also the respect in which the Faculty is held by you all. I want to serve and lead you well and am eager to be accessible and approachable with a view to us moving together, on to the very best, through difficult and challenging times.

I start this article with a tribute to Professor Dave Rowbotham as outgoing Dean. The most striking thing about Dave is his clarity of thought and openness, which are combined with immense ability. Through these he has created a vision and direction over the past 3 years. His achievements have been memorable including the creation of the e-Pain project which is to be launched in December, the driving of the research agenda in Pain Medicine, evolving the commissioning process and the production of key documents on Spinal Cord Stimulation, Intrathecal Drug Delivery and on the practice of paediatric Pain Medicine and cancer pain management. We owe Dave huge thanks for having taken us successfully through difficult times.

As I step down as Chair of the Training and Assessment Committee (TAC) and of the Examination, Dr Barry Miller becomes Chair of the TAC, with Dr Jon McGhie as his deputy and Dr Karen Simpson becomes Chair of the Examination. Dr Beverly Collett is to take over as Chair of the Professional Standards Committee with Dr Tony Davies as deputy. I wish them the very best in these roles. I am pleased to be supported by Dr Mark Taylor who continues in office as Vice Dean.

The work of both committees is well established and known to you. We are now moving to 'quality assure' the output of both; a working party of the Training and Assessment Committee will look at potential quality enhancement of our Pain Medicine curriculum and training, and scrutinise workforce issues. Similarly, the Professional Standards Committee is reviewing its output and developing further published Faculty standards.

In the few weeks since my appointment work has moved apace.

- The Care Quality Commission has declared pain as one of the draft fundamental standards of care; the Faculty, with the British Pain Society (BPS) and the Chronic Pain Policy Coalition (CPPC) which critically includes patient charities and advocacy groups, has written a response in support of this new standard.
- We have a close eye on developments in commissioning and await release of our final joint FPM, RCGP, BPS, CPPC support document which has come out of the work which has followed the Pain Summit of 2011.
- We have submitted a response to a Department for Transport consultation document on regulations surrounding drugs and driving.
- We are working an invited response to *The Lancet Neurology* on changes, obstacles and progress since the 2008 Report of the Chief Medical Officer on aspects of pain assessment and management.
- Currently as part of the Anaesthesia Clinical Services Accreditation, we are determining standards for pain services.

We are delighted that Dr Stephen Ward, a Board Member has been appointed Chairman of the new NICE Low Back Pain Guidelines Development Group. This is very good news for us and we wish him well in this very important work.

I am aware that there is a degree of anxiety surrounding revalidation. By way of addressing that here is a statement from Dr Rob Searle, our Faculty lead:

"Revalidation is underway, with some individuals already having completed the process. The College revalidation helpdesk is available to help those

Prof Rowbotham, Dr Grady and Dr Taylor at the September 2013 Board meeting. ***Photo:*** **Dawn Evans**

Faculty Members who require advice, with questions requiring input from a clinician referred to a dedicated Pain Medicine Revalidation Specialty Advisor. Questions regarding the minimum number of sessions required to maintain competency are common, especially for those members whose practice includes both Anaesthesia and Pain Medicine. The College does not provide a list of recommended case numbers or lists to undertake in order to maintain competency. Judgments will needs to be made on an individual basis, with the annual appraisal process key to determining individual requirements.

CPD is an integral part of this appraisal process and the College continues to support this through the online CPD system. Further enhancements to this system are planned over the next year and aim to improve the functionality of this online tool."

The Faculty events programme is running well and is we hope serving you well in your preparation for revalidation or even 're-revalidation' for those in the early cohorts.

Although I would like to be able to relate more in this piece of the activity of the Faculty at the present time, the constraints of the character count and the fact that our activities are superbly covered by other articles in this edition of *Transmitter* constrain me.

I would however draw your attention to Dr Clare Roques' article and call for support for the Essential Pain Management Course, a combined initiative of the Faculty and the Australian and New Zealand College of Anaesthetists.

Please forward to me your ideas, suggestions, questions, and concerns via fpm@rcoa.ac.uk.

2013/2014 Faculty Calendar

EVENT: FPM Annual Meeting	**22 November 2013**
MEETING: Board of the FPM	12 December 2013
MEETING: FPM Professional Standards Cmte	13 December 2013
MEETING: FPM Training & Assessment Cmte	31 January 2014
EVENT: Acute Pain Management Study Day	**3 February 2014**
EVENT: Diagnostic Investigations in Pain Medicine Study Day	**4 February 2014**
MEETING: FPM Professional Standards Cmte	7 February 2014
MEETING: Board of the FPM	27 February 2014
MEETING: FPM Training & Assessment Cmte	11 April 2014

Please note that all dates may be subject to change.

Training and Assessment

Dr Mark Taylor

Vice Dean

With the election of Dr Kate Grady as the Dean of the Faculty of Pain Medicine she relinquishes her role as Chair of the Faculty Training and Assessment Committee (TAC). We must thank her for the enormous contributions made to the development of Pain Medicine training over the last 4 years. Some of the highlights include: the establishment of Advanced Pain Training; development and introduction of assessment methods for APT; the writing and implementation of the Pain Medicine content of the 2010 anaesthetic curriculum with the introduction of spiral learning; development and introduction of the Pain Logbook; development and chairmanship of the FFPMRCA exam.

The committee remains in experienced hands and we congratulate Dr Barry Miller, appointed as Chair and Dr John McGhie as deputy. Dr Miller is a long-serving member of the committee and for the last 2 years has been Lead Regional Advisor in Pain Medicine.

Most of the workings of the Faculty committees remain invisible to our Fellows and in the remainder of this article I review some of the important agenda items from the meeting held in July. This was a telephone conference call. The TAC has four meetings each year, half of which are by telephone. Communication and developments between meetings are by email.

The FFPMRCA examination is a standing agenda item. Dr Grady, the chief examiner, reported on the progress of question writing and feedback, largely positive, received from trainees. Dr Jackson reported on the most recent Examination Tutorials which received excellent evaluation from trainees. The problems of producing an exam reading list were discussed, with concern about liability and endorsement issues.

Dr Plunkett produced a draft document for a FFPMRCA counselling system which would be offered to trainees if they fail the Fellowship exam twice. Small numbers were anticipated. Eventually a web page explaining the process will be produced. Dr Mendis and Dr McGhie have produced, after a survey of RAPMs, a future Pain Medicine Workforce development report. This is full of interesting data such as a prediction of the annual number of Pain Medicine consultant retirements over the next 30 years.

Mr Waeland, Head of Faculties, reported on the results of the Advanced Pain Medicine trainee survey and Dr Miller on an analysis of APT logbook data. In some regions trainees were concerned about lack of access to specialist modules particularly cancer pain, while the logbook data showed considerable variation in sessions attended, number of patients seen and exposure to some training areas. Although training is competency driven, the committee discussed at length whether quality assurance would be improved if guidelines concerning the minimum numbers of APT session attended and the number of patients seen were produced. This will be subject to further discussions with the RAPMs. No immediate changes will be made to the curriculum.

However, I was tasked to make recommendations about cancer pain which was the area of most concern to APT. Palliative Medicine as a specialty was established in 1987 and there have been great changes in cancer symptom control and referral patterns over the last 25 years. However, Pain Medicine still makes a very useful contribution to the management of difficult cancer pain problems. The establishment of good working relationships with the Palliative Medicine team, which may include joint clinics and MDT working are essential. Palliative Medicine trainees have specific Pain Medicine competencies in their curriculum and usually visit Pain Medicine clinics for part of their training. These issues will be discussed with the RAPMs. On average, a trainee should achieve at least 210 Pain Medicine training sessions over 12 months of APT. Many trainees achieve far more than this. I propose a minimum of 8-10% of these sessions should be devoted to cancer pain management, which could be in clinics, inpatient referrals, attachments to hospices, community teams or specialised pain clinics at cancer centres. If you have any thoughts about this proposal please email me directly at mark.taylor23@nhs.net.

Professional Standards

Dr Karen Simpson

FPMPSC Chair

This will be my last contribution to *Transmitter* as Chair of the PSC. I have been on the Board of the FPM since its inception and I have been honoured to be part of the team that has advanced our speciality of Pain Medicine. When I was a medical student in Leeds in 1978 I met a doctor called Ian Clarke who told me about a new discipline called 'chronic pain'; he went to live and work in Canada as a Pain Medicine doctor – he was very brave as it was rare to migrate in those days as most people stayed put! I realised immediately that this was the only career for me. I became an anaesthetist in Bradford as it was a Pain Medicine centre and I was tutored by some of the best. Last week I went to dinner with my old boss Keith Budd who qualified in Leeds in 1962. He has been retired for several years but keeps an eye on Pain Medicine. As a Bradford trainee I watched him in his role as pain clinician and President of the British Pain Society (then called the Intractable Pain Society). His driving ambition was for Pain Medicine to be recognised as a legitimate and respected profession. I hope that I have helped in a small way to turn that concept into reality.

We as Pain Medicine doctors can now hold our heads up high as the only physicians with a Royal College and a national examination in Pain Medicine. This achievement has been hard won and we have a debt of gratitude to the major players in our field many of whom I have had the privilege to know as colleagues and friends over the years.

The doctors who have helped me to realise what an amazing speciality Pain Medicine is are too numerous to mention but include Sam Lipton, Chris Glynn, John Lloyd, Ed Charlton, Michael Bond, Doug Justins, Dave Rowbotham and of course Kate Grady. We must also recognise others with talent for now and the future and I hope that by bringing new members onto the Professional Standards Committee the FPM has done this.

The Communications Working Party under the leadership of Beverly Collett worked well. I am delighted to announce that when I step down as Chair of the PSC Beverly has kindly agreed to take over. I can think of no one better. Her wealth of experience in many roles within and outside the UK has given her unique insight into present and future key issues for Pain Medicine. She has many important links with key organisations and individuals that will shape and influence our specialty over the coming years e.g. NHS England and in government. I know that the PSC could not be in safer hands and I wish her and the committee members well.

I will always be grateful to our administration team who have supported me and the PSC so ably and my last communication could not end on any other note. However I want to pay special tribute to Daniel whose wise counsel and clear thinking have kept me on course through some choppy PSC seas. He always calms the storm and subtly steers the boat often without me even realising. Thanks Daniel!

Ethical Issues in Patient Safety Research

A new WHO publication, *Ethical Issues in Patient Safety Research*, recently published, reflects on the specific ethical questions that can arise in the conduct of patient safety research and improvement activities, and aims to provide clear guidance on how to interpret internationally accepted ethical principles in such contexts.

The publication also includes patient safety and quality improvement activities, not always considered research, but which sometimes contain some ethical risks to patients or providers.

You can access and download the publication at: http://www.who.int/patientsafety/en

e-PAIN

Dr Douglas Justins

e–Pain Clinical Lead

The Faculty of Pain Medicine and the British Pain Society are involved in a joint project to produce an e-learning programme on pain management. Production is well underway and the current plans are for the first modules to 'go live' at the beginning of November 2013 and for an official launch to be held at the Royal College of Anaesthetists on 3rd December 2013.

e-Learning for Pain (e-Pain) is a multiprofessional, multidisciplinary e-learning programme in pain designed to improve the knowledge, skills and attitudes of all staff in the NHS who deal with patients who have acute or chronic pain. It is important to emphasise that e-Pain is not aimed at healthcare professionals who specialise in Pain Medicine or at trainee anaesthetists. Hopefully the programme will help to rectify the well documented deficiencies in generic pain training for many healthcare professionals in the UK and translate this into a step change in the quality, safety, efficacy and patient experience of care in the community and hospital setting.

The development of the e-Pain project utilises the knowledge and skills of the team at the RCoA and its partners who successfully delivered the e-Learning Anaesthesia (e-LA) programme. This team has also delivered the academic medicine module on behalf of the Academy of Medical Royal Colleges.

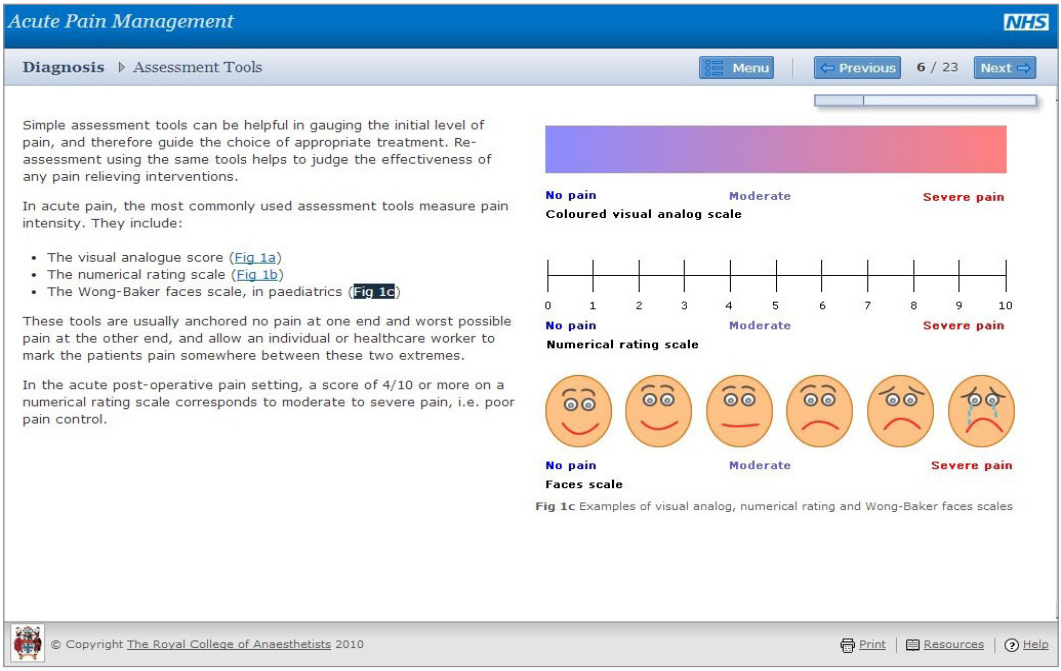
We were fortunate that the e-Pain project was able to be built on the success of e-LA which is now the largest NHS e-learning programme. e-LA is well established and won a prestigious gold award for best online or distance learning project in 2009. Andrew McIndoe and Ed Hammond were the inspirational clinical leads for e-LA and Ed has provided a huge amount of invaluable advice during the development of e-Pain.

e-Pain and e-LA are part of e-Learning for Healthcare (e-LfH) which in turn is part of the Health Education England Programme funded by the Department of Health. We have received excellent support and encouragement from Alan Ryan, National Programme Director of e-LfH and from Julia Moore, National Director of e-LfH. Julia chairs the regular meetings of the e-Pain Project Executive. In addition Nick Cleary has assumed the role of Project Manager for e-Pain and brings all his extensive experience and knowledge from the e-LA project. Management of the e-Pain project at the Faculty is being led by Daniel Waeland, Head of Faculties, and financial aspects are being carefully overseen by Sharon Drake, Director of Education at the College.

A brilliant team of volunteers have been writing and editing the sessions that will provide about 200 hours of on-line learning. We are extremely grateful to them all for the high quality material that they have produced and for their good humour in the face of tight time schedules and other editorial demands. Overall editorial responsibility rests with four clinical leads: Richard Langford, Douglas Justins, David Rowbotham and William Campbell.

e-Pain will present e-learning in 30 minute sessions incorporating verified MCQ assessments and the ability to collect information for CPD recording. e-LA has established an online e-Library consisting of copies of CEACCP (Continuing Education in Anaesthesia, Critical Care and Pain) from the last 12 years. Hopefully we can create something similar for e-Pain so that healthcare professionals can extend their learning beyond the relatively basic level provided in the e-Pain modules; with appropriate links for the different levels of the e-learning content.

For this very general target audience of healthcare professionals the aims of e-Pain are to improve (a) the *recognition* of unrelieved acute and chronic pain, (b) the *assessment* of pain, (c) the *management* of pain, and (d) *patient safety* issues in relation to pain relieving techniques.



Screenshot of the e-Pain programme under development.

The modules cover the following broad topics: basic pain management, basic science, pharmacological treatment, non-pharmacological treatment, acute pain, musculoskeletal pain, neuropathic pain, other chronic pains (e.g. visceral pain), special populations (e.g. children, older people, sickle cell disease) and cancer pain. Pain in pregnant patients forms one session but pain relief in labour is not included for this general target audience. Where possible some sessions have been adapted from e-LA. The number of 30 minutes sessions in each module varies with up to nine being the maximum.

We are now in the process of establishing links with relevant Colleges, Faculties and other appropriate professional groups to ensure that the e-learning approach and the content is widely acceptable to the target audience. Expressions of support in principle for this e-learning initiative for pain have been obtained from the CMOs and CNOs from England, Wales and Northern Ireland and from the Scottish Chronic Pain Steering Group.

Sessions are now flowing from our editors and authors to Nick Cleary and his exceptional instructional designers, Lynne Perry and Liz Boynton, at a steady and encouraging pace.

Our next step as an Executive is to prepare the coming public launch of this project and communicate as widely and effectively as possible with the many multiprofessional colleagues who will hopefully find this resource of great value.

This is an exciting and potentially very important project. The target audience is not trainee anaesthetists or established pain specialists but rather those many, many thousands of healthcare practitioners of all varieties who encounter pain in their patients every day. Module 5a of e-LA covers pain management mapped to the ST1 and ST2 curriculum. The widespread incidence of unrelieved pain and the shortcomings in its management have been highlighted in various reports such as the National Pain Audit so this is a good time to be launching a new educational initiative.

If e-Pain can help to improve the recognition, assessment and safe treatment of unrelieved pain then we will have improved the care of patients in a highly significant way. Once again we offer our grateful thanks to all the authors and editors and to all the other enthusiastic contributors.

Summary of UK Chronic Pain Workforce 2013

Dr Jonathan McGhie

Co-Lead, Workforce project

Dr Victor Mendis

Co-Lead, Workforce project

The Department of Health (DH) and Health Education England (HEE) have commissioned the Centre for Workforce Intelligence (CfWI) to conduct an in depth review of anaesthetic and Intensive Care Medicine (ICM) workforces. The Faculty of Pain Medicine undertook this analysis to inform the initial process of future workforce modelling in Pain Medicine. The final review will make recommendations for achieving a sustainable anaesthetic and ICM workforce in England and will inform workforce planners, commissioners and local authorities.

Method

The 2012 FPM census was used to identify Pain Medicine specialists and centres within the UK. A list of Pain Medicine specialists and referral rates per region was created using new deanery boundaries. Population data per region was extracted from the 2011 national census. Where data was incomplete, Regional Advisors in Pain Medicine (RAPMs) were contacted to confirm the census information. Paediatric and acute pain practitioners were excluded from this analysis. The RCoA Caldicott Guardian released date of birth data for FPM registered Pain Medicine specialists to facilitate calculation of age for the current workforce.

Results

Cumulative data from England, Wales and Northern Ireland was analysed. Data from Scotland was analysed in a separate census. Complete data was returned from 12/15 deaneries (as RAPM regions).

Overall

86% of the population (50.7 million people) was represented within the returned regions, there are 419 chronic pain specialists covering this population =0.8 chronic pain clinicians/100,000 population; 26% of this population was referred as a new patient to chronic pain services in 2011/12 (range 0.17-0.31); the new patient referral rate was 132,422 in 2012, which equals approximately 316 new patients per chronic pain specialist. (Range 203-501 for complete region data); between 2013-2045 there will be an average retirement rate of 13 chronic pain clinicians/year; due to the uneven age distribution of the current workforce, there will be periods when the frequency of retirement exceeds the average rate.

Cautions

Referral rates are calculated on a 52 multiplier of average weekly new patients seen and therefore do not reflect actual patients seen, nor inform upon the nature of clinic templates in each hospital; 27% of age calculations were based upon age at graduation and this will result in a slight underestimate of the age of the workforce; retirement is a personal choice and cannot be predicted fully, in addition pension changes in the UK means that specialists can retire aged 60 until 2020; future consultants retirements will be closer to age 66-68 and therefore this survey should be repeated when pension changes have stabilised.

Discussion

Chronic pain specialist recruitment in England and Wales has been 31.5 posts/year on average. This represents an expansion in workforce, relative to the calculated future average retirement rate of 13 specialists per year. In the absence of a future increase in service provision, a minimum of 13-19 chronic pain specialists/year will need to gain their CCT until 2040.

Summary

There has been expansion in the chronic pain workforce in recent years. It is likely that this will need to continue to meet the needs of the ageing population. Continued output of CCT holders with Advanced Pain Training is advised at current levels (around 33/year) until at least 2017, with an upward adjustment in this figure needed for any additional service reconfiguration.

Problematic Pain

Dr Ann Taylor

Problematic Pain Project Lead

Dr Chris Barker

Chair, BPS Primary&Community Care SIG

Following the English Pain Summit in 2011, the Faculty of Pain Medicine adopted Recommendation A: "*Clear standards and criteria must be agreed and implemented nationally for the identification, assessment and initial management of problematic pain*". This reports on the background and progress to date on the first part of this recommendation: "*Identifying an early warning system to alert clinicians to the potential development of chronic 'problematic' pain, including clear definitions of terms e.g. problematic pain*".

Rationale

In the preparation of a Quality Standard on Pain Management, it is necessary to consider how a GP register may look and function. Simply gathering data on those with 'persistent' or 'chronic non-malignant' pain will be unhelpful for those who manage without the need for regular healthcare input, or those who have acute pain and are at risk of developing chronicity. The already significant burden of pain is likely to increase, and primary care must be proactive in screening for risk and managing established persistent pain. To capture both groups in one GP register, it has been proposed that the term 'problematic pain' be used.

Problematic pain

Existing terms such as persistent pain, chronic pain, acute pain and sub-acute pain describe the chronology of pain but do little to identify the risk or morbidity associated with pain. Currently it is unclear how many clinicians routinely offer diagnostic and prognostic assessment to acute or sub acute pain presentations. In the UK approximately a third of the population suffer from chronic pain, however whilst there is reliable data to indicate the significant morbidity and healthcare usage associated with established chronic pain, there is no reliable data regarding those with chronic pain who do not have significant disability or distress, and who will rarely seek help from a clinician for it. By defining 'problematic pain' it is anticipated that primary care clinicians will be better equipped to correctly identify pre-morbid chronic pain at an early stage, concentrate management strategies for those who are most in need, and refer on for specialist care more appropriately. A proposed working definition for problematic pain is "*pain associated with, or with the potential to cause, significant disability and/or distress*".

Actions

A multiprofessional meeting was held in April 2013 with the aim of planning the processes required and the participants needed to achieve a consensus statement for problematic pain. A further meeting is planned for September 2013 with the following aims:

- To develop a consensus statement that defines 'Problematic Pain'
- To identify standardised, valid and reliable screening tools to address 'at risk' and 'established persistent pain' groups using one system, and delineate core primary care assessment tools.
- To prepare for a Quality Outcome Framework entry
- To develop a Read Code for problematic pain
- To help support educational resources for the Initial Assessment and Management Map of Medicine pathway
- To help develop the e-learning DH pain resources
- To identify future audit processes and research agendas

It could be argued that all pain is problematic; however, not all those with an acute pain presentation develop chronic pain. Additionally there are people who successfully manage their pain and do not see their pain as problematic. In a healthcare system that requires the appropriate cost effective allocation of resource to the appropriate patient, the stratification of risk and need is essential if we are to effectively manage both the incidence and prevalence of this condition.

Neuromodulation in the UK

Dr Ganesan Baranidharan

Pain Consultant, Leeds

Neuromodulation is defined as electrical and chemical modulation of the central or peripheral nervous system to reduce pain. As well as being indicated for the management of chronic pain conditions it is also currently used for other neurological problems such as gut dysmotility, incontinence, movement disorders and epilepsy. This is a very rapidly growing area in medicine.

History

Electrical stimulation goes back to 15AD, when Scribonius Largus, used Torpedo's (aquatic animals capable of electrical discharge) for medical applications. "The live black torpedo when applied to the painful area relieves and permanently cures some chronic and intolerable protracted headaches [...] carries off pain of arthritis [...] and eases other chronic pains of the body." Norman Shealy did the first dorsal column implant in 1967.

What is SCS?

Spinal Column Stimulation (SCS) is a minimally invasive reversible procedure involving either percutaneous or open placement of small electrical wires into the epidural space, connected to a power source. Low voltage electric stimulation helps with managing pain and replaces this with a pleasant paraesthesiae. NICE recognised SCS as a cost effective treatment option for chronic neuropathic pain; this is due for review in 2014/15. SCS is currently used for Failed Back Surgery Syndrome (FBSS), Complex Regional Pain Syndrome (CRPS) and other neuropathic pains.

Innovation

There is constant development in devices available for SCS such as better anchors, electrodes and improved implantable pulse generators (IPG). Such improvements have contributed to reduction in complications including lead migration and have also improved the ability to deliver current to the neuraxis. Traditional tonic stimulation using low frequency current has been challenged by the use of very high (10,000 Hz) frequency stimulation. New electrodes have been devised, enabling safe placement close to the Dorsal Root Ganglion (DRG). These advances have expanded the patient population who can be treated successfully with neuromodulation.

Neuromodulation in the UK

The UK prevalence of neuropathic back and leg pain alone is 5,800 per 100,000 population. Health Technology Assessment (HTA) that guided NICE estimated that at least 4000 patients could gain benefit from SCS. We currently implant around 1000 patients per year in the UK and this is 25% of the estimated chronic back pain population. The availability of this therapy is very variable around the country. The 2010-11 hospital episodes statistics (HES) showed that the number of SCS commissioned ranged from 9-32 per million population. 20 PCTs had never had any patients approved for this therapy compared to some PCTs approving 42 patients per year.

SCS for pain in the UK is offered mainly by pain specialist or neurosurgeons. There are around 60 centres offering this service; only 35 centres perform more than 5 cases per year. The question is how many does a doctor need to do to maintain competency? The funding for this is based on individual funding request (IFR) to the PCT. This process can be time-consuming and might be a reason for some centres not doing many cases. There is emerging evidence on the use of Peripheral Nerve Stimulation (PNS) and Occipital Nerve Stimulation (ONS) to manage pain. IFRs are currently submitted for these but future funding for these treatments remains unclear.

Certain hospitals have agreements with PCTs and can offer this therapy without going through the IFR as long as the patient goes through an agreed pathway. We now have Clinical Commissioning Groups (CCG) that hold the purse string locally and NHS England that funds specialised services. There are plans to have 6 -10 centres approved and paid for by NHS England that can undertake these

complex interventions. Concerns include that the volume and the infrastructure available to deliver this therapy might not be available in all the centres. Will CCGs pay for neuromodulation not performed in a selected specialised centre? These and many more questions are unanswered but will have a significant impact on the delivery of neuromodulation in the future.

National Database

Neuromodulation Society of the United Kingdom and Ireland (NSUKI) is a chapter of the International Neuromodulation Society (INS). A NSUKI and National Institute for Cardiovascular Outcomes Research (NICOR) collaboration will launch a national neuromodulation online database in September 2013. This will enable capture of more information on activity and outcome of neuromodulation. The first dataset is focused on SCS, intrathecal pumps and PNS including Occipital Nerve Stimulation (ONS) for migraine. The second phase is to include deep brain stimulation, sacral nerve stimulation, motor cortex stimulation and gastric stimulation. The audit outcomes of this database will be presented at the Annual Scientific Meeting of NSUKI. Taking part in this data collection will be very useful for centres; it might be essential for their future funding. The clinical governance group includes NICE, Medicines and Healthcare Products Regulatory Agency (MHRA), the Faculty of Pain Medicine and the commissioners.

On-going studies

The NICE technology appraisal on SCS (TA 159) has excluded vascular indications (peripheral vascular disease and refractory angina) as there was insufficient evidence. A randomised controlled study is currently recruiting patients with refractory angina (RASCAL Trial) at Dudley, Middleborough and Basildon Hospitals. The newer innovations of using very high frequency and DRG stimulation is undergoing a Food and Drug Administration (FDA) trial in the United States.

Intrathecal drug delivery

Intrathecal administration of drugs can help in modulating the nervous system. There are various agents available such as opioids, Clonidine, local anesthetics, Baclofen and Ziconotide. The Polyanalgesic Consensus Conference (PAC) held in 2012 is the gold standard for drug selection.

Ziconotide is a cono-pepetide derived from the cone snail species *Conus magus* that is useful in managing neuropathic pain. It is first line according to PAC 2012. There are very few centres in the UK (Leeds, Middleborough) that use this therapy, as an IFR has to be submitted for its use and there is uncertainty how this will be funded in the future. Currently funding is being sought by application to the Adult Specialised Pain Clinical Reference Group (CRG) that advices the Department of Health (DH).

Intrathecal Baclofen is used to control spasticity. There is currently a clear pathway for this and most centers that employ a multidisciplinary treatment approach are able to offer this service.

Conclusions

In summary neuromodulation is a cost effective high-end intervention to manage chronic pain. Future delivery of this service will be determined by the restructuring of the NHS. The CRG that advises the DH will play a key role in establishing the future of this therapy. Smaller units with low volumes of cases might have to work with the bigger centers to deliver this service effectively and safely.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

2013 Trainee Publication Prize

Congratulations to **Dr Oliver Seyfried**, who was awarded the 2013 Trainee Publication Prize for his work on a British Journal of Pain paper on 'Opioids and Endocrine Dysfunction.'

Dr Seyfried will present a short summary of the article at the FPM Annual Meeting on 22nd November 2013 and receive his certficiate. Part of his prize will be the opportunity to attend all the lectures on the day and meet Fellows and Members of the Faculty as well as the Faculty Board.

The Faulty Board wish to thank all of those who entered a publication into the competition.

Details of the next round of the Trainee Publication Prize will be featured in a future issue of *Transmitter*.

Essential Pain Management

Clare Roques

Member of EPM–UK Working Group

Many of you will already be aware of an educational initiative called Essential Pain Management (EPM) that was created by Roger Goucke and Wayne Morriss with the Australian and New Zealand College of Anaesthetists (ANZCA). EPM provides a set of workshops aimed at improving pain management through education in basic principles and the identification of local barriers to delivering effective care.

A vital component is the early handover of the teaching of EPM to the local healthcare workers. A standard EPM course is completed in just 3 days. Initially designed for low resource settings, EPM has now been run in many countries and across several continents, with support from various organisations including ANZCA, the World Federation of Societies of Anesthesiologists and the International Association for the Study of Pain.

I contributed to a set of EPM workshops in Malaysia, Douglas Justins taught on an EPM course in Myanmar and Jonny Rajan, an anaesthetic trainee, assisted on an EPM course in Nepal. The Association of Anaesthetists of Great Britain and Ireland (AAGBI) supported both Douglas and Jonny's trips to Asia. A series of EPM workshops, generously sponsored by the British Pain Society (BPS) and the AAGBI Foundation, will be run in Mulago Hospital, Kampala, Uganda, later this year.

The increasing worldwide popularity of EPM workshops and the need to spread the workload has led to the creation of a UK-based EPM Working Group which has the support of the Faculty of Pain Medicine Board, the BPS Council and the EPM Sub-Committee of ANZCA. The remit of this working group, led by Douglas Justins, Kate Grady and myself, is to coordinate future EPM workshops to be run by UK based instructors in parts of Africa in the first instance. More specific details regarding the EPM workshops, including some sample, basic, course materials are available at http://www.anzca.org.nz/fpm/fellows/essential-pain-management.

If you have contacts in Africa or experience of teaching in Africa, we would love to hear from you.

EPM-UK CALL FOR VOLUNTEERS

We are looking for UK based instructors who are interested in teaching pain management in an overseas setting.

Please contact Dawn Evans at the FPM via fpm@rcoa.ac.uk if you are interested in finding out more about this project or would like to be included in future correspondence related to the work of the UK EPM Working Group.

New shingles vaccination and surveillance system for shingles and post-herpetic neuralgia

Dr Iain Kennedy

Public Health England

A new vaccination programme against shingles aimed at individuals aged 70 and over has been introduced across the UK. Public Health England (PHE) are leading on the disease surveillance and vaccine programme monitoring in England, including, with support of the British Pain Society, the burden of post-herpetic neuralgia (PHN) in pain clinics.

Epidemiology

Shingles (herpes zoster) is caused by reactivation of varicella zoster virus which has remained latent in sensory ganglia. Incidence increases with age, and it is also more common in those with immunodeficiency. It is estimated that 50,000 over 70s develop shingles every year in England and Wales. Whilst it is often mild and self-limiting, it can be devastating in the elderly with 1 in 1,000 cases in the over 70s being fatal[1]. PHN, defined as persistence of pain for an extended time following shingles infection, is a severe complication. There is no strict definition of 'extended time', though it is often taken to be 90 days. There are approximately 14,000 cases of PHN in over 70s each year in England and Wales. Age is the strongest predictor of PHN following shingles. PHN treatment is included in the 2013 Guidance on management of pain in older people[2].

Shingles vaccination programme

A live attenuated vaccine was licenced in 2006, and in 2010 the Joint Committee on Vaccination and Immunisation (JCVI) recommended its inclusion in the UK routine immunisation programme. The vaccine will prevent shingles in some people, and in vaccinated people who develop shingles, disease severity will be reduced. Clinical trials reported that the vaccine reduced the incidence of PHN by 66.8$_3$. The new vaccination programme started on 1st September 2013, and all patients who were 70 years on that date (born between 2nd September 1942 and 1st September 1943), are eligible to receive the vaccine this year. There is also a catch-up campaign running, which this year will focus on those aged 79 years on 1st September (born 02/09/1933 to 01/09/1934).

Surveillance

PHE has a statutory duty to monitor communicable disease and the impact and effectiveness of new vaccine programmes. However, because shingles is primarily a clinical diagnosis, and is not notifiable, PHE relies on clinicians participating in voluntary surveillance schemes. One aspect of the new surveillance system is monitoring PHN which has required referral to pain clinic services for management. At the end of August, PHE wrote to pain clinics across England asking for expressions of interest in the PHN surveillance system and for important background information on the structure and function of pain clinic services. Prospectively, participating clinics will be asked to complete a simple 'postcard' data return of counts of PHN seen, similar to the longstanding system used by the British Paediatric Surveillance Unit[4]. Participating clinics who report cases of PHN will then be asked to complete a short enhanced questionnaire on cases so that the vaccine programme's success can be monitored effectively. PHE will also be working with GP colleagues, and reviewing other data sources from primary and secondary care to monitor shingles disease incidence, incidence of PHN, vaccine coverage, effectiveness and vaccine failure. Surveillance of PHN seen in pain clinics is an important part of this new surveillance programme.

If your clinic has not yet had the opportunity to become involved in the surveillance programme, or if you have any other questions about the shingles vaccine, please get in touch. The shingles team can be reached on shingles@phe.gov.uk.

1. Joint Committee on Vaccination and Immunisation Statement on varicella and herpes zoster vaccines 29/03/10. http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@ab/documents/digitalasset/dh_133599.pdf
2. 2 Guidance on the management of pain in older people. Age and Ageing; 42: i1-i57. Oxford University Press 2013 Doi 10.1093/ageing/afs200
3. Oxman MN and Levin MJ (2008) Vaccination against Herpes Zoster and Postherpetic Neuralgia. J Infect Dis 197 Suppl 2 S228-36
4. http://www.rcpch.ac.uk/what-we-do/bpsu/british-paediatric-surveillance-unit

Go west young man. Go west!

Dr Gerry Browne

RAPM, Northern Ireland

Northern Ireland is the smallest of the regions in the United Kingdom. Due to our location you have to fly, sail or swim to reach our shores. At our widest we stretch for 110 miles, maximal elongation is 80 miles measuring just 5400 square miles in total. It is however well worth the journey – just ask the G8 summiteers, they came this year amid great fanfare to County Fermanagh. There are many local treasures including the North Antrim coast, the Giant's Causeway, the Titanic Quarter and this year's City of Culture – Derry/Londonderry.

The population of Northern Ireland is 1,800,000 (2011 census) and we have apparently the highest incidence of chronic pain in the UK at approximately 19% of the adult population. We number 16 Consultants who provide Pain Medicine services, the vast majority retaining some anaesthetic sessions. As well as an RAPM (me!) there are four appointed LPMESs – most of us are 'home grown' though we do have colleagues from further afield.

> **"The population of Northern Ireland is 1,800,000 and we have apparently the highest incidence of chronic pain in the UK at approximately 19% of the adult population"**

Our School of Anaesthesia is very supportive of chronic Pain Medicine as a speciality, encouraging those who wish to undertake HPT along with our allocation of one APT placement per annum. We encourage our Advanced trainees to look for further training opportunities across the UK either as day release or as a short attachment and would welcome the possibility of 'exchange fellows'.

At present we have no formal basic Pain Medicine research but maintain local audits and projects. There is an MSc in Pain Management at Queen's University, Belfast. In addition, active participation and feedback continues between Pain Medicine Consultants and patients via PANI (Pain Association of Northern Ireland). We currently do not have PCTs but are managed by five Trusts notionally divided across four board areas.

There is a vibrant local multidisciplinary pain society – the Northern Ireland Pain Society (NIPS) which holds regular meetings during term-time and an annual study day.

Geographically our closest academic link is with the Irish Faculty of Pain Medicine, many of our Consultants being founding Fellows. I am an elected member of that Faculty's Board. Some of the preparation of this article was conducted on the 2 hour train journey linking Belfast and Dublin.

The Irish Pain Faculty Annual Scientific Meeting attracting world class speakers is within easy reach and in February 2014 will hold a joint meeting with NSUKI - a definite date for any calendar. We also have had and will further explore joint meetings with our colleagues in the west of Scotland.

In the near future, the amalgamation of three Pain Medicine Clinics in Belfast will be completed and should then provide, for the purposes of training the Pain Medicine Fellow and Higher trainees, a hub with spokes radiating to other Pain Medicine Clinics, thus further improving our multidisciplinary approach to chronic Pain Medicine.

Whilst not wishing to single out any individual it would be remiss not to congratulate Dr William Campbell, current President of the British Pain Society, who has been active with NIPS since its inception and is responsible for its logo (visible on some notepaper and ties of a certain vintage).

In summary we are a small (growing) band of dedicated Pain Medicine practitioners – keen to educate and be educated and like our ex-world boxing champion 'The Pocket Rocket', we pack a strong pain punch.

Regional Update

Dr Barry Miller

RAPM Chair

"And now, the end is near..."" — *Paul Anka*

This is my last piece as Chair. Two years is too short a time to get to know, even, the two dozen or so of my fellow RAPMs, but it has been a thoroughly enjoyable experience to be at the front line of Pain Medicine education. I would recommend it to anyone.

My thanks especially to Daniel Waeland, Anna Ripley, James Goodwin, Dawn Evans and Maria Burke at the Faculty, whose constant reminders, cajoling, pleading emails and agitated phone calls enabled me to keep (mostly) to deadlines, and remind me what it was I was supposed to be doing.

The summer months seem a relatively peaceful time, from the BPS meeting in Spring to the Autumn Faculty meeting (November 14th - is it in your diary? Have you requested the Professional Leave?): it might seem that not much happens, but this is an illusion. Change is always around.

The 3Cs – Change, Cancer & Cheerleaders

The Faculty came into being at the same time that curricula in post graduate medical training were being re-written with the (then) new training board, PMETB. This created a unique opportunity to take the various *ad hoc* ideas from around the UK and beyond and fashion the shape and core of Pain Medicine training, with the RAPMs as local architects.

This potted history conceals three important issues: The first is that the curriculum is not 'set in stone'. There have been a number of additions since its first publication, which may be found in newer versions of the document, or in 'curriculum updates' and it is important for RAPMs, LPMESs and Trainees to keep an eye on the curriculum links and check whether changes affect them. The most recent (April 2013) gives guidance on the perennial issue of 'diagnostic skills', which were emphasised in recent BPS talks, publications and in Faculty debates.

The second is that the curriculum is an open document designed to encourage teachers and trainees alike to review local training schemes looking for strengths and weaknesses. One area highlighted recently is that of training and links with Palliative Care. Even at Intermediate level, cancer pain is recognised as an essential component to education. There are important differences in short and longer term cancer pain management that face the anaesthetist in the theatre environment and the Pain Physician in clinic or by request. We are justly recognised as the experts in complex pain management, with a wider base of skills than any other group involved in its treatment. It is essential, certainly in Higher and Advanced levels that interactions, particularly with palliative care, are fostered and incorporated into training, and this is especially important when the core training site(s) may have limited palliative interactions. This is a task of the RAPM, working with the local school, deanery and Training Programme Director to help organise; but it is also the duty of the trainee.

The third is the essential role of the RAPM as ambassador. Like Professor Dumbledore (of Harry Potter fame), although the organisation of training is the core requirement, acting as an envoy for the profession is of almost equal importance. Reviewing new job plans, giving advice to trainees and post-CCT enquirers, considering whether to act as a college assessor, attending career days (undergraduate, postgraduate or anaesthetic). These, and other, activities help to keep us on the map; to recruit to the future, to make our case.

Last Word

Communication – I may have mentioned this one, or twice, or more, before, but it remains the cornerstone of our profession; with our patients and our colleagues. My inbox receives more and more emails every month, and I want to encourage this. There is no question that doesn't deserve to be heard and answered. Keep them coming.

Well, that should keep my successor occupied :)

Trainee Update

Dr Emma Baird

Faculty Trainee Representative

I hope you all had a good summer. Thank you to everyone who took the time to fill in the trainee survey. We have collated the results (anonymously) and have presented them to the Training and Assessment Committee. When analysing the results it is important to note that by anonymising it we are dealing with national rather than local problems and that we only had a response from about a third of all Higher and Advanced Pain Trainees. I have outlined the most important issues below and how the Faculty intends to try and address them.

No formal teaching sessions were accessible to 20% of those trainees that responded. The majority of trainees did feel that they get adequate informal teaching within the clinical setting. TAC will encourage the Regional Advisors in Pain Medicine (RAPMs) to set up teaching sessions and consider the feasibility of cross regional teaching. A quarter of trainees believe they have an inadequate case mix with some suggesting up to 90% of their cases are in a single pain area (non-malignant back pain). A number of trainees are also having trouble accessing adequate training in specialist areas of Pain Medicine:

- **Spinal cord stimulators** – 26 % had no access
- **Paediatric pain** – 66 % had no access
- **Intrathecal drug delivery** – 57 % had no access
- **Cancer pain** – 31 % had no access
- **Psychology services** – 31 % had no access

Training centres will be evaluated every 3 years to ensure that each region retains adequate access to all pain services. The TAC was especially concerned about the lack of access trainees have to cancer pain and are encouraging the RAPMs to establish relationships with local Palliative Medicine services.

The Faculty are going to publish guidance on the minimum number of cases that trainees need to see during their Advanced year. It believes that the case mix and clinical experience is more important than the number of patients seen but will consider providing an amendment to the curriculum in April 2014 to include a minimum number. This number will be based upon trainees carrying out 5 sessions of pain related activity per week for 42 weeks of the year (210 sessions).

A third of trainees believe they do not get to see an adequate number of follow up patients. This they attribute partly due to the EWTR and moving hospitals every 3-6 months. A further 20% of trainees do not believe they get enough hands on procedural experience. The number of pain procedure sessions trainees should be aiming to undertake during their Advanced year will be included in an amendment to the current curriculum. The Faculty will not be including a set procedure list as exposure to different types of procedures varies around the country. It is felt that some of the procedural skills for specific Pain Medicine Consultant roles may need to be developed post-CCT.

Other issues raised in the 'free comments section' included not having enough time for audit and having little opportunities for research. However, although 44% of trainees believed that on-call commitments impacts on their Pain Medicine training "a lot" many trainees reiterated that they would not want to lose the anaesthetics on-call commitment as they felt that they would become too de-skilled. There were minor concerns about obtaining a Consultant post in Pain Medicine although evidence from AACs indicates that the number of Pain Medicine Consultant jobs coming up for recruitment remains steady.

The results made interesting reading and as you can see the Faculty have taken your opinions very seriously. Hopefully with your input the Faculty can continue to shape the future of pain training to rival that offered by more established faculties. If we carry out further trainee surveys we will need full engagement from everyone and a near to 100% response rate to be able to make useful longitudinal data which allows us to keep the results anonymous but still highlight specific post and hospital issues.

Revising for the FFPMRCA Examination

A personal view from a Pain Medicine Trainee

Dr Graham Simpson

Pain Medicine Trainee

As a recent graduate of the FFPMRCA examination I have prepared a list of some useful resources for future candidates to consider. The FFPMRCA is a formidable challenge for a number of reasons. Relative to other postgraduate exams the FFPMRCA requires us to acquire depth and breadth of knowledge in a relatively short space of time, and arguably over a much wider field. A Google search of 'pain' yields 548,000,000 results, versus 6,960,000 for anaesthesia. I also found the Pain Medicine literature a lot harder to navigate than the (possibly) more defined area of anaesthesia, and therefore found it difficult to know where to begin. My goal was to aquire as much detail and knowledge as possible, as efficiently as possible, and to try and limit the impact of studying on day to day life.

I have listed the books that I used to study for the exam. They comprised a core of short books, backed up by the larger textbooks. The shorter books formed the basis from which I could search further into a topic if I felt I needed more information, or had unanswered questions.

Short texts

Oxford Pain Management Library

The Oxford pain management library formed the backbone to my learning and subsequent revision. Each text is short, easily readable, and has a wealth of information. Although they do not quite provide everything you need to know, there is a great deal of expertise behind them, and they provide a good structure and foundation of knowledge.

Acute Pain edited by Lesley Bromley and Brigitta Brandner.

Cancer-related breakthrough pain edited by Andrew Davies.

Chronic Pain edited by Andrew Dickman and Karen H. Simpson.

Opioids in Cancer Pain edited by Karen Forbes.

Opioids in Non-Cancer Pain by Cathy Stannard, Mike H. Coupe, and Tony Pickering.

Pain in Older People edited by Peter Crome, Chris Main, and Frank Lally.

Migraine and other Primary Headaches edited by Anne MacGregor and Rigmor Jensen.

Neuropathic Pain edited by Michael Bennett.

Medium size texts

Spinal Interventions in Pain Management (Oxford Specialist Handbooks in Pain Medicine) - K Simpson, G Baranidharen and S Gupta.

A concise yet very informative book relating to our needle based interventions.

Essential reading.

Core topics in Pain medicine – Sian Jagger

I found this an excellent resource for learning neurobiology. Each chapter is relatively succinct, but with a suitable level of complexity. I recommend this book to form the basis of neurobiology knowledge.

Neuroanatomy – Crossman & Neary

I first used this book at medical school. It is very readable in a short space of time, and a good refresher on the different neural pathways.

Evidence Based Chronic Pain Medicine – Stannard

An excellent book. There are superb chapters on the challenges of research in Pain Medicine, and each clinical chapter has a good summary of the available evidence.

Pain Refresher 2012 – Irene Tracey

No better place to go for an up to date overview of Pain Medicine. Again there is a wealth of knowledge inside but I had to order it from the USA. (a colleague who went to the IASP in Milan last year may have a copy).

IASP pharmacology

This text is very heavy on detail and needs to be read in a quiet room without distraction. I found the chapters on paracetamol and NSAIDS particularly useful.

Large reference texts

Textbook of Pain (Melazack and Wall) 5th/6th Edition

I only really started to venture into this textbook in the last two months before the exam. The new edition is very nicely laid out in my opinion, and much easier to navigate than previous editions. I thought the psychology chapters in the 5th edition gave me the best understanding of the psychological principles of anything else I had read.

Waldmans Textbook of Pain

This textbook has a more biomedical approach. The chapters are short, and give a good account of clinical syndromes presentations. The neurobiology chapters at the beginning of the book complement previous reading.

Clinical Pain Management Series

This is a four volume series of textbooks from Hodder-Arnold Publishing, which are nicely laid out and easily readable. I found the chronic pain textbook very good for neurobiology and clinical topics, which are very detailed and informative. The clinical chapters were probably one of the most important parts of my revision for the viva.

Online resources

www.paincommunitycentre.org is a pain education website developed by Cardiff University. There is a number of excellent expert lectures on topics in Pain Medicine, and I recommend this website to everyone. www.pain-topics.org is another excellent resource based in the USA. It has links to a number of journal articles and guidelines.

Journals and other resources

Best to look for Cochrane reviews, meta-analyses, and review articles. There are a number of NICE guidelines, clinical guidelines (e.g. CRPS, headache), and publications available from the Faculty of Pain Medicine, IASP, and BPS, which are relevant for the exam and a must read.

Conclusion

When I started studying towards the FFPMRCA exam, it felt at times like standing in the desert without a compass. By starting with the shorter textbooks and working my way up, the subject (especially the neurobiology), started to become strangely familiar. Soon it began to dawn on me, just how intriguing and fascinating Pain Medicine is, and how lucky we are to have chosen this sub-specialty. Those who haven't had the privilege of studying or practicing Pain Medicine, think I've gone mad.

Examination Calendar August 2013 – July 2014

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees not accepted before		Monday 21 Oct 2013	Thursday 12 Sep 2013	Thursday 23 Jan 2014
Closing date for FFPMRCA Exam applications		Thursday 5 Dec 2013	Thursday 26 Sep 2013	Thursday 27 Feb 2014
Examination Date		**Wednesday 15 Jan 2014**	**Tuesday 15 Oct 2013**	**Wednesday 2 Apr 2014**
Examination Fees		*£485*	*£690*	*£690*

Examination Calendar August 2014 – July 2015

	FFPMRCA MCQ		FFPMRCA SOE	
Applications and fees not accepted before	Monday 23 Jun 2014	Monday 5 Nov 2014	Thursday 4 Sep 2014	Thursday 19 Feb 2015
Closing date for FFPMRCA Exam applications	Thursday 18 Aug 2014	Thursday 18 Dec 2014	Thursday 25 Sep 2014	Thursday 26 March 2015
Examination Date	**Wednesday 3 Sep 2014**	**Wednesday 4 Feb 2015**	**Tuesday 21 Oct 2014**	**Tuesday 28 Apr 2015**
Examination Fees	*TBC*	*TBC*	*TBC*	*TBC*

Faculty Events

Dr Sanjeeva Gupta

Educational Meetings Advisor

Dr Shyam Balasubramanian

Deputy Educational Meetings Advisor

The Faculty organises educational events to cover all the important revalidation and examination topics in Pain Medicine. On behalf of the Faculty we would like to thank all the speakers who have contributed to these events. We would also like to thank the delegates who made the past educational events successful.

The Annual Meeting of the Faculty is on the 22nd November 2013. Eminent speakers will be delivering on: persistent post-surgical pain, pain management in primary care, medico-legal issues in chronic pain management, whiplash injury and cancer pain management.

The programme also includes the Patrick Wall Lecture, an update on the developments in the Faculty and an interesting debate on 'The role of opioids in functional pain syndromes'. As well as a useful updates day, it is an opportunity for Pain Medicine doctors to get together with other members of the Faculty and the Faculty Board.

The Faculty also conducts the FFPMRCA Examination Tutorial series. Dr Mark Jackson is organising the next tutorial on the 11th October 2013 at the RCoA London. Please visit the FPM website for more information.

Your attendance, contribution, and feedback are essential to the success of all the events. Please find below some of the feedback from the previous meetings.

Pencil your diary for the future study days which include 'Acute Pain Management' on 3rd February 2014 and an interactive workshop on 'Diagnostic investigations in Pain Medicine' on 4th February 2014.

These events provide a forum for networking with peers and experts in the field, as well as making an important contribution to your CPD. More detail on event registration is available at: http://www.rcoa.ac.uk/faculty-of-pain-medicine/news-and-events.

Contact:
SGupta6502@aol.com
doctorshyam@hotmail.com
sandeshakothari@nhs.net

Comments from previous events

Opioids in Persistent Non-Cancer Pain - The Future (June 2013)

"Engaging"
"Really informative, particularly the case-based discussions"
"Case discussions were excellent"

Core Competencies in Mental Health (January 2013)

"Very relevant topics. Presentations and workshops were outstanding"
"Excellent coverage of the subject"
"A good insight into how another specialty can interact with my service"

Managing the Pain Service (January 2013)

"Very useful especially for trainees to prepare for the consultant role"
"Extremely useful array of talks"
"Excellent programme, good speakers and relevant topics"

FPM response to NICE Draft Clinical Guideline:

The pharmacological management of neuropathic pain in adults in non-specialist settings (June 2013)

Professor Andrew Rice

Faculty Respondent

In June 2013 NICE released for comment their draft clinical guideline (CG) for the management of neuropathic pain in non-specialist settings. This is a very brief summary of the draft guidance and the Faculty's response.

Summary of draft guidance

This is an update to CG 96 (2010), which was required in order to take into account new evidence and make attempts to correct some deficiencies in the 2010 guidance. The guidance was formulated using conventional CG NICE methods – a discussion of the pros and cons of that approach is beyond the scope of this summary. Suffice to say, that the draft CG is founded upon an extensive systematic review and meta-analysis of the literature. A more extensive attempt to analyse health economic data is made than was the case in 2010.

Importantly, the draft CG makes key recommendations pertinent to principles of care and suggests pragmatic criteria for referral to specialist care. These include: people in severe pain, when pain significantly limits daily activities or a deterioration in the underlying health condition. Whilst these seem sensible, it is difficult to make such robust recommendations about care pathways from a position of limited evidence. Recommendations are also made about the process of initiating and monitoring treatment..

> **"The draft CG is founded upon an extensive review and meta-analysis of the lierature. A more extensive attempt to analyse health economic data is made than was the case in 2010"**

The draft CG recommends that for all neuropathic pain (except trigeminal neuralgia) amitriptyline, gabapentin or nortriptyline be used as initial treatment, with duloxetine or pregabalin as second line. This is a departure from the 2010 position. The CG recommends tramadol for acute rescue therapy only and low concentration capsaicin cream for localised neuropathic where there is reason to avoid oral treatment. For trigeminal neuralgia carbamazepine is recommended as the initial treatment.

The draft CG specifically recommends against non-specialist treatment of neuropathic pain with cannabis extract, high concentration capsaicin patch, lacosamide, lamotrigine, levetiracetam, oxcarbazepine, topiramate and venlafaxine.

The Faculty response

I completed the Faculty response with the benefit of international and primary care input from colleagues on the International Study of Pain Specialist Interest group on Neuropathic Pain (NeuPSIG) Treatment Committee and others.

The Faculty made extensive comments and a summary of selected responses are listed below. The full response can be accessed at www.fpm.ac.uk.

- The Faculty welcomes this CG, which addresses a complex condition and which provides accessible guidance for non-specialists.
- The Health Economic analysis is particularly detailed, in contrast with the previous version. However, there is concern that this is based on several unjustified assumptions.
- The whole CG, including clinical and health economic evaluation, is notable for the repeated statements to the effect that evidence is generally "poor" or "very poor" and therefore that conclusions must be limited. Many of the conclusions therefore rely on the consensus of the GDG, rather than on high quality evidence; we note that only one GDG member and a co-opted expert have a significant publication record in the field.
- We are concerned that no attempt was made to access evidence from the considerable number of unpublished trials in this field nor to assess the impact of publication bias.

- The analysis appears to be based upon the assumption that placebo response size is fixed and consistent across trials. Scrutiny of the trials clearly demonstrate that this is not the case. Therefore, we are concerned by the use of this flawed assumption and the impact on the analysis. Placebo treatment for pain is not the same as no treatment.

- The statement, and consequential detrimental effect upon the analysis decisions, that "similar underlying causes of neuropathic pain could be expected to respond to treatment analogously" is simply inaccurate and contrasts with available evidence on the topic. However, we acknowledge that the decision to "lump" or "split" evidence obtained from trials conducted in different conditions is not easy and that a pragmatic approach may be justified when providing guidance for non-specialists. We are pleased however, that a decision was made to separate trigeminal neuralgia, but suggest that the issue of condition specific responses be highlighted; this is particularly important where there is evidence of a lack of effect of recommended treatments (e.g. HIV neuropathy).

- Whilst reports of clinical trials and meta-analyses are usually based on group average response to analgesics; recognition of the importance of variations in individual patient responses should be made. The inference for this CG is to be quick in switching between drugs in the event of apparent non-response in an individual patient.

- We are concerned that the CG appears to require that "all three" first line drugs (amitriptyline, gabapentin, nortriptyline) be tried before a switch to duloxetine or pregabalin. This could take 6 months or so and it does not seem logical to switch from nortriptyline to amitriptyline in the event of absent benefit or side effects before moving on to second line drugs.

- We are concerned that where cannabis is mentioned (although we recognise that the CG does not recommend use of this drug by non-specialists) that no mention is made of the appreciable risk of precipitating psychosis, schizophrenia and other mental illness with cannabis use.

- The issue of poor tolerability of amitriptyline in the elderly, especially sedation and falls could be better highlighted. Similarly for non-specialist use there should be clear guidance on advice regarding driving etc. with all the drugs recommended.

- Whilst allodynia and hyperalgesia do indeed sometimes occur in association with neuropathic pain, the more frequent presentation, especially with polyneuropathies, is pain in the context of sensory loss.

- CRPS 1 is not a neuropathic pain condition according to IASP definition used. CRPS 2 is.

- "Mixed neuropathic pain" is not a diagnosis we understand.

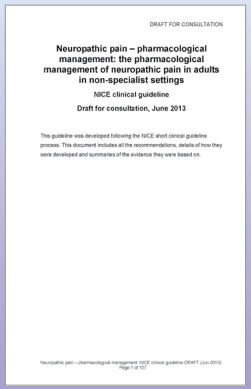
- The "underlying cause … is not always known" by non-specialists, yet even a diagnosis of "Possible Neuropathic Pain" (a lowest sub-category of the IASP definition quoted in the guideline) requires:

  1. Pain with a distinct neuroanatomically plausible distribution; and
  2. A history of a relevant lesion or disease affecting the peripheral or central somatosensory system.

  This CG therefore needs to clarify importance of appropriate diagnosis of neuropathic pain before applying the recommendations.

- CG is for non-specialist settings, the included trials were usually conducted in specialist settings: It would be helpful to highlight this confound.

Professor Andrew Rice is a Professor of Pain Research at Imperial College London and an Hon. Consultant in Pain Medicine at the Chelsea and Westminster Hospital NHS Foundation Trust.


DRAFT FOR CONSULTATION

Neuropathic pain – pharmacological management: the pharmacological management of neuropathic pain in adults in non-specialist settings

NICE clinical guideline

Draft for consultation, June 2013

This guideline was developed following the NICE short clinical guideline process. This document includes all the recommendations, details of how they were developed and summaries of the evidence they were based on.

Neuropathic pain – pharmacological management: NICE clinical guideline DRAFT (Jun 2013) Page 1 of 157

The full NICE draft guidance document is available now online and can be accessed at:

http://www.nice.org.uk/nicemedia/live/13566/64189/64189.pdf

NHS
National Institute for Health and Clinical Excellence

Faculty Update

New Fellows

Dr Andrezj KROL
Dr Yvetter COLDICOTT
Dr Senthil JAYASEELAN
Dr Jan RUDIGER
Dr Manish GUPTA
Dr Emma BAIN
Dr Sami ALAWAD
Dr Juan GRATEROL GRATEROL
Dr Yarolsav STEFAK
Dr Lisa MANCHANDA

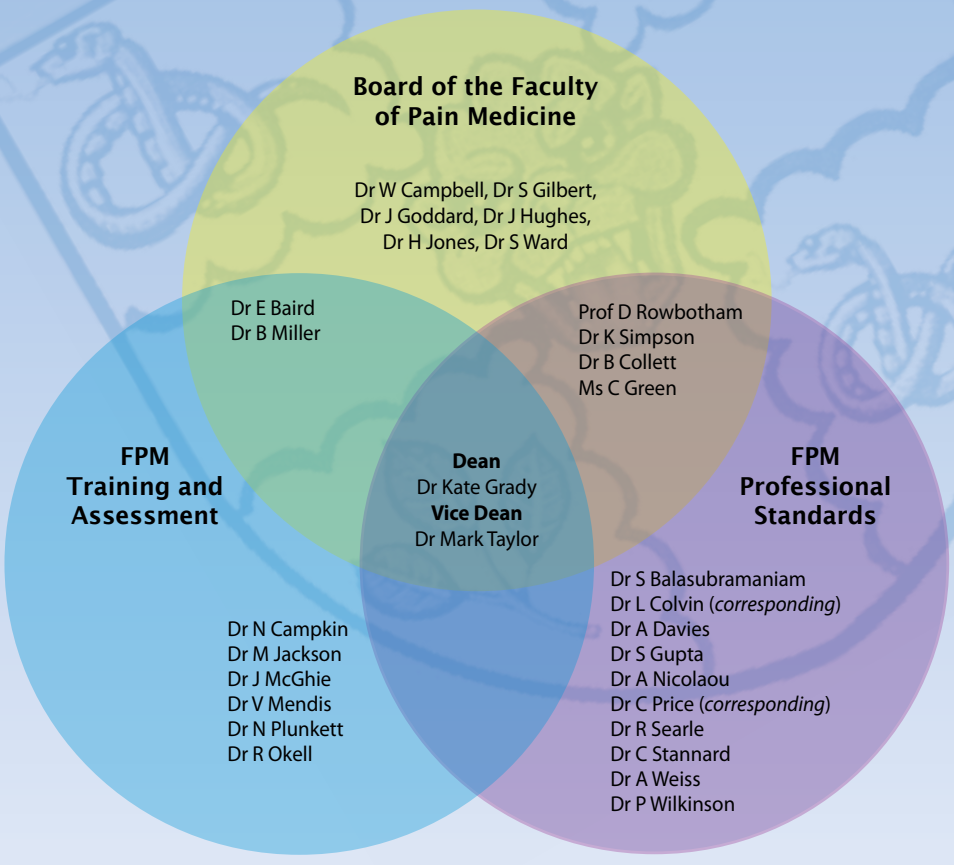
New Associate Fellows

Dr Anil SONI
Dr Blair Hamilton SMITH

New Members

Dr Madhusudana NAGARAJ

Committee Membership



Faculty of Pain Medicine 6th Annual Meeting:

Recent Advances in Pain Medicine

Friday 22nd November 2013

9.30 to 10.00	Registration
10.00 to 10.30	Persistent post-surgical pain (2E01,3E00) *Dr Robert Searle, Cornwall*
10.30 to 11.00	Pain management in Primary Care (3E00) *Professor Blair Smith, Dundee*
11.00 to 11.15	Discussion
11.15 to 11.40	Refreshments
11.40 to 12.10	Medico-legal issues in chronic pain management (1I04, 1I05) *Dr K Markham, Surrey*
12.10 to 13.00	Patrick Wall Lecture *Professor Martin Koltzenburg, London*
13.00 to 13.50	Lunch
13.50 to 14.00	Award of Fellowship by Election
14.00 to 14.40	Debate: 'Opioids have a role in functional pain syndrome' (2E02, 3E00) *For: Dr T Vasu, Bangor; Against: Dr A Rayen, Birmingham*
14.40 to 15.00	Whiplash Injury (3E00) *Dr S Kapur, Dudley*
15.00 to 15.15	Discussion
15.15 to 15.30	Refreshments
15.30 to 16.00	Cancer pain management - basic principles and interventions (1A02, 3E00) *Dr J Antrobus, Warwick*
16.00 to 16.15	Trainee publication prize
16.15 to 16.30	Developments: FPM
16.30 to 17.00	Discussion and close

Programme organised by Dr Sanjeeva Gupta and Dr Shyam Balasubramanian

RCoA, London
5 CPD Points
£185 for Consultants, £135 for trainees.
Code: B08

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Faculty of Pain Medicine Study Day:

Acute Pain Management

Monday 3rd February 2014

09.00 – 09.30	Registration
09.30 – 10.00	Effective Acute Pain Management – Identifying the Challenges *Dr Namita Singh, Scunthorpe*
10.00 – 10.30	Pain Management in the Opioid Dependent Patient *Dr Cathy Stannard, Bristol*
10.30 – 11.00	Pain Management in the Paediatric Patient *Dr Davandra Patel, Manchester*
11.00 – 11.15	Discussion
11.15 – 11.35	Refreshments
11.35 – 12.05	Pain Management in the Obstetric Patient *Dr N Lucas*
12.05 – 12.35	Pain Management in the Morbidly Obese Patient *Dr A Mallick*
12.35 – 12.50	Discussion
12.50 – 13.50	Lunch
13.50 – 14.20	Enhanced Recovery after Hip and Knee Arthroplasty – *The Oswestry Success Story - Dr John, Oswestry*
14.20 – 14.50	Enhanced Recovery after Surgery – What's Regional Anaesthesia got to do with it? D*r Matthew Checketts*
14.50 – 15.05	Discussion
15.05 – 15.25	Refreshments
15.25 – 15.55	Evidenced Based Postoperative Pain Management: what's it all about? *Dr Barrie Fischer, Redditch*
15.55 – 16.25	Ultrasound Guidance for identifying Epidural Space – The Hows and Whys? *Dr Vijay Kumar, Scunthorpe*
16.25 – 16.40	Discussion
16.40	Closing remarks

Programme organised by
Dr Namita Singh

RCoA, London
5 CPD Points
£165, £135 for trainees.
(book along with the 4th February for a reduced rate of: £315, £255 for trainees)
Code: B28

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Faculty of Pain Medicine Study Day:

Diagnostic Investigations in Pain Medicine

Tuesday 4th February 2014

9.00 to 9.30	Registration and coffee
9.30 to 9.40	Introduction
9.40 to 10.10	Role of Investigations in Pain Medicine *tbc*
10.10 to 13.00	Three workshops of 50 minutes each (case-based discussions / problem solving exercises) Groups to rotate:
10.10 to 11.00	Indication & Interpretation of a Normal and Abnormal MRI Scans *Dr Chandramohan, Consultant MSK Radiologist, Bradford*
11.00 to 11.20	Refreshments
11.20 to 12.10	Indications & Interpretation of a Normal and Abnormal CT Scans *Dr C Groves, Consultant MSK Radiologist, Bradford*
12.10 to 13.00	Indications for X-rays, Bone Scan, Ultrasound scan in Pain Medicine *tbc*
13.00 to 13.45	Lunch
13.45 to 16.20	Three workshops of 50 minutes each (case-based discussions / problem solving exercises) Groups to rotate:
13.45 to 14.35	Nerve Conduction studies: Indications and limitations. *tbc*
14.35 to 15.25	Ultrasound guided diagnostic procedures for neck and shoulder pain *Dr A Krol, London*
15.25 to 15.40	Refreshment
15.40 to 16.30	Ultrasound Guided Diagnostic Blocks *Dr S Balasubramanian, Coventry*
16.30 to 16.50	Discussion, Feedback and close

Programme organised by Dr Sanjeeva Gupta and Dr Shyam Balasubramanian

RCoA, London
5 CPD Points
£165, £135 for trainees.
(book along with the 3rd February for a reduced rate of: £315, £255 for trainees)
Code: B28

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

The Faculty of Pain Medicine
of The Royal College of Anaesthetists

Churchill House
35 Red Lion Square
London WC1R 4SG

tel: **020 7092 1727** or **020 7092 1746**
email: **fpm@rcoa.ac.uk**

www.fpm.ac.uk