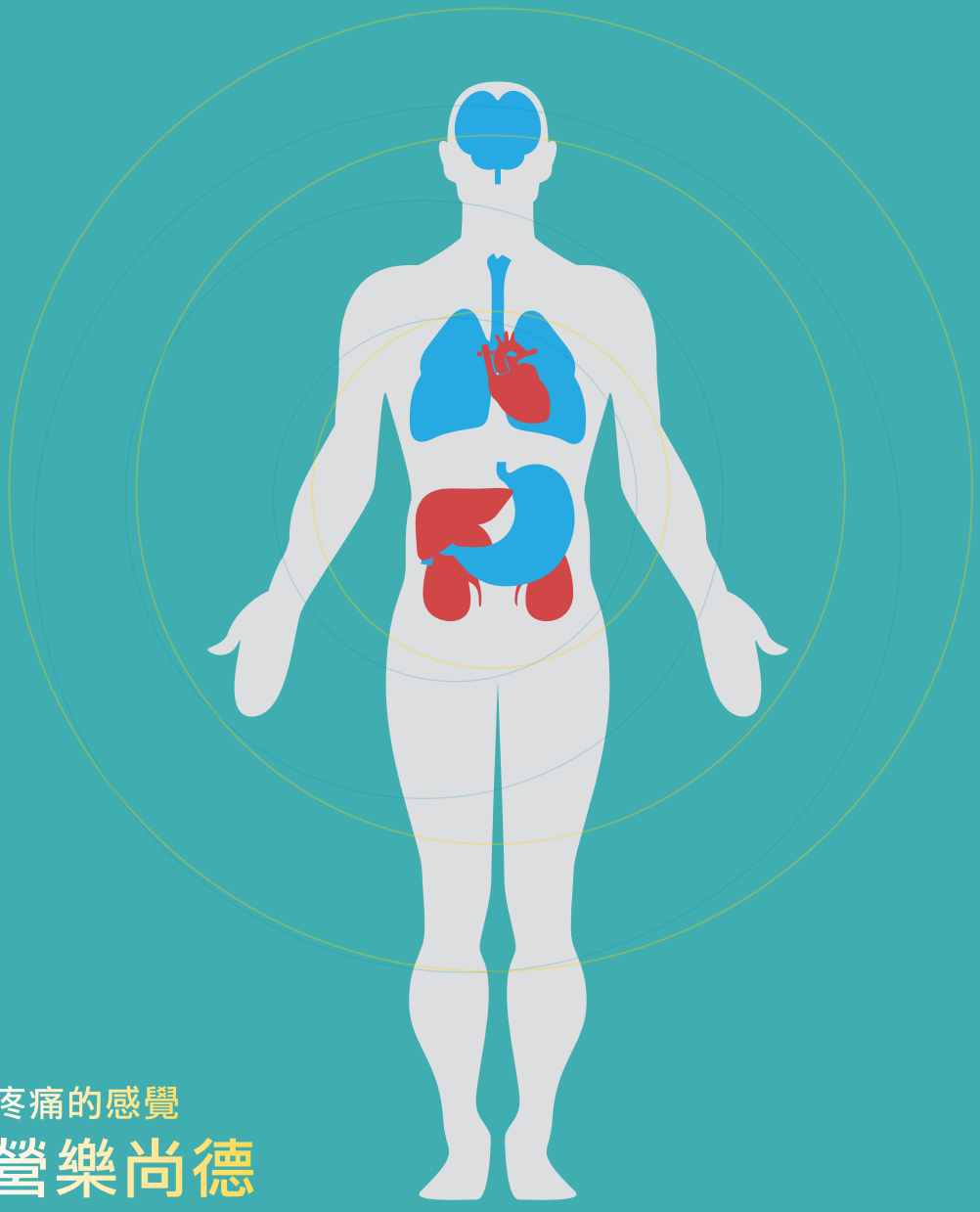
Pain NEWSLETTER
香港疼痛學會
The Hong Kong Pain Society
September 2013

Lumbar Discogenic Pain – minimally invasive management



疼痛的感覺
營樂尚德

A to Z of Pain

Successful elements of Pain Program in Sydney

Message from the President

Dear colleagues and friends,

Thank you to your continuous support to the Hong Kong Pain Society. Since our inauguration in 2006, the Society has maintained our important role as a unique local organization for continued education of health care professionals on study and management of pain. Our workshops, symposiums and scientific meetings were very well attended, with good sharing of knowledge and experience among local and overseas participants.

In the coming year, the Society has planned to extend our role in the community, to fulfill our mission of promoting public understand toward pain and to cultivate a positive attitude towards persons with pain. Our vision is to set up a Pain Foundation to collaborate and assist patient groups and relevant organizations to provide support and resources to patients suffering from pain.

I am confident that with all your support our Society will continue to raise the awareness of pain as a health concern and to achieve our goal of "Relief of pain as a basic human right".

Dr Steven Wong
President
Hong Kong Pain Society

Council 2011 - 2013

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References: 1. National Institute for Health and Clinical Excellence. Quick reference guide, 2010. Neuropathic pain: The pharmacological management of neuropathic pain in adults in non-specialist settings. Available at: http://www.nice.org.uk. Accessed October 18 2010. **2.** Dubinsky RM, et al. Practice parameter: treatment of postherpetic neuralgia: an evidence-based report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2004;63:959-965. **3.** Attal N, et al. EFNS guidelines on pharmacological treatment of neuropathic pain. Eur J Neurol 2006;13:1153-1169. **4.** Institute for Clinical Systems Improvement (ICSI). Assessment and management of chronic pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI) 2008:84. **5.** Moulin DE, et al. Pharmacological management of chronic neuropathic pain – consensus statement and guidelines from the Canadian Pain Society. Pain Res Manag 2007;12:13-21. **6.** Suarez L. New Guidelines Boast Benefits for Patients Suffering with DPN pain. Diabetic Microvascular Complications Today 2006;May/June:21-22. **7.** Dworkin RH, et al. Pregabalin for the treatment of postherpetic neuralgia: A randomized, placebo-controlled trial. Neurology 2003;60:1274-1283. **8.** Siddall PJ, et al. Pregabalin in central neuropathic pain associated with spinal cord injury. A placebo-controlled trial. Neurology 2006; 67:1792-1800.

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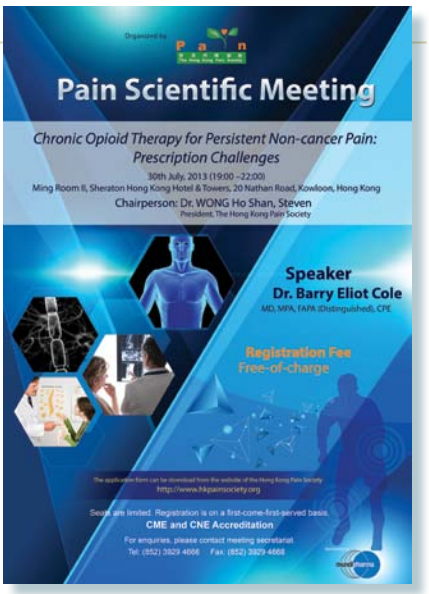
Events highlight

1. Public Education Talk collaborated with Health Action
Common Pain Condition in Elderly and Management

Date : 15 June 2013

2. Scientific meeting
"Chronic Opioid Therapy for Persistent Non-cancer Pain: Prescription Challenges"

Date : 30 July 2013



3. First Conference Grant 2013 Results:

Congratulations to Dr. CHAN Chi Wing, Timmy and Mr. LEE Wai Chi, Edwin.Second Conference Grant will be opened for application soon.

Editor's Note

Hong Kong Pain Society's Newsletter acts as platform for members to share knowledge and experience of pain management in Hong Kong. We received inputs from different specialties to reflect their perspectives in pain management. In this issue, Dr. Assad Hussain gives an overview of Discogenic Back Pain and Ms. Vanessa Ng shares her interesting experience of Pain Program in Sydney. Moreover, Ms. Flori Lam and Ms. Bebe Tam describe their perceived pain and inspiration from "Joyful Club".

If you want to share your knowledge or experience with us, please send the article at: newsletter.painsociety@gmail.com. Book coupon will be given as rewards once get published. Last but not least, I would like to thank all the members in Editorial Board for their enthusiasm and efforts in the past year.

Dr LEUNG Wing Yan, Doris

Hong Kong Pain Newsletter is published quarterly. For advertising enquiries, please contact **Dr. Doris Leung** at newsletter.painsociety@gmail.com

Lumbar Discogenic Pain – minimally invasive management

Dr Assad Hussain, *MBBS, FHKCA, FHKAM (Anaes), FANZCA, FFPMANZCA, Dip Pain Mgt (HKCA), FHKAM (PainMed).*

The management of lumbar discogenic pain remains a challenge despite accounting for almost 40% of patients with low back pain. Internal disc disruption (IDD) is a condition marked by alternation in the internal structure of the intervertebral disc – annular tears are major forms of IDD. [1]

Anatomy

The intervertebral disc is composed of the nucleus pulposus (located in the centre) and annulus fibrosis. The nucleus pulposus has a chondroid matrix of proteoglycans and collagen – 70-90% of the nucleus content is water. This structure allows the disc to act like a shock absorber. The annulus is composed of a three dimensional network of collagen fibers surrounding the nucleus. The posterior portion of the annulus is thinner than the rest of the annulus providing the anatomical basis for more posterior tears. [2]

Pathophysiology

With aging the number of viable cells in the inner regions of the disc diminishes, and the normal collagen fibril organisation starts to disappear. Loss of large proteoglycan molecules reduces the amount of hydration in the disc, which changes its shape and volume.

The nucleus becomes stiffer and less able to dissipate energy, acting more like a solid substance rather than a gelatinous one. As a result, the pressure within the degenerated discs is unevenly distributed. These alterations in load-bearing capacity can cause unusually high stress at specific points in the disc, leading to development of localised soft tissue damage, such as IDD or annular tears. [3]

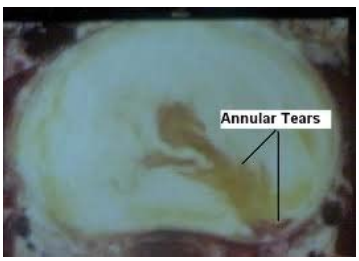


Figure 1:
Cadaveric study of annular tear

Diagnosis

Despite the development of magnetic resonance imaging (MRI) and discography the diagnosis of discogenic pain remains controversial. No specific history or findings in physical examination has high diagnostic value or specificity.

Young patients may have a history of trauma, the pain being described as aching or burning in the low back area, with radiation to bilateral lower extremities. Sitting often aggravates the pain, especially with leaning forward. This is supported by findings that intradiscal pressure is higher in the unsupported, flexed sitting position as compared to lying supine.

MRI

A major advantage of MRI in diagnosing IDD is its noninvasiveness. A high signal contained within the annulus of a disc, separated from the nucleus pulposus, on lumbar MRI is termed as a High Intensity Zone (HIZ). [4] Correlation with CT discography found that it has a positive predictive value of 86% for a severely disrupted, painful disc on discography. Other investigators have identified abnormal discography in patients with normal MRIs, pointing out the value of provocative discography. [5]

Figure 2:
High Intensity Zone signifying annular tear.

Discography

Discography is the most reliable tool currently available for the diagnosis of discogenic back pain. It involves the insertion of a needle into the centre of the disc under fluoroscopic guidance and the subsequent injection of contrast into the disc. The injected volume and the patient's responses including pain location, severity, and quality are documented. If the patient experiences similar pain as his or her "usual pain", it is called *concordant pain*. Nonconcordant pain means the pain is dissimilar from the "usual pain". Disc morphology including height and any leak are documented. [6]

Figure 3:
3 level discography. The highest level showing a normal disc. The middle level showing a grade 5 annular tear.

Discs can be classified into 4 categories:

1. Normal disc has no pain
2. Chemically sensitive discs have pain at a pressure <15psi above opening pressure
3. Mechanically sensitive discs have pain provoked at pressure between 15 and 50 psi above opening pressure
4. Indeterminate discs experience pain between 51 and 90 psi above opening pressure.

The current standard for a positive (abnormal) disc is provocative concordant pain with a radiographic image of an abnormal disc, and as a control, stimulation of at least 1 other disc fails to reproduce pain

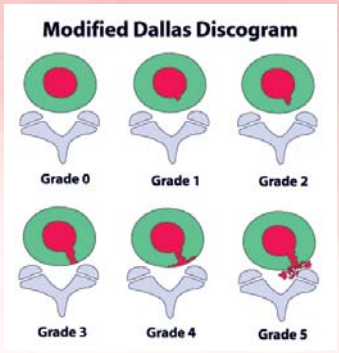


Figure4:
Modified Dallas classification.
Grade 0: Normal disc
Grade 1: Leaked contrast to inner 1/3 of annulus
Grade 2: Leaked contrast to outer 2/3 of annulus
Grade 3: Contrast completely to outer 3 layers of annulus
Grade 4: Grade 3 tear with contrast spreading circumferentially around annulus more than 30 degrees
Grade 5: Contrast leaking from disc

Treatment

Adjunctive treatments for IDD include:

- Nonsteroidal anti-inflammatory drugs
- Physical therapy
- Accupunture
- Anti-neuropathic medications

Minimally invasive treatments

- *Intradiscal steroid injections:* the purpose of intradiscal steroid injections is to suppress inflammation. The efficacy of this procedure has been controversial.
- *Intradiscal electrothermy (IDET):* The procedure involves the percutaneous insertion of a special catheter into the disc under fluoroscopy. The cathether is coiled along the inner aspect of the posterior annulus. The distal 5cm of the catheter is gruadually heated over 15minutes up to a maximum temperature of 80-90degrees centrigrade. Earlier studies has reported success rates of about 50-70% in patients post-IDET. However, debate continues regarding the clinical efficacy of this procedure. [7]
- *Biacuplasty:* Also termed RF annuloplasty these procedures involve inserting 2 needles in the outer annulus of the treated disc and an RF dual lesion with conventional heat or pulsed RF treatment is performed.
- *Ramus communicans block:* Recently it is thought that the L2 dorsal root ganglion (DRG) neurons may be the main afferent pathway of pain from the lower intervertebral discs, presumably via sympathetic afferents from the sinuvertebral nerves. Therefore infiltration of the L2 nerve may be a useful diagnostic test and therapy. Blockade or destruction of ramus communicans has also been reported to decrease pain originating from discs. [8]
- *Cell transplantation:* Researchers suggest that restoring the cellular function within the disc by cell transplantation may provide a new direction for future treatment of IDD. The potential cells for transplantation include stem cells, autologous disc cells, or chondrocytes from other tissues other than discs.

Conclusion

Discogenic low back pain continues to be a challenge to manage. Various promising minimally invasive intradiscal procedures are currently available, though despite being safe, there is still a lack of convincing literature for their routine use.

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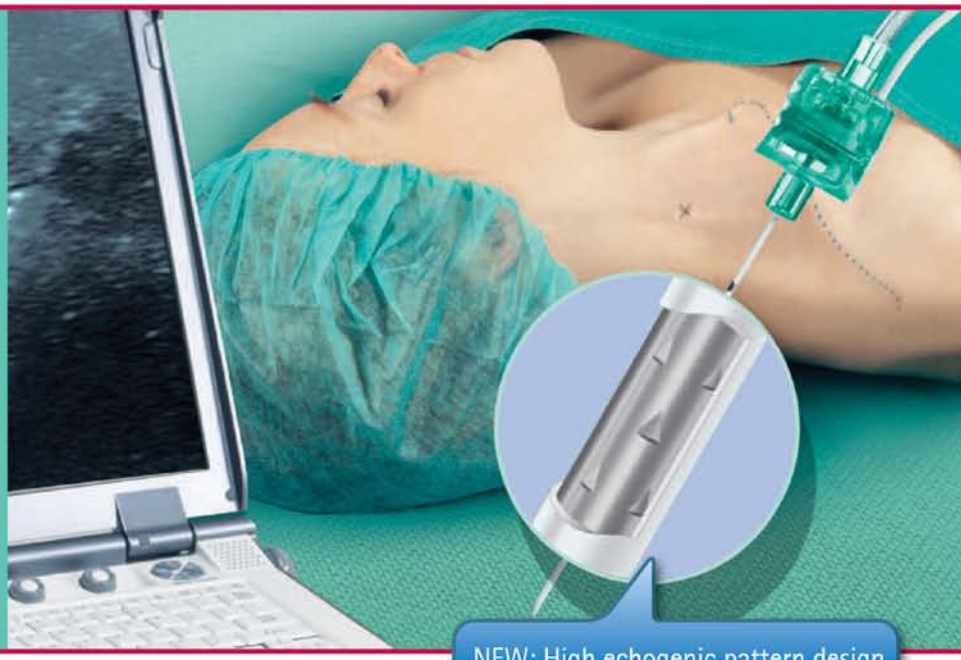

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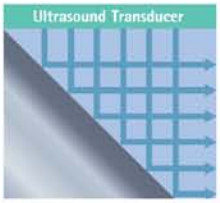
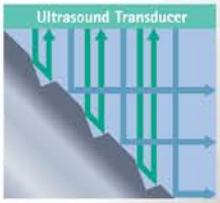


Conventional needle
At steeper angles, most of the ultrasound beam is reflected away from the probe and thus the needle is hardly visible under the ultrasound image.



New needle
Due to the special pattern design, even at steeper angles, part of the beam is reflected back to the probe creating a strong ultrasound image.

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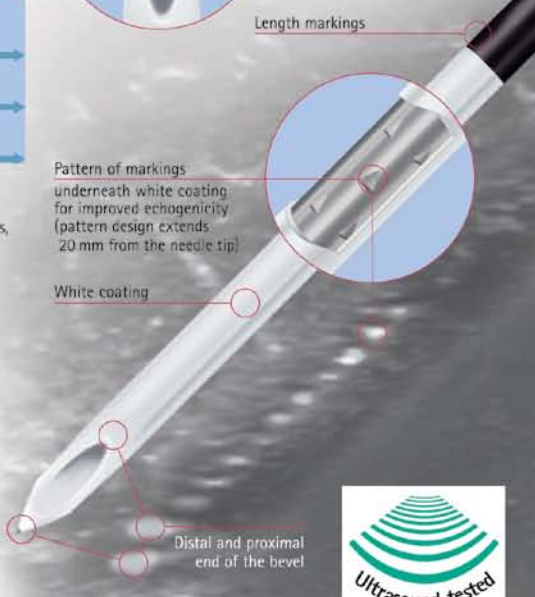

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HC06/RA/13/JUL

Successful elements of Pain Program in Sydney

Vanessa Ng, *Clinical Psychologist, PMH.*

In January 2013, I had the honor to attach to the ADAPT program organized by the Royal North Shore Hospital, Sydney. ADAPT is a 3-week (15 full-day) cognitive-behavioral based group program for the chronic pain, renowned for its treatment efficacy. It is run by a multi-disciplinary team included pain specialist, clinical psychologist, psychiatrist, nurse and physiotherapist. I would like to share some elements of their success here.

- Motivated and well-prepared patients: After the initial assessment, the team would brief the patient on the basic concept of pain self- management approach, motivate patient for change and instruct patient to read a book back home. On the second assessment day, the team would then check the patient's understanding and acceptance of the concept. Only those motivated and ready would be accepted into the program.
- Early intervention: The patient in ADAPT is referred to the service as early as 3 months after pain onset, when he/she did not respond well to previous treatments (and not suitable for further treatments). In contrast, in Hong Kong, it would take years for patient to be referred to pain clinic, most likely, after all means of traditional and non-traditional treatments are exhausted. In my daily clinical work, my pain patients may have suffered from pain for 2 years or more, and the treatments are complicated by multiple psychosocial sequelae, which would often tax the patients' resources on coping or learning to cope adaptively with pain.
- Multi-disciplinary approach: All staff involve in the program closely collaborate from intake to intervention process. The team would meet 2 times a week formally for reviews of each participant's progress. They would exchange views on case conceptualization and management from a biopsychosocial perspective, and then prompt immediate responses. In addition, the whole ADAPT team have solid knowledge on CBT and psychology of chronic pain. They have good clinical sensitivity to notice even the most subtle forms of maladaptive pain behaviors and beliefs. The team would then intervene accordingly.
- Involvement of employer, rehabilitation worker and family: The team would liaise with the employer and rehabilitation worker for a return-to-work plan as appropriate, in order to maximize patient's chance of successful reintegration into usual role. The family would join the group for 1 day, attend lecture on chronic pain and be advised on ways to support patient's continuous practice of pain self-management strategies.

In Hong Kong, we may not have the luxury to have a multi-disciplinary team in every setting, or get the involvement of employer/ rehabilitation worker/ family, or meet the patient 3 months after onset of pain problem, but we surely can spend a little more time on educating and motivating patient for a more adaptive pain coping approach. We can also take the initiative in sharing the idea of pain self-management with other chronic pain care professionals who are not familiar with this approach.

From the personal perspective, I am quite impressed by the work-life balance attitude of the team. The team could get off work before 5pm on most of the day. On one of the usual working day, the team's physiotherapist took 1-hour drive after work to a beach for surf. I joined her and enjoyed the luxurious Australia clear sky, sunshine and breeze for 1.5 hour.

A to Z of Pain

Allodynia : is a pain due to a stimulus which does not normally provoke pain.

Burning sensation : a kind of pain description indicating component of visceral or neuropathic pain, e.g. heartburn, UTI or neuropathy.

Cognitive-behavior therapy : is a psychotherapeutic approach that addresses dysfunctional emotions, maladaptive behaviors and cognitive processes and contents through a number of goal-oriented, explicit systematic procedures. CBT is "problem focused" (undertaken for specific problems) and "action oriented" (therapist tries to assist the client in selecting specific strategies to help address those problems).

Depression : is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and sense of well-being. Depressed people may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions. Chronic pain patients commonly suffer from depression.

Exercise : level one evidence for management of chronic pain condition such as myofascial pain and low back pain.

Functional abdominal pain : is a disorder in which a person experiences chronic abdominal pain for which there is no known cause or any visible physical injury or disease. It is distinguished from irritable bowel syndrome by that there is no change in the appearance or frequency of bowel movements.

Gabapentin : is an anti-neuropathic agent used in seizures and neuropathic pain, it interacts with cortical neurons at auxiliary subunits of voltage-sensitive calcium channels. Gabapentin increases the synaptic concentration of GABA, enhances GABA responses at non-synaptic sites in neuronal tissues, and reduces the release of mono-amine neurotransmitters. Common side effects in adult patients include dizziness, fatigue, weight gain, drowsiness, and peripheral edema.

Hyperalgesia : is an increased sensitivity to pain, which may be caused by damage to nociceptors or peripheral nerves. Primary hyperalgesia describes pain sensitivity that occurs directly in the damaged tissues. Secondary hyperalgesia describes pain sensitivity that occurs in surrounding undamaged tissues.

Infection, Inflammation, Injury : possible organic causes of ongoing pain, which can develop to chronic pain by mechanism of peripheral and central sensitization.

Joint : is the location at which bones connect. They are constructed to allow movement and provide mechanical support. Many different conditions can lead to painful joints, including osteoarthritis, rheumatoid arthritis, bursitis, gout, strains, sprains, and other injuries. Knee pain was the most common complaint, followed by shoulder and hip pain.

Ketamine : is a non-competitive NMDA receptor antagonist results in analgesia by preventing central sensitization in dorsal horn neurons; it also acts as a noradrenergic and serotonergic uptake inhibitor, which are involved in descending anti-nociceptive pathways.

Lumbar sympathectomy : alleviates lower limb pain such as complex regional pain syndrome, phantom limb pain and other peripheral neuropathies by either chemical neurolysis or radiofrequency ablation. Procedure is performed under X ray guidance and the needle tip aims at anterolateral border of L234.

Malingering : is fabricating or exaggerating the symptoms of mental or physical disorders for a variety of "secondary gain" motives, which may include financial compensation; avoiding school, work or military service; obtaining drugs; getting lighter criminal sentences; or simply to attract attention or sympathy. Malingering is different from somatization disorder and factitious disorder

Neuropathic pain : results from disorder of the peripheral nervous system or the central nervous system (brain and spinal cord). It associates with abnormal sensations called dysesthesia, and pain produced by normally non-painful stimuli and may have continuous or episodic components. Common qualities include burning or coldness, "pins and needles" sensations, numbness, electric shock and itching.

Opioid : binds to specific opioid receptors in the nervous system and other tissues. There are three principal classes of opioid receptors, μ, κ and

δ, although up to seventeen have been reported. Another receptor of clinical importance is the opioid-receptor-like receptor 1 (ORL1), which is involved in pain responses as well as having a major role in the development of tolerance to μ-opioid agonists used as analgesics. These are all G-protein coupled receptors acting on GABAergic neurotransmission.

Prolotherapy : is also known as "proliferation therapy," "regenerative injection therapy," or "proliferative injection therapy". It involves injecting an otherwise non-pharmacological and non-active irritant solution into the body, generally in the region of tendons or ligaments for the purpose of strengthening weakened connective tissue and alleviating musculoskeletal pain.

Quality : Chronic pain management aims at improving general functional quality rather than pain free condition.

Red Flags : are possible indicators of serious spinal pathology: Thoracic pain, Fever and unexplained weight loss, Bladder or bowel dysfunction, History of carcinoma, Progressive neurological deficit, Disturbed gait, saddle anaesthesia, Age of onset <20 years or >55 years.

Spine : human spine is composed by 33 vertebrae including cervical (7 vertebrae), thoracic (12 vertebrae), lumbar (5 vertebrae), and the 5 fused sacrum and 4 coccygeal bones that form the tailbone. Back pain is one the major source of chronic pain and brings significant implication to the society.

Trigeminal neuralgia : is a neuropathic disorder characterized by episodes of intense pain in the face, originating from the trigeminal nerve which has three major branches: the ophthalmic nerve (V1), the maxillary nerve (V2), and the mandibular nerve (V3). It commonly involves the maxillary branch and mandibular branch. About 10-12% cases are bilateral.

Ultrasound : Emerging technique for many pain procedure, e.g. stellate ganglion block, facet join and sacroiliac joint injection. It has the advantages of absent radiation hazard and direct visualization of blood vessels to prevent incidental puncture.

Visceral pain : results from the activation of nociceptors of the thoracic, pelvic, or abdominal viscera. The structures are highly sensitive to distension, ischemia and inflammation, but relatively insensitive to other stimuli that normally evoke pain such as cutting or burning. Visceral pain is diffuse, difficult to localize and often referred to a distant, usually superficial structure. It may be accompanied by symptoms such as nausea, vomiting, changes in vital signs as well as emotional manifestations.

Waddell's signs : are a group of physical signs, first described in a 1980 article in SPINE, and named for the article's principal author, Gordon Waddell. It may indicate non-organic or psychological component to chronic low back pain. Historically they have also been used to detect malingering in patients with back pain. Waddell described five categories of signs: Tenderness tests; Simulation tests; Distraction tests; Regional disturbances and Overreaction. When three or more categories were positive, the finding was considered clinically significant

X-Ray : commonly used to assist needle guidance in conventional pain intervention, e.g. radiofrequency ablation for trigeminal neuralgia, medical branch block for facet joint pain and epidural steroid injection.

Yellow flags : are psychosocial indicators suggesting increased risk of progression to long-term distress, disability and pain. It is designed for assessing low back pain and key factors include: Belief that pain is harmful or severely disabling; Fear-avoidance behavior; Low mood and social withdrawal; and Expectation that passive treatment rather than active participation will help

Zygapophysial joint : also named as facet joint, is a synovial joint between the superior articular process of one vertebra and the inferior articular process of the vertebra directly above it. It accounts for ~ 30% cause of low back pain.

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Reference:
1. Shigeo Ohmura, et al.
   Systemic Toxicity and Resuscitation in Bupivacaine-, Levobupivacaine-, or Ropivacaine-Infused Rats. Anesthesia and Analgesia 2001; 93: 743- 748
   In an animal study with drug infused-rats, the systemic toxicity of Levobupivacaine is intermediate between Ropivacaine and Bupivacaine when administered at the same rate.
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   The Median Effective Dose of Bupivacaine, Levobupivacaine and Ropivacaine After Intrathecal Injection in Lower Limb Surgery. Anesthesia and Analgesia 2009; 109: 1331- 1334
   Levobupivacaine and Bupivacaine showed similar potency in a prospective, randomized, double blind study of 75 patients who had intrathecal anesthesia for lower limb surgery.
3. Chirocaine® Product Monograph, Abbott Laboratories Inc. 2010

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艾伯维

疼痛的感覺

Flori Lam, 伊利沙伯醫院，痛症科專科護士

相信很多人也感受過疼痛的感覺，不論或短或長、極度的痛楚或輕微的難受。痛是很個人的！相信分享快樂是件比較容易的事，但提到與別人共享痛苦！究竟如何做較貼切？如何明白別人的感受？

因為不安，所以疼痛。
因為焦慮，所以疼痛。
因為孤單，所以疼痛。
因為恐懼，所以疼痛。
因為迷惘，所以疼痛。
因為疼痛，所以就踏入那討厭，難纏像咒語的旋渦裡！

一些因手術或受傷而引起的「急性疼痛」，通常透過休息、止痛藥、物理治療和時間，那些疼痛便漸減，隨著時間...漸漸消失。相比，長期的「慢性疼痛」便成為一般棘手的問題了！這不單是身體感受到非一般的痛楚，因長期用藥引來的副作用如昏睡、便秘、意識障礙、依賴、成癮，又或角式轉換、價值動搖和信念改變...這一一都給疼痛者及家人長期受到無比的壓力。

疼痛病人背後的故事...

相信每個人都會有他們的經歷和故事！患者有！醫護人員也有！

每個人都會想作自己生活的主導！但自從患者生活上起了變化時，很多時患者會選擇沿舊有的思想模式框架去過現時的生活，容易便會碰上釘子，連僅有的能量也白白送掉了，又讓負面情緒一層層的壓抑著！

醫護人員的每句說話...對病人來說都十分入「心」，第一個印象是十分重要的而且亦影響極深遠，將來的合作、信任、如何在這疼痛的同路上攜手同行，都建基於大家的關係和溝通上。溝通的藝術在醫患之間是必放在首位！所以用不同的方法如文字、圖表、身體語言、面對面、透過書信、電話通訊等讓他們明白治療的目的和過程是必須的。一句鼓勵帶有希望的說話就能深深令他們感受到你的關顧。輕輕的拍他們的肩膊，能讓他們感受「此時此刻」的真實感，令他們知道在旁人的支持。

明白別人的心意從來都不是件容易事，更何況與正面能量較少的長期疼痛者。透過尋找、學習、擴大、融合在他/她們的生活裡！讓他們漸漸掌管自己的思想、情緒、信念！從團隊合作去管理疼痛病人的需要而達至全人照顧是必須的。團隊精神的重要性在於溝通、互相學習和信任，大家各自有自己的角式和職務，透過無間斷高水準的合作，定期的個案會議相討作出更適合每個患者的治療計劃。

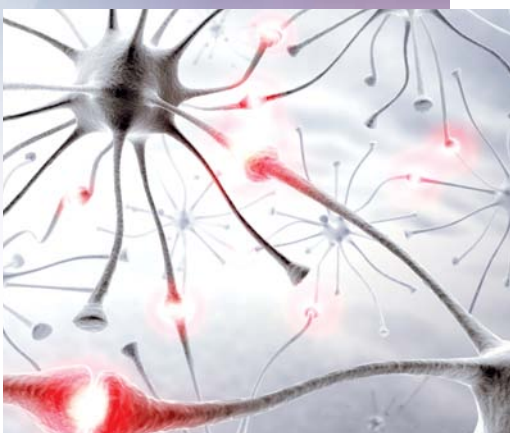
此外，積極參與由患者主導舉辦的活動，如病人自助小組，從中與他們分享知識、痛苦、夢想、快樂...。鼓勵他們將「疼痛」生活化。

Bebe是一個給我印象深刻的病人，外表堅強，打扮入時而獨立的女性。情緒平穩時，會有有強大的能量去幫助別人。相反，情緒低落的時候，會不斷自責、自殘身體，因用藥過量而送入病房也有幾次。每次到病房探望了解她時，她總帶著歉意像訴說，知道醫護人院如何的關心她，但因不能自控亦不能將自己的潛能轉化成正能量。所以一個讓患者自導的組織，透過這平台令他們懂得自理，令他們「忙碌」起來，令他們從新掌管自己的生活。所以支持這病人自助組織可達到三贏的效果，促進患者走出病困，重返正常生活，而其家人亦能減少壓力，此外可令公共資源更靈活運用。

有句說話，就像是人生的座右銘：「沒有人能輕易打垮你，但只有你自己，要每日都勝過昨天的我。」

營樂尚德

Bebe Tam, 樂德會候任會長



“痛”在每個人生命中都會發生，如受傷、頭痛、肚痛.... 等等。看似是好普通而且經常會發生。如果你聽到有人話“真係痛到想死”，你會覺得有無咁誇張呀?

我，Bebe 正正是一個被長期痛症折磨得要尋死的病人。

我無法用說話來形容這種痛，即使每天在你身邊的人，佢地唔理解你點痛，起初還會聽到一些關懷和擔心的說話，但日子耐了便感到家人抱怨、被忽視。越痛就越亂想，我曾有一段長時間把自己關起來連房門都不出，負面情緒不停在腦裡面轉，加上身上疼痛，每天不斷用酒精麻醉自己、用酒樽扑頭，用刀界手，目的就是要把身上痛楚轉移。痛楚令我整個人生都改變了，從前的我是一個有幹勁，充滿自信心的女強人，是一間上市公司中國區的總經理，前途一片光明。現在不但不能繼續以前工作、家庭又出了問題、所有唔好事都在同一時間發生。人亦變得脆弱，好容易哭，無晒人生目標，自殺行動更做完一次又一次。

經歷好幾年咁既生活，直到兩年多前，痛症科主診醫生轉介我參加由職業冶療部主辦的一個叫“生活重整課程”，參加病人主要都是有痛症，短短十堂課程，我認識到一班同路人，大家一齊分享同學習從痛苦中把亂七八糟的生活重整起來。學懂接受這個痛，尋找生活目標，把快樂儲蓄起來，令未來生活過得更充實和有意義。但我們一班同學亦好明白課程完結後，大家見面機會自然就會少左，部份同學亦會因不用上堂，又回復到最初發病時生活。為了令這些同學們，完成課堂之後依然保持正面生活態度，職業冶療部聯同病人資源中心協助我們組織了一個“樂德會”同學會，目的是希望畢業同學無論在心理或心態上，都能延續在課堂上學到的，從新站起來，甚至可以再重投社會。

現在“樂德會”同學會，已經成立差不多兩年，剛剛過去的半年，我們“樂德會”跟醫院一同參與義工項目，在過程中雖然遇到好多問題，對我們是個好好訓練，最重要是我們這群同路人能做到放下、包容和接受。

最後感謝大家給我今次機會， 我以“樂德會”侯任會長身份多謝各位醫生、醫務人員可以比我在這個機會讓你們更加認識我們這班痛症病人需要，希望日後還有更多事可以為我們這羣長期痛症病人。

樂德會 Joyful Club Happiness in Life!

同學會名為「樂德會」取其「營樂尚德」之意，會員要學習突破症狀及功能局限，努力經營快樂生活，並在能力範圍內積極服務與貢獻。

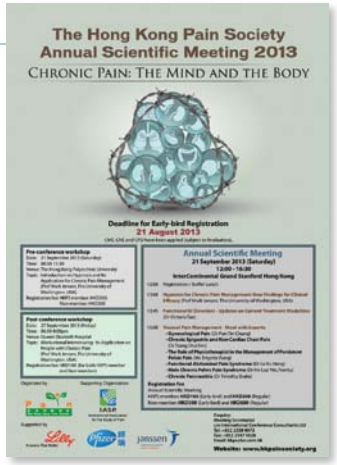
成立背景：伊利沙伯醫院職業治療部“生活重整課程”目標是要協助病人在慢性症狀及功能障礙影響下，學習和實踐適應方法，逐步建立成功及愉快生活方式。畢業同學希望透過同學會平台，延續學習和實踐、維繫同學間的友誼和支援，分享成功的生活經驗。

Future Event

1. Annual Scientific Meeting

Date : 21 September 2013
Venue : InterContinental Grand Stanford Hong Kong

- Pre-conference workshop on 21 September 2013:
  Introduction on Hypnosis and its Applications for Chronic Pain Management
- Post-conference workshop on 27 September 2013:
  Motivation Interviewing and its Application on People with Chronic Pain
- 7th Annual General Meeting of the Hong Kong Pain Society



2. Research Seminar: Publishing Your Research Findings: Strategies for Success

Speaker : Mark P Jensen, Ph.D.
Date : 27 September 2013 (12:30-13:30)
Venue : ST522, Block T,
The Hong Kong Polytechnic University

3. Pain Education Series

Topic : Contemporary Management of Pain
Date and Time : 25th Oct, 1st Nov and 8th Nov 2013
(Every Friday, 7-8:30pm)
Venue : Lecture Hall, 4/F,
Duke of Windsor Social Service Building

Preliminary programs:
Day 1 : Current understanding of pain - myths and misconceptions
- Physiology and pharmacology of pain
- Genetic influence on pain perception
Day 2 : Dealing with Pain - low back pain and beyond (Part I)
- "Living with your pain" – how to take an active role
- Cognitive behavioral approach - physiotherapy program & case sharing
Day 3 : Dealing with Pain - low back pain and beyond (Part II)
- Introduction to interventional procedures
- Psychological interventions

4. Public Education Talk

Topic : Irritable Bowel Syndrome and Visceral Abdominal Pain
Date : 14 September 2013
Venue : Duke of Windsor Social Service Building

HKPS membership

There are different membership plans for our society. Lifetime membership offers single time payment ($3000) and saves the trouble of annual renewal ($300).

Benefits of members:

- Discounted price on conferences and meetings
- Conference grant
- Regular newsletter

Please see details at:
www.hkpainsociety.org

Welcome of new members:

Life member :
Ms. CHAN So Kwan

Regular member :
Ms. LAI Chui Wa Irene
Ms. LEE Mi Suen Connie
Ms. Ho Kit Sheung Vicky
Mr. WONG Pak Chun
Ms. CHAN Hsiao Mandy
Ms. CHIU Mei Chun
Dr. CHUNG Kin Kwok
Ms. WONG Hiu Yin
Ms. TSANG Hung Mei
Mr. CHENG Chun Yuen
Ms. LIANG Mei Ching Mimi