Pain
香港疼痛學會
The Hong Kong Pain Society

NEWSLETTER 01
December 2014

Message from the President

Dear colleagues,

I am sure that most of our members would agree with me that what happened in the past month has been a painful experience to citizens in Hong Kong. Like all painful conditions, it is a "bio-psycho-social" phenomenon. There will never be a "magic bullet" to solve the problem. The treatment plan should be "multi-modal" and requires "collaboration from multiple disciplines".

I hope this issue of our newsletter will catch up with our annual scientific meeting. Thanks to Dr Doris Leung and the editorial board. This year, we have combined our annual meeting with the 5th Multidisciplinary Musculoskeletal Ultrasound Symposium on Pain Management. Under the chair of Dr Carina Li, the meeting would offer an opportunity for interchange of knowledge and experience between overseas and local experts.

The Hong Kong Pain Society continued to be a provider of continued education for healthcare providers. This year, we have organized, solely of in partnership with other organizations, a series of education programmes, including certificate course, lecture and symposium on a number of topics on pain management.

Public education has always been an important mission of our society. We are exploring to extend further our role in providing advice and resource to patients suffering from pain. We are in the process of setting up a Pain Foundation. Thanks to Dr David Sun who is the coordinator for this meaningful project.

Lastly, I would like to thank our council members and everyone who has helped and supported the activities of the society. I wish all of you a peaceful Christmas and happy New Year!

Dr Steven Wong
President
Hong Kong Pain Society

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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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LYR11010P

HKPS Announcements:

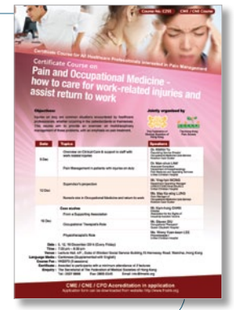
1. **Combined Scientific Meeting of HKPS** and 5th Multidisciplinary Musculoskeletal Ultrasound Symposium on Pain Management

Date : **5-7th December, 2015**

Online registration : **http://mweb.hksh.com/mskuspm/home.html**

Annual General Meeting will be held on 6th December 2014 in InterContinental Grand Stanford Hotel, members are welcomed to join.

2. Pain and Occupational Medicine - **how to care for work-related injuries and assist return to work**



Date and Time : **5, 12, 19 December 2014 (Every Friday) 7-8:30pm**

Venue : **Lecture Hall, The Federation of Medical Societies of HK. Duke of Windsor Social Service Bldg, Wan Chai**

Website : **http://www.fmshk.org/fmshk.php?id=496**

3. **Conference Grant** 2014 Application

Regular and life members of the Hong Kong Pain Society are invited to apply for the conference grant to attend overseas international conference related to pain management and preferably involving multidisciplinary participation. The grant will cover the conference registration fees and return economy air-passage with a maximum of HKD15,000.

Application : **http://hkpainsociety.org/index.html**

Deadline : **30th December 2014**

Editor's Note

Hong Kong Pain Society Newsletter serves as a platform for interaction between specialties in pain management. In this issue of newsletter, Dr. CK Shum gives a comprehensive summary of Common Musculoskeletal Pain in Elderly and Dr. Savio Lee has briefly described The Ultrasound Use in Management of Shoulder Pain in Stroke Rehabilitation. Besides, the Management of Musculoskeletal Pain from Chinese Medicine perspective will be discussed by Dr. Tsang and finally, Dr. Alice Man shares her experience in attending an interesting conference in Singapore. Members are welcomed to submit article related to clinical updates or sharing experience in managing pain in daily practices. A book coupon will be rewarded once the article is published and don't miss the chance!

I would like to thank the hard work of the Newsletter Editorial Board and special thanks to our graphic designer Ming and IT support Bryan.

Dr LEUNG Wing Yan, Doris

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

Common Non-Malignant Musculoskeletal Pain Syndromes in Older People –

a Geriatric Perspective

Dr. Shum, Chun Keung
Specialist in Geriatric Medicine
Tuen Mun Hospital

Introduction

Older people with musculoskeletal disorders may present with pain (joint pain, myalgia, back pain), fever (inflammation, infections), falls and fractures, neurological complications (cervical myelopathy, cauda equina syndrome), complications of immobility (incontinence, pressure ulcers), drug treatment (steroid-induced osteoporosis), functional decline, psychosocial responses (depression, social withdrawal), and increased healthcare use (1).

Musculoskeletal pain is common, frequently under-reported and inadequately treated in older people. Barriers to pain assessment and management include beliefs about pain as a normal part of aging, poor health education, misinterpretation of symptoms due to comorbid diseases, cognitive impairment and other communication problems, altered disease pattern and atypical presentation in old age with non-specific symptoms and signs (Table 1) (2).

Table 1: Non-Specific Symptoms and Signs of the Presence of Pain in Older People (1)

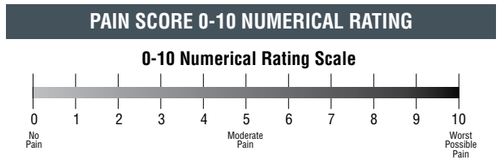
Vocalization	Moaning, sighing, groaning
Facial expression	Frowning, grimacing, fearful facial expressions
Change in body language	Fidgeting, guarding, bracing, withdrawn
Mental status change	Increasing restlessness or agitation, depressed affect of sudden onset
Behavioral change	Refusing to walk, eat or sleep, paucity of speech and interaction, resisting certain movements during care
Physiological change	Temperature, blood pressure or pulse outside normal limits, tachypnea

Pain Assessment in Older People

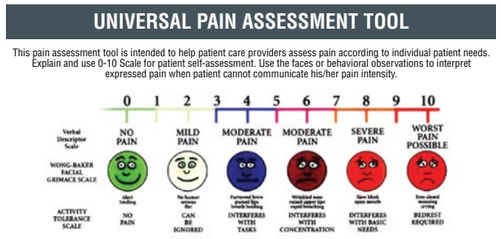
Initial assessment is to distinguish the cause of musculoskeletal pain, to identify comorbid diseases influencing pain management or presenting with musculoskeletal pain, and to recognize complicating psychosocial issues. Repeated assessment of pain levels and functional status is crucial for optimal pain management (1).

For cognitively intact older people, self-reported measures can be used for pain assessment (e.g. numerical and graphic rating scales) (Figures 1, 2) (3).

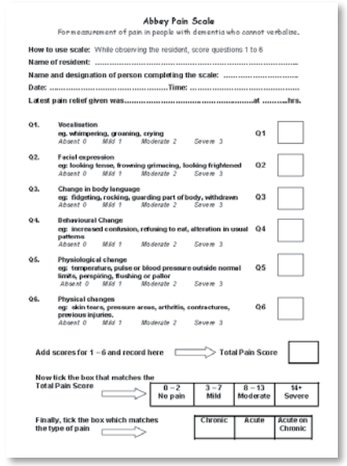
For cognitively impaired older people, non-verbal pain assessment tools can be used (e.g. Abbey Pain Scale) by observing patient's facial expressions, behaviors and activities (Figure 3) (3) (4).



▲ Figure 1: Numerical rating scale



▲ Figure 2: Graphic rating scale



▲ Figure 3: Abbey Pain Scale (4)

Common Musculoskeletal Disorders in Older People

Sites	Etiologies*	Special Issues in Older People
Joints	Degenerative arthritis –	**Osteoarthritis** (of hips, knees, hands) as degenerative arthritis is a misnomer with inflammatory component
	Inflammatory arthritis –	Elderly onset **rheumatoid** arthritis can present with abrupt or gradual oligoarthritis involving large proximal joints (shoulders, wrists, knees) with disabling morning stiffness, more sicca symptoms and systemic reaction
	Crystal-induced arthropathy –	Elderly onset **gout** can present with subacute polyarticular gout with early tophi formation over fingers (may spare the feet), more systemic reaction, associated with diuretic use, coexisted with blood dyscrasia, osteoarthritis or septic arthritis **Pseudogout**
Bones	**Osteoporotic fractures**	
Soft tissues (tendons, bursae, ligaments, muscles)	Rotator cuff syndrome Adhesive capsulitis (frozen shoulder)	
Chronic low back pain (CLBP)	Multiple etiologies –	Include lumbar spondylosis and spondylolisthesis, disk disease, osteoporotic vertebral fracture, spinal stenosis, paraspinal muscle spasm Referred pain from hip and sacroiliac joint diseases Important to look for red flags of spinal malignancy, infection and consider visceral diseases

▲ Table 2: Common non-malignant musculoskeletal disorders in older people (1) (5) (6)
*(*Please refer to the literature for detailed description of each musculoskeletal disorder.)*

Management

Older people are often excluded from studies assessing pain management strategies and most approaches have been extrapolated from clinical experience with younger patients and patients with cancer pain. The management of musculoskeletal pain in older people is *complex* and should be *individualized*. It requires a *multidisciplinary* approach with a combination of *non-pharmacological* and *pharmacological* modalities and aims to *relieve pain, restore function* and *maintain quality of life. Drugs* should be *reviewed* for any iatrogenic rheumatic syndromes (e.g. diuretic-induced gout) (2) (7).

Non-Pharmacological

Non-pharmacological therapies include *physical therapy* (weight-bearing exercise for osteoporosis, Tai Chi for arthritis, physical modalities e.g. TENS, ultrasound, heat or ice for pain relief), *occupational therapy* (for patients' independence and hazard reduction with assistive devices, joint rest with splinting for active synovitis), *patients'/caregivers' education* (self-management, drug use), *lifestyle advice* (weight reduction for osteoarthritis, dietary advice for osteoporosis and gout), *alternative medicine* (herbs and acupuncture), *psychosocial support* (2) (7) (8).

Pharmacological

Older people are *vulnerable to adverse drug reactions*. Drug choice should be based on individual profiles of renal, liver functions, cardiovascular risk factors and gastrointestinal disorders with constant alertness to drug-drug and drug-disease interactions (1).

A stepwise pharmacological approach can be used in the pain management of osteoarthritis and CLBP: [1] Acetaminophen as first-line therapy for mild-to-moderate pain; [2] NSAIDs as added-on if pain is not relieved or for inflammatory pain. However, NSAIDs can cause gastrointestinal bleeding, fluid retention, renal, liver impairment and precipitate heart failure in older people. The lowest effective dose should be used for the shortest period of time. COX-2 inhibitors still have an increased risk of cardiovascular events; [3] [4] weak and strong opioids for moderate-to-severe pain (2) (7) (8).

Drugs specific for diagnosis: DMARDs for rheumatoid arthritis along with symptomatic therapy with NSAIDs and low dose prednisolone; calcium, vitamin D supplements and anti-osteoporotic drugs for osteoporotic fracture. Because of increased toxicities of NSAIDs and colchicine in old age, corticosteroids have been used more often in treating acute attacks of gout with urate-lowering therapy (allopurinol, febuxostat) to prevent recurrent attacks (1).

Others: topical analgesics (topical NSAIDs, anesthetics), adjuncts (anti-convulsants, anti-depressants)

Injection Therapy: Intra-articular injection (e.g. hyaluronic acid for osteoarthritis, corticosteroid for inflammatory arthritis, adhesive capsulitis), *epidural injection* of local anesthetics or corticosteroid for CLBP have been used (1) (7). *Prolotherapy* for osteoarthritis, CLBP and tendinopathies appears safe with sustained improvement of pain and function (9).

Surgery: Joint replacement and *spinal surgery* are reserved for people not responding to medical therapy and with impaired daily activities. Rates of failed *back surgery* syndrome are substantial in older people due to factors including scoliosis, hip disease and osteoporotic compression fractures (8).

Reference:

1. Kong TK. Chapter 26: Musculoskeletal Disorders. *The Hong Kong Geriatrics Society Curriculum in Geriatric Medicine.*
2. Podichetty VK, et al. Chronic non-malignant musculoskeletal pain in older adults: clinical issues and opioid intervention. *Postgrad Med J.* 2003;79(937):627-33.
3. Lord B. Paramedic assessment of pain in the cognitively impaired adult patient. *BMC Emerg Med.* 2009;9:20.
4. Abbey J, et al. The Abbey pain scale: a 1-minute numerical indicator for people with end-stage dementia. *Int J Palliat Nurs.* 2004;10(1):6-13.
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中醫如何治療
肌肉骨骼筋腱疼痛

曾淑芬醫師

病因

引起肌肉、骨骼、筋腱疼痛的中醫病因可分為內因、外因、不內外因三種。肌肉筋骨有賴於經絡中氣血的溫煦濡養，保持正常的狀態。臟腑內在精氣損傷的情況下，氣血化生不足，經絡空虛可導致筋骨脆弱，肌肉疲軟而產生疼痛。風、寒、濕、熱等自然的天氣變化可侵襲人體成為“六淫”外邪。“六淫”外邪可阻滯人體經絡氣血的運行，此為疼痛產生的外因。過度勞倦，跌打創傷等不內外因對肌肉、骨骼、筋腱直接造成損傷而產生疼痛。

治療

中醫治療以調整臟腑機能，疏通經絡，祛除局部瘀阻為目的，使臟腑氣血得生，經絡暢通，加強機體的修復機能，而達到止痛的功效。中醫治療疼痛的方法大同小異：有內服中藥和外治法兩種。針刺、括痧、拔罐、艾灸、刺絡放血、熏洗熱熨是常見的外治法。

不論何種病因或中醫辨證分型，都可以不但內服中藥或進行針刺來治療。通過配伍不同性味，行走不同經絡、臟腑的中藥可以促進臟腑氣血化生，又可以通過機體氣血的運行，達到祛除局部瘀阻，疏散“六淫”外邪的功效。因脾主肌肉四肢；肝主筋；腎主骨生髓，臟腑調整以恢復肝、脾、腎三臟精氣為主，促進其所主的肌肉、筋腱、骨骼修復。針刺可以直接刺激在疼痛部位或鄰近的穴位，達到止痛的作用。也可以通過遠端取穴、辨證取穴等方法進行全身性的調整，恢復經絡、臟腑功能。

括痧、拔罐可以祛除阻滯於局部的風寒濕熱等外邪，產生通經活絡止痛的功效。艾灸與熏洗熱熨屬溫熱療法，多用於寒證、濕證、虛證。刺絡放血則多用於祛除局部的瘀血或熱邪。

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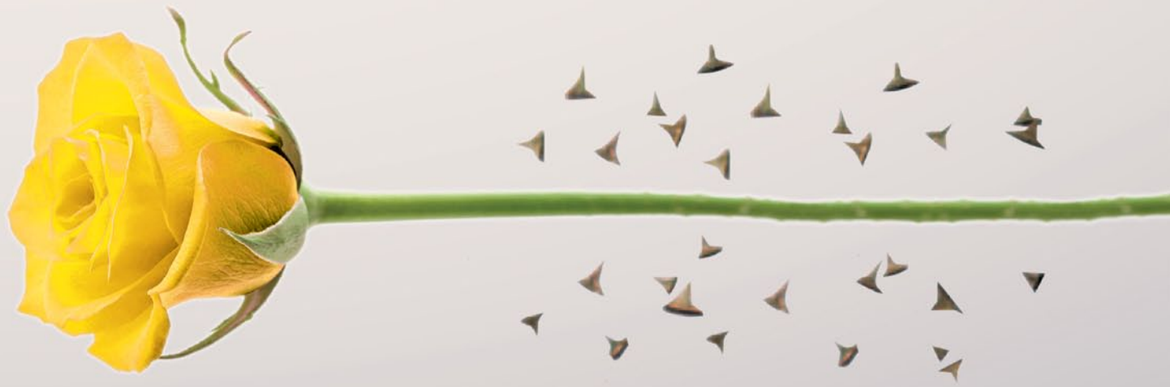

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Reference:
1. Shigeo Ohmura, et al.
Systemic Toxicity and Resuscitation in Bupivacaine-, Levobupivacaine-, or Ropivacaine-Infused Rats. Anesthesia and Analgesia 2001; 93: 743- 748
In an animal study with drug infused-rats, the systemic toxicity of Levobupivacaine is intermediate between Ropivacaine and Bupivacaine when administered at the same rate.
2. Lee Ying Y, et al.
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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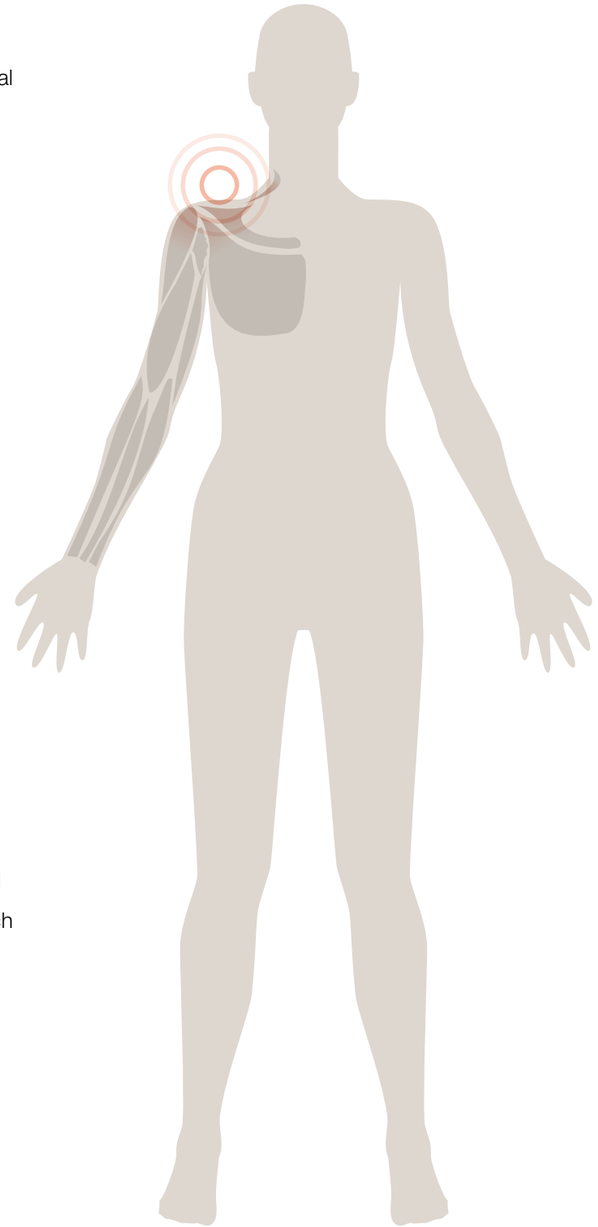
Ultrasound Use in Management of **Shoulder Pain in Stroke Rehabilitation**

Dr Savio LEE
Rehabilitation Specialist



SHOULDER PAIN is a common medical problems; impingement syndrome or rotator cuff disease is the most frequent diagnoses. The exact mechanisms of pain in rotator cuff disease are not known. Shoulder pain resulting from hemiplegia is a common clinical consequence of stroke. It can negatively affect rehabilitation outcomes.
Non-traumatic shoulder pain can be differentiated into different categories: extrinsic vs intrinsic & glenohumeral vs extraglenohumeral. If an intrinsic problem is present, the clinician must next determine whether its focus is the glenohumeral joint or not. Ultrasound can be useful in initial evaluation of tendon disorders. Assessment of shoulder range of motion, strength, and signs of impingement will help to distinguish among such diagnoses as rotator cuff tendinopathy.

Musculoskeletal ultrasound can provide images of tendons, muscles, bursae, joints, cartilage, and peripheral nerves and can detect bone erosions and synovitis. Therefore it is widely use as the initial modality for evaluation of rotator cuff injury, for which it has high sensitivity and specificity for rotator cuff tear. It is recommended when MRI is not available or contraindicated (such as pacemaker inserted). It is equally effective in evaluation of rotator cuff and biceps tendons. It is also highly sensitive in detection of calcification and subacromial bursitis with effusion.

Shoulder pain

Frozen shoulder:

Non-operative treatment for shoulder pain primarily consists of active physiotherapy, which may be supplemented with oral analgesics, steroid injections, and electrotherapy.

Intra-articular glucocorticoid injections appear to be beneficial in the treatment of frozen shoulder (adhesive capsulitis), leading to improved range of motion and pain reduction. However, the effect is of limited duration. Successful treatment probably depends on the duration of symptoms: patients who receive injections early in their course are more likely to obtain benefit, possibly due to reduction of synovitis. The combination of intra-articular glucocorticoid injection followed by physical therapy may be more effective than either therapy alone for frozen shoulder. Ultrasound guided intra-articular dilation (distension) is another treatment option for frozen shoulder. It combines intra-articular injection of an anaesthetic with an infusion of saline to dilate the glenohumeral capsule. It provides short term benefits in pain reduction, range of motion, and overall shoulder function in patients with frozen shoulder.

Shoulder Subluxation:

Shoulder subluxation occurs early on in the hemiplegic arm due to flaccid supporting shoulder musculature. It may be a cause of shoulder pain after stroke. Glenohumeral joint subluxation is reported to occur in the early flaccid stage of stroke. Radiographic measurements are considered the best method of quantifying glenohumeral subluxation. Ultrasound was recommended as diagnostic tool to measure the degree of shoulder subluxation.

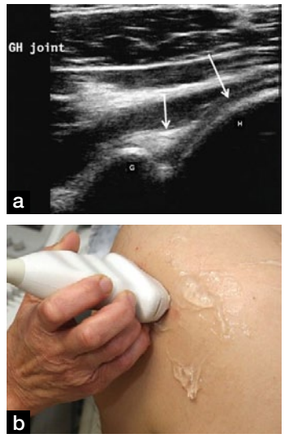


Figure (a) Glenohumeral joint. Humeral head (H) covered by the thin hypoechogenic articular cartilage (long arrow), the glenoid margin (G) and a homogeneously echogenic triangular structure- the fibrocartilagenous posterior labrum (short arrow). (b) The transducer is positioned slightly lower and medially in an axial plane.

Impingement Syndrome:

Shoulder impingement syndrome causes pain on overhead activity, musculoskeletal ultrasound can often show the site of impingement and tendons involved. It is important to distinguish impingement from rotator cuff tear. As surgical treatment approach is generally reserved for complete rotator cuff tear.

Shoulder pain is a common pain syndrome, especially after neurological or orthopaedic insult. It hinders the rehabilitation progress and affects patient's quality of life. Patient's functional status would significantly impaired if condition not recognised and managed at the early stage.

Reference:

1. Ebrsr, uptodate, Journal Rehab Med 2007; 39 u/s mesurement of shoulder subluxation in patients with post stroke hemiplegia
2. Gaitini D. Shoulder Ultrasonography: Performance and Common Findings. J Clin Imaging Sci 2012;2:38

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Reference: 1. Hong Kong Cymbalta® product insert, version PV9472AMP

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Dr. Man Kwan Yin, Private Anaesthetists

This visit to Singapore was unique in that I was attending the "Pain at the Cutting Edge: Surgery and Pain" refresher course and the joint conference of Australian and New Zealand College of Anaesthestists and the Australian College of Surgeon "Working together for our Patients" in Singapore. The Venue was at the iconic Sands Convention and Exhibition Centre-somebody nicknamed as a sailboat.

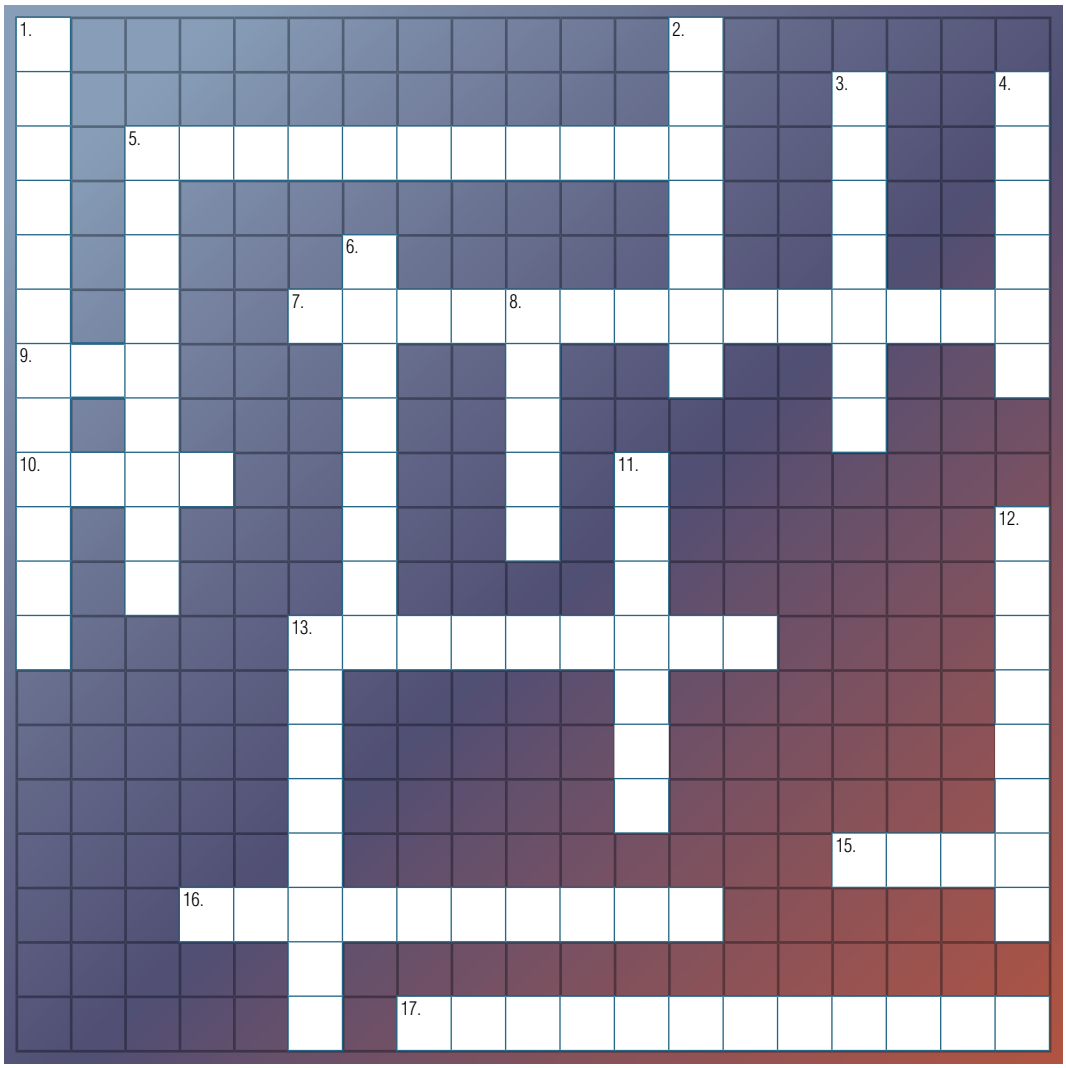
The highlight of the Pain refresher talk was delivered by Professor Jane Ballantyne on "Tackling the Opioid Issue: the US Perspective". I was excited to meet my idol in pain medicine. In US, the long-acting opioid was marketed as safer drug with less addiction risk in chronic pain management in the past, but only leading to catastrophic consequence. Obstetrics and Gynaecology senior consultant Dr Chew Ghee Kheng from Singapore, shared her high opinion of transversus abdominis block, NSAID, paracetamol, high energy CHO drink and early re-feeding as pearls for early recovery after surgery. Associate Professor Yeo Seng Jin highly recommended periarticular injection of local anaesthetic / steroid antibiotic/ NSAID mixture, peroperative use of NSAID, paracetamol, gabapentin and corticosteroid in total knee replacement. Professor Matthew Chan from Hong Kong gave an in-depth discussion on the transcriptional regulation leading to chronic post surgical pain. The burst mode of neuromodulation in back pain was revisited at the end of the lecture.

The itinerary was packed with exciting workshops and talks from paediatric airway, resuscitation and Ear Nose and Throat anaesthesia. It was precious chance to learn the most updated ERAS (early recovery after surgery) from anaesthetists and surgeons, aiming at preoperative patient education techniques for reduction of surgical stress and postoperative rehabilitation. Their effort in designing a conference apps was worthy of appreciation.

Apart from lectures, I was so grateful to catch up with previous Royal North Shore Hospital colleagues Joey (acute pain nurse), Dr. Lewis Holford (pain refresher course convenor), Dr Charles Brooker (pain consultant) and the most charming Professor Michael Cousins.

Can you imagine getting a glimpse of the tropical rainforest with kids in Singapore? Yes, we did. The Gardens by the Bay was fantastic with the world's tallest indoor waterfall and plant life. Universal Studio added colours to our relaxing yet energetic experience. How can on leave Singapore without chilly crab and Hainanese chicken rice? My wishes were all fulfilled together with the knowledge of the most advanced development in pain medicine and anaesthesia. My satisfaction score was 100%.

Word Puzzle



Down

1. Common cause of knee pain in elderly
2. A drug usually injected into joint space or epidural space to relieve pain
3. Psychological term meaning the ability to imagine or project oneself into another person's position and experience all the sensations involved in that position
4. Skill that enables you to consistently carry out activities without causing extra pain. It is a middle ground between doing nothing and over-exertion.
5. A kind of pain due to a stimulus which does not normally provoke pain
6. Pain in the head
8. Therapy which adopts remedial body technique that works on the soft connective tissue (fascia) of the body. It is used to treat musculoskeletal or related neurological problems including acute sports injuries.
11. A kind of pain or sensation in the area of a missing limb or other body part, as a breast
12. An efficient activity to manage chronic pain condition such as myofascial pain and low back pain
13. A set of symptoms including pain caused by general compression or irritation of spinal nerve roots of sciatic nerve

Across

5. Chinese medical practice of inserting needles into the specific sites of body to reduce pain or induce anesthesia
7. Process of helping a person who has suffered an illness or injury restore lost skills and so regain maximum self-sufficiency
9. A color of flag to describe indicator of serious spinal pathology in low back pain
10. Technique used to relieve pain in an injured or diseased part of the body in which electrodes applied to the skin deliver intermittent stimulation to surface nerves and block the transmission of pain signals
13. Chemical produced by the brain that functions as a neurotransmitter, its level is associated with mood disorders, particularly depression
15. A local organization for continued education of health care professionals on study and management of pain
16. Cranial nerve responsible for facial sensation
17. Therapy of 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

Pain

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ANSWER :

Down
1. DEGENERATION
2. STEROID
3. EMPATHY
4. PACING
5. ALLODYNIA
6. HEADACHE
8. BOWEN
11. PHANTOM
12. EXERCISE
13. SCIATICA

Across
5. ACUPUNCTURE
7. REHABILITATION
9. RED
10. TENS
13. SEROTONIN
15. HKPS
16. TRIGEMINAL
17. PROLOTHERAPY