

- 📍 Pain education in Hong Kong –
where we are now and the way forward
- 📍 A report on “**4-day Workshop of Cognitive Therapy for People with Pain**”
- 📍 **Mindfulness practice:** feeling, witnessing, understanding, and embracing the pain





Enhanced Visibility without Compromise with Ultraline 360

Improved results in Regional Anesthesia
with Ultraline 360 needles

HC008/RA/19/MAY

The President's Message

Dear Members, Colleagues and Friends,

It is my honour to take up the post of President of the Society again since I stepped down in 2015. Thanks to our council members, I can see that our society has grown stronger and stronger to become a unique local organization that is centered at providing continued education for multidisciplinary healthcare professionals with interest in pain management.

This year has been quite chaotic for the society. With the COVID-19 pandemic, most of the conventional face-to-face educational activities have been cancelled or postponed. Nevertheless, we have managed to hold some of our activities in between waves of pandemic, or via the online platform.

Next year we will be celebrating our 15th anniversary. We will continue to strive to increase the awareness of pain among healthcare professionals and improve the care of our patients suffering from pain. We will explore more modalities of learning opportunity for our members

May I wish every one of you wisdom and courage to face our future challenges.

Dr. Steven Wong

President
Hong Kong Pain Society

Pain education in Hong Kong – where we are now and the way forward

Dr Fiona Tsui
 Supervisor of Trainee (Pain Medicine) and Associate Consultant
 Department of Anaesthesia, Pamela Youde Nethersole Eastern Hospital Hong Kong

Persistent pain is becoming more common in our aging population, and is often accompanied by disability when poorly managed. In 2013 the WHO's Global Burden of Disease study identified 4 pain related disorders in their top 10 causes of years lived in disability (YLDs), with low back pain being top of the list (neck pain at 4th, migraine at 6th and other MSK disorders at 10th), and this trend has remained largely the same since then.^{1,2} (Figure 1) In Hong Kong, the prevalence of chronic pain has increased from 10.8% in 1999 to 28.7% in 2013.³ The IASP Global Year in Pain Education in 2018 highlighted a significant gap between knowledge and practice in pain management.⁴ It is important for us as pain educators to narrow this gap in order to reduce or even prevent pain related disability in our population.

Pain is everyone's business

Pain is a common symptom of disorders of many body systems. Almost all health professionals have come across a patient with pain, but few would treat pain as a disorder itself. While most pain will resolve with treatment of the underlying disorder, there are some which will persist and become a disorder of its own. Evidence suggested that many chronic pain conditions could be prevented at early stages.⁵ Hence non-pain specialists and health professionals may play a huge part in mitigating the disease burden of pain, if they are equipped with the knowledge and skills for early detection and treatment of pain.

The International Association for Study of Pain (IASP) was formed in 1974 by the University of Washington Professor John J. Bonica, with a mission to bring together scientists, clinicians, health-care providers, and policymakers to stimulate and support the study of pain and to translate that knowledge into improved pain relief worldwide. Since then the IASP has become a global leadership in the field of pain medicine. Being an IASP Chapter, the Hong Kong Pain Society has fostered the collaboration between different health professionals to promote pain education and knowledge to healthcare workers and the public.

Pain medicine as a medical specialty

In the 80's of 20th century the world of western medicine began to recognise persistent pain as a disorder of its own. This had led to the establishment of pain medicine as a speciality. Faculties, colleges, societies and advocacies have been set up all around the world (e.g. Australia and New Zealand, United Kingdom and United States etc).

The Hong Kong College of Anaesthesiologists established the Diploma in Pain Management in 1999 and is well recognised as a professional qualification for pain specialists for over a decade. The College has made an advancement in 2012 and bring forward the Fellowship of Pain Medicine. It is recognised by the Hong Kong Academy of Medicine and allows its fellows to register as a Specialist in Pain Medicine with the Medical Council of Hong Kong. Trainees with at least 3 years of basic training and passing the intermediate exam of their parent speciality may enter a 24-month vocational training in pain medicine, with a curriculum encompassing various aspects of the bio-psycho-social model of pain. Since 2015 the college has admitted 13 pain fellows via examination, and there are new trainees and training centres joining our course. Our pain fellowship is also gaining international recognition, with 2 of our training centres accredited by the Faculty of Pain Medicine, Australia and New Zealand College of Anaesthetists as Level 1 training centres in Hong Kong (Kowloon East Pain Management Centre, Department of Anaesthesia, Pain Medicine and Operating Service and Pain Service of Department of Anaesthesia, Pamela Youde Nethersole Eastern Hospital).

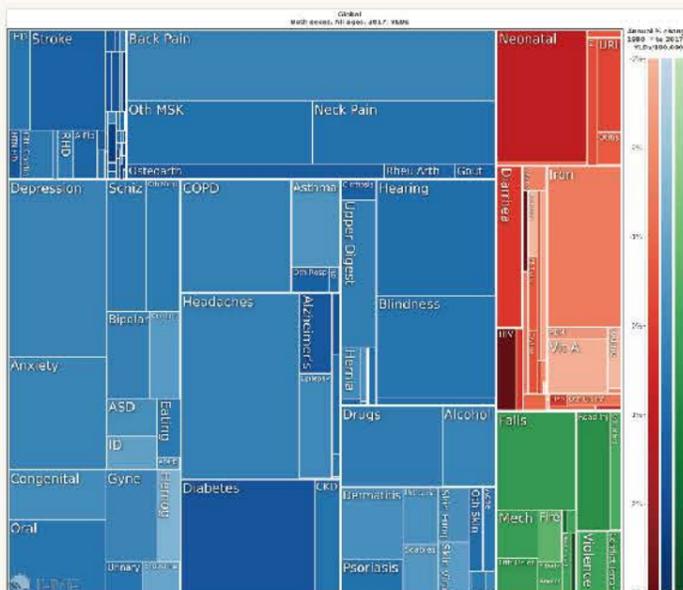


Figure 1. Treemap of leading causes of Years Lived with Disability (YLD), Global Burden of Disease 2017.

Pain education for healthcare workers

While patients with complex pain programs may require specialist care, most patients with pain can be managed in non-specialist settings. However, pain education had remained scarce in most of our undergraduate education for health professionals (see Table 1). The Essential Pain Management Workshop (EPM) was introduced to Hong Kong during the World Congress of Anaesthesiologists 2016 as a basic pain education program for all health professionals. The workshop adopts an interactive approach to equip participants with essential pain management skills, via an acronym called RAT (Recognise, Assess and Treat pain). (Figure 2) During the workshop, participants from various health disciplines (including doctors, nurses, clinical psychologists, occupational therapists and physiotherapists etc) gather and exchange ideas about multidisciplinary pain management. The Pain Management Service Committee of Hospital Authority has adopted and modified EPM into a format suitable for our frontline healthcare workers, and we have over 1200 staff underwent this workshop with very positive feedbacks. (Figures 3 and 4) Globally, EPM has also been implemented in undergraduate programs of medical, nursing and other health disciplines (e.g. New Zealand, Phillipines and United Kingdom).

Table 1. Show of hands on questions about pain education in undergraduate training (data extracted from: Essential Pain Management Workshops, 2017 – 2020)

Question	Yes	No
Do you recall receiving specific, formal undergraduate training in the multidisciplinary management of pain?	24%	76%
Do you feel that your personal undergraduate training in pain management was adequate?	10%	90%
Do you feel that undergraduates in all healthcare professions currently receive adequate training in multidisciplinary management of pain?	10%	90%

Transending from multidisciplinary to interdisciplinary pain management

Pain is a common problem to all health professionals, and once it becomes persistent, it will require huge effort to reduce disability and improve quality of life of those affected. In stead of working on the parts related to their respective disciplines, health professionals should start to adopt an interdisciplinary approach by increasing our shared understandings in pain management. The corner stone of this shared understanding is pain education. It is hoped that pain education will be available for all undergraduates and post-graduates of health professionals, with EPM as an example and platform to promote basic and essential pain education.

References:

- Rice AS, Smith BH, Blyth FM. Pain and the global burden of disease. Pain. 2016 Apr;157(4):791-6. doi: 10.1097/j.pain.0000000000000454. PMID: 26670465.
- The Global Burden of Disease VizHub. <https://vizhub.healthdata.org/gbd-compare/>
- Cheung CW, Choi SW, Wong SSC, Lee Y, Irwin MG. Changes in Prevalence, Outcomes, and Help-seeking Behavior of Chronic Pain in an Aging Population Over the Last Decade. Pain Pract. 2017 Jun;17(5):643-654. doi: 10.1111/papr.12496. Epub 2016 Oct 13. PMID: 27735140.
- Fact Sheet 1. The gap between knowledge and practice. IASP Global Year for Excellence in Pain Education. <https://www.iasp-pain.org/GlobalYear/PainEducation>
- Fricton J. The need for preventing chronic pain: the "big elephant in the room" of healthcare. Glob Adv Health Med. 2015 Jan;4(1):6-7. doi: 10.7453/gahmj.2014.075. PMID: 25694846; PMCID: PMC4311557.



Figure 2. Bookmark for EPM Workshop



Figure 3. Instructors and participants of EPM HK workshops



Figure 4. Group discussion during EPM HK workshop

A report on “4-day Workshop of Cognitive Therapy for People with Pain”

Ms. Flori LAM
Course Director,
4-day Workshop of Cognitive Therapy for People with Pain

Cognitive-Behavioural Therapy (CBT) was founded by Dr Aaron Beck in 1960s. It is a well-established, systematic and evidence-based psychotherapy which is extensively used in clinical settings for people with various mental health problems, and in non-clinical situations like general physical well-beings, schools, occupational distress. The applications can be in the format of individual, couple, family and group therapy. This approach applies what is known as Socratic dialogue, in which the questioner explores the implications of the opinions and statements of the other person, in order to stimulate rational thinking and insight. Evidenced-based cognitive-behavioral interventions, capably applied, can help to fight chronic pain. The treatment focuses specifically on helping patients to understand that it is important to optimize self-management strategies by restructuring dysfunctional thoughts, while they continue to look for a diagnosis and the right medical treatment. Guiding patients to focus on what they can do and to view the world in an understanding way as early on as possible will facilitate recovery and rehabilitation.

The Hong Kong Pain Society (HKPS) co-organized with the Department of Anesthesiology & OT Services, Kwong Wah Hospital and Yang Memorial Methodist Social Service to hold a “4-day Workshop of Cognitive Therapy for People with Pain” to train participants in the basic concepts of CBT and its application in pain management. One of objectives of the HKPS is to promote training and continued education. So we partially sponsored around 30 healthcare professionals to attend this course to equip them in treating chronic pain conditions. Due to COVID-19 Pandemic, the course was held by classroom as well as on a virtual basis from June to September 2020. The feedback was very positively and participants reported that it was very helpful not only for their clinical practice but also to their social life. Besides, some responses reported that if the course could be extended to cover the concept and handling of patient core belief. Another comment stated that the zoom arrangement was surprisingly good. All replies positively motivated us to consider holding the certificate course in Cognitive Therapy model in future.

Cognitive-Behavioural Therapy (CBT) was founded by Dr Aaron Beck in 1960s. It is a well-established, systematic and evidence-based psychotherapy which is extensively used in clinical settings for people with various mental health problems, and in non-clinical situations like general physical well-beings, schools, occupational distress. The applications can be in the format of individual, couple, family and group therapy. This approach applies what is known as Socratic dialogue, in which the questioner explores the implications of the opinions and statements of the other person, in order to stimulate rational thinking and insight. Evidenced-based cognitive-behavioral interventions, capably applied, can help to fight chronic pain. The treatment focuses specifically on helping patients to understand that it is important to optimize self-management strategies by restructuring dysfunctional thoughts, while they continue to look for a diagnosis and the right medical treatment. Guiding patients to focus on what they can do and to view the world in an understanding way as early on as possible will facilitate recovery and rehabilitation.

Chronic pain is associated with negative impacts across an array of physical and psychosocial domains, including physical functioning, sleep, mood, emotions, cognition, work, and relationships. It is a major cause of disability, financial loss, social withdrawal, and isolation. Depression, anxiety, posttraumatic stress disorder, and other psychological disorders commonly co-occur with chronic pain. For people with chronic pain, their thoughts are often automatic but not necessarily clear in the immediate consciousness, and have an intense impact on both short-term reactions and long-term adjustment about pain. In the course, participants learnt to identify chronic pain people’s maladaptive pain beliefs and the Cognitive model of Pain, the basic knowledge of assessment and case formulation.

Improved patient care remains the most important aspect for the pain care team because the integration of pain management strategies into their daily lives that will give them the optimal results. Best pain care involves a comprehensive biopsychosocial approach and includes psychosocial and proactive self-management modalities. As a healthcare provider, we play a critically important role in helping to shift patients’ perception away from a biomedical perspective about their chronic pain treatment. We educate them about the cognitive mode in changing the pain experience and coping pain properly. We validate their pain experience, provide education, and empower them with their resources to reduce their suffering. Future directions may include the broad integration of free or low cost resources into health care, including;

- Essential pain management for health professionals
- Education for patients and providers on pain care
- Hong Kong Pain Foundation

Finally, better training in pain is needed on all levels. To meet the increasing public needs and demands to prevent chronic pain, more similar training programmes should be developed. With better understanding about the definition of pain, educational policy, and scientific research efforts, the prevention and treatment of pain and suffering can be more effectively targeted.



Mindfulness practice is now being widely accepted as a clinical intervention to help the patients, professionals, or the general public handle physical and emotional distress. Apart from the most commonly promoted mindfulness-based interventions, namely, Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT), a wide variety of mindfulness-based therapeutic protocols are now welcome by healthcare teams to enrich their resources in helping patients' in the clinical settings.

The featuring of the Jon Kabat Zinn in the documentary "Healing from Within" captured his aspiration started in the late '70s in helping patients who suffered deeply, both physically and emotionally. The distressful physical condition had eroded the patients' sense of hope. Kabat Zinn's MBSR groups offered in the hospital became a turning point to instill hope for patients. Since then, numerous research studies in the past 40 years shows promising results for mindfulness practice in helping patients who suffered from chronic pain and other physical and emotional conditions.

While mindfulness practice is getting popular as an intervention, contemplating "why it helps?" is vital for future development. The positive outcomes are usually being ascribed scientifically as an indicator of the mind-body connection. Nevertheless, the quality of presence demonstrated by the mindfulness teacher is sometimes overlooked. Started from Kabat Zinn's story, the quality of presence and compassionate care received by the patients in his group was indeed one of the essential components of the healing atmosphere in his MBSR group. Patients' physical and emotional pain was felt, witnessed, understood, and embraced in the group environment. The capacity to be able to sit with the pain was enhanced.

In traditional medical practice, the primary goal points towards fixing the pain rather than "being present" with the pain. The humanistic value of being able to be present with the patients and the pain they are going through are usually forgotten. Any attempt to put it into practice seems like a test of mental and emotional stability among the professionals, especially in a highly stressful working environment with critical time pressure.

In recent years, mindfulness practice is gaining its popularity among medical teams. Apart from being promoted as the skills for stress management, its impact to cultivate clarity and compassion in medical practice is being recognized. Such training guides the medical profession to acknowledge frustration, uncertainties, and grief as typical medical care components. Through the formal meditation training, appreciative inquiry, and the narrative exercises, practitioners are reminded of the importance of self-care for the individual and relational care for their fellow team members. These factors become the building blocks for a caring atmosphere in the medical practice environment.

Mindful Practice® for healthcare professional training is currently offered by the Centre on Behavioral Health, The University of Hong Kong. Registration is now open for the Nov 2020 and Jan 2021 training groups. The project is sponsored by The D. H. Chen Foundation and offered for free.

For more information, please visit:
<https://www.cbh.hku.hk/4-day-mindfulness-training-extra>

Mindfulness practice:
feeling,
witnessing,
understanding,
embracing the pain

Dr Venus P. Y. WONG
Lecturer and Acting Program Director –
Master of Social Sciences (Behavioral Health)
The University of Hong Kong.

FPM
ANZCA



The 2021 Combined Spring Meeting
of the Faculty of Pain Medicine and the
Hong Kong College of Anaesthesiologists

Moving with pain

15-17 October 2021 | Millennium hotel | Queenstown, New Zealand

The Faculty of Pain Medicine, ANZCA, and the Hong Kong College of Anaesthesiologists organising committee are excited to announce that the Combined Spring Meeting will now take place in October 2021 in Queenstown, New Zealand. The theme will be "Moving with pain".

This meeting will take place across three days, 15-17 October 2021 with a range of workshops, sessions, and social events. The meeting will be run in a hybrid format, allowing for those restricted from travel to participate and continue their professional development from any location.

The Combined Spring Meeting will welcome speakers from across Australia, New Zealand, Hong Kong, the UK and Taiwan. They will bring their experiences to the meeting to provide a uniquely international perspective where the east meets west.

Professor Paul Cameron, our international keynote speaker from the United Kingdom, will be presenting on barriers to moving with pain, pain advocacy and pain moving

through the ages. He will be joined by experts sharing their knowledge on a variety of topics focusing on how to get people moving including sports medicine, regenerative medicine, nutrition, and the gut microbiome. We will also have a range of experts discussing the alternative and complementary treatments of tai chi, yoga and acupuncture.

The international speaker representation will provide opportunity for a panel discussion on the pros and cons of the differing national pain strategies.

Visit the ANZCA website for more information. Details regarding the program, speakers and registration will be made available over the coming months so stay tuned!

#painCSM21





Announcements

- Annual Scientific Meeting cum Annual General Meeting of HKPS (Virtual webinar)
Date: 7th Nov 2020
Registration link:
https://cuhk.zoom.us/webinar/register/WN_exHGk0WqSg-TGg07hbW7sw
- Promotion:
Pain Association of Singapore - Annual Scientific Meeting (Virtual meeting)
Date: 27th Mar 2021
Registration link:
<https://www.pain-asm.com/registration>

HKPS Council 2019-2021:

President:
Dr. WONG Ho Shan, Steven
Vice President:
Dr. HUI Kit Man, Grace
Hon Secretary:
Dr. LEUNG Wing Yan, Doris
Hon Treasurer:
Ms. LAM Chi Wing, Flori

Council members:

Dr. KWOK Oi Ling, Annie
Dr. LAW Sheung Wai
Dr. LI Ching Fan, Carina
Dr. LEUNG Carmen
Dr. LEUNG Siu Man, Simon
Ms. MA Wai Ling, Eva
Dr. POON Sau Kwan, Connie
Dr. SUN Tin Fung, David
Dr. TSANG Man Han, Sharon

Newsletter Editorial Committee (2020)

Editor:
Dr. CHENG Wai Hui, Christina
Treasurer:
Dr. CHAN Chi Wing, Timmy
Ms. FOK Yan Yan
Ms. LAM Flori
Mr. LEUNG Kenneth
Dr. LEUNG Wing Yan, Doris
Ms. NG Terry
Dr. WONG Chung Hin, Willy

HKPS membership:

Benefits:

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

Lifetime membership with single payments \$3000
Regular membership with annual renewal \$300

Please click on:
www.hkpainsociety.org/memberships.htm
for details and membership form.

Dynastat™
(parecoxib sodium for injection)

A SIMPLE and TRUSTWORTHY WAY on Pain Management



The First and Only Injectable COXIB Indicated for the Short-term Treatment of Postoperative Pain^{1,2}

- ◆ Same dose for IV or IM administration²
- ◆ Can be used with opioid analgesics²

Fast Acting

- ◆ Dynastat 40 mg IV relieves pain as soon as 7 mins³
 - after total abdominal hysterectomy or myomectomy

Long Lasting

- ◆ Dynastat 40 mg IM provides sustained pain relief up to 12 hrs⁴
 - after gynecologic surgery

Opioid Sparing

- ◆ Dynastat 40 mg reduces postoperative morphine consumption
 - after open prostatectomy⁵, GI laparotomy⁶ or orthopedic surgery⁷

Promising Safety Profile

- ◆ GI-related AEs comparable with placebo⁸
- ◆ No significant effect on arachidonate-induced platelet aggregation⁹

*Median onset time, ranged from 3-13 mins
AEs: Adverse events; COXIB: Selective cyclooxygenase-2 inhibitor; GI: Gastrointestinal; IM: Intramuscular; IV: Intravenous

References
1. Drug Office, Department of Health. HKSAR. Drug Database Search. Available at: <https://www.drugoffice.gov.hk/epa/drug/productSearchOneFieldAction> (Accessed on 10 May 2019). 2. Dynastat (parecoxib) Prescribing Information. Pfizer Corporation Hong Kong Limited. HK Version May 2017. 3. Birkhøj GB et al. Am J Obstet Gynecol. 2004; 191: 1183-91. 4. Malan TP et al. Anesth Analg. 2005; 100: 454-60. 5. Dirkmann et al. BMC Anesthesiol. 2015; 15: 31. 6. Essex MH et al. Int J Gen Med. 2017; 10: 319. 7. Diaz-Borjon E et al. Pain Ther. 2017; 6: 61-72. 8. Schug SA et al. J Pain Res. 2017; 10: 2451-59. 9. Nowacki R et al. Clin Drug Invest. 2001; 21: 465-75.

DYNASTAT ABBREVIATED PRESCRIBING INFORMATION
1. TRADE NAME: Dynastat 2. PRESENTATION: 40 mg powder vial. Each vial contains 40 mg parecoxib (present as 42.36 mg parecoxib sodium) for reconstitution. After reconstitution, the final concentration of parecoxib is 20 mg/ml. When reconstituted in sodium chloride 9 mg/ml (0.9%) solution, Dynastat contains approximately 0.44 mmol of sodium per vial. 3. INDICATIONS: short-term treatment of postoperative pain. 4. DOSAGE: 40 mg administered intravenously (IV) or intramuscularly (IM), followed every 6 to 12 hours by 20 mg or 40 mg as required, not to exceed 80 mg/day. Dynastat should be used at the lowest effective dose for the shortest possible time. 5. CONTRAINDICATIONS: hypersensitivity to the active substance or to any of the excipients; history of previous serious allergic drug reaction of any type, especially cutaneous reactions such as Steven-Johnson syndrome, toxic epidermal necrolysis, erythema multiforme or patients with known hypersensitivity to sulphonamides; active peptic ulceration or gastrointestinal (GI) bleeding; patients who have experienced bronchospasm, acute rhinitis, nasal polyps, angioedema, urticaria or other allergic-type reactions after taking acetylsalicylic acid or NSAIDs including COX-2 (cyclooxygenase-2) inhibitors; third trimester of pregnancy and breastfeeding; severe hepatic dysfunction (serum albumin <25 g/l or Child-Pugh score >10); inflammatory bowel disease; congestive heart failure (NYHA III-IV); treatment of post-operative pain following coronary artery bypass graft (CABG) surgery; established ischaemic heart disease; peripheral arterial disease and/or cerebrovascular disease. 6. WARNINGS & PRECAUTIONS: Modes of administration other than IV or IM (e.g. intra-articular, intrathecal) have not been studied and should not be used; limited clinical experience with Dynastat treatment beyond three days; COX-2 inhibitors have been associated with increased risk of cardiovascular and thrombotic adverse events when taken long term; NSAIDs may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal, in patients with cardiovascular disease; patients with significant risk factors for cardiovascular events should only be treated with parecoxib sodium after careful consideration; not a substitute for acetylsalicylic acid for prophylaxis of cardiovascular thrombotic diseases because of their lack of antiplatelet effects; co-administering with warfarin and other oral anticoagulants; may mask fever and other signs of infection in surgical patients; increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal; caution is advised in treatment of patients most at risk of developing a gastrointestinal complication with NSAIDs; the elderly, patients using any other NSAID or acetylsalicylic acid concomitantly, glucocorticoids, selective serotonin reuptake inhibitors, patients ingesting alcohol or patients with a prior history of gastrointestinal disease; further increase in the risk of gastrointestinal adverse effects, when parecoxib sodium is taken concomitantly with acetylsalicylic acid (even at low doses); serious skin reactions, including erythema multiforme, exfoliative dermatitis, and Steven-Johnson syndrome (some of them fatal), should be discontinued at the first appearance of skin rash, mucosal lesions, or any other sign of hypersensitivity; patients with a history of sulphonamide allergy may be at greater risk of skin reactions; in patients with impaired renal function or hypertension, or in patients with compromised cardiac or hepatic function or dehydration or other conditions predisposing to fluid retention; not recommended in patients with advanced renal disease; caution in patients with moderate hepatic impairment (Child-Pugh score 7-9). If during treatment, patients deteriorate in any of the organ system functions described above, appropriate measures should be taken and discontinuation of parecoxib sodium therapy should be considered. 7. INTERACTIONS: fluconazole, angiotensin-converting enzyme (ACE) inhibitors, angiotensin II inhibitors, diuretics, beta blockers, ciclosporin, tacrolimus, warfarin or other anticoagulants, NSAIDs, including selective COX-2 inhibitors, lithium, rifampicin, phenytoin, carbamazepine, dexamethasone, methotrexate, substrates of CYP2C19 (e.g. omeprazole, phenytoin, diltiazem, or imipramine) and CYP2D6 and which have narrow therapeutic margins (e.g. flecainide, propafenone, metoprolol). 8. PREGNANCY AND LACTATION: contraindicated in the third trimester of pregnancy; increased risk of miscarriage when used in early pregnancy; should not be used during the first two trimesters of pregnancy unless clearly necessary; must not be administered to women who breast-feed. 9. COMMON SIDE EFFECTS: dizziness, abdominal pain, vomiting, constipation, hyperhidrosis, anaemia post-operative, hypokalaemia, agitation, insomnia, hypoesthesia, hypertension, hypotension, respiratory insufficiency, pharyngitis, alveolar osteitis (dry socket), dyspepsia, flatulence, pruritus, back pain, oliguria, oedema peripheral, blood creatinine increased.
Reference: HK PI (version date May 2017)
Date of preparation: Feb 2019
Identifier number: DYN0219
FULL PRESCRIBING INFORMATION IS AVAILABLE UPON REQUEST.



Pfizer Corporation Hong Kong Limited
18/F., Kerry Centre, 683 King's Road, Quarry Bay, Hong Kong
T +852 2811 9711 F +852 2579 0599 www.pfizer.com.hk

Paracetamol B. Braun

Reliable and Effective Pain Relief for Postsurgical and ICU Patients



>2x more likely to reduce fever versus placebo¹



Significantly reduces opioid consumption²



Similar safety profile to placebo³



Patients were >2x as likely as those receiving placebo to report 'Excellent' satisfaction rating⁴



Recommended by ASA and ERAS Society guidelines for use in postoperative patients^{5,6}

Paracetamol B. Braun is licensed for the treatment of pain or fever when IV administration is clinically justified⁷ or other routes of administration are not possible⁷



¹Urgent need to treat pain or hyperthermia.

ASA, American Society of Anesthesiologists; ERAS, Enhanced Recovery After Surgery; ICU, intensive care unit; IV, intravenous.

References

1. Tsaganos T, et al. *Br J Clin Pharmacol* 2017;89:742-750. 2. Memis D, et al. *J Crit Care* 2010;25:438-462. 3. Koh W, et al. *Korean J Anesthesiol* 2015; 58:3-12. 4. Apfel C, et al. *J Healthc Qual* 2015;37:155-162. 5. American Society of Anesthesiologists Task Force on Acute Pain Management. *Anesthesiology* 2012;116:249-273. 6. Feldheiser A, et al. *Acta Anaesthesiol Scand* 2016;60:289-334. 7. Paracetamol B. Braun 10 mg/mL Solution for Infusion Prescribing Information. Revised April 2019.

Paracetamol B. Braun 10 mg/mL Solution for Infusion

Indications: • Short-term treatment of moderate pain, especially following surgery • Short-term treatment of fever, when administration by intravenous route is clinically justified by an urgent need to treat pain or hyperthermia and/or when other routes of administration are not possible. **Dosage and administration:** The dose to be administered and the bottle size to be used depend exclusively on the patient's weight. *50 mL bottle restricted to toddlers and children weighing > 10 kg to < 33 kg; 15 mg/kg (1.5 mL/kg) per administration on, max daily dose 60 mg/kg (not exceeding 2 g).* *100 mL bottle restricted to adults, adolescents and children weighing > 33 kg; 15 mg/kg (1.5 mL/kg) per administration for patients > 33 kg to < 50 kg, max daily dose 60 mg/kg (not exceeding 3 g); 1 g (100 mL) per administration for patients > 50 kg with no additional risk factors for hepatotoxicity, max daily dose 4 g; 1 g (100 mL) per administration for patients > 50 kg with additional risk factors for hepatotoxicity, max daily dose 3 g. The max daily dose should be adjusted accordingly taking the administration of other paracetamol-containing products into account. No more than 4 doses to be given in 24 hours. **Administration:** The paracetamol solution is administered as a 15-minute IV infusion. The minimum interval between each administration must be at least 4 hours, and at least 6 hours in patients with severe renal insufficiency. The product can be diluted in a 9 mg/mL (0.9% sodium chloride solution or 50 mg/mL (5% glucose solution or a combination of both solutions up to one tenth (one volume Paracetamol B. Braun into nine volumes diluent). In this case, use the diluted solution within the hour following its preparation (infusion time included). For single use only. **Contraindication:** • Hypersensitivity to paracetamol, propacetamol hydrochloride (prodrug of paracetamol) or to any of the excipients (Mannitol, Sodium citrate dihydrate, Acetic acid glacial and Water for injections). • Cases of severe hepatocellular insufficiency. **Special precautions:** Risk of medication errors due to confusion between mg and mL. Prolonged or frequent use is discouraged. May require dose adjustment if other medicines administered contain either paracetamol or propacetamol. Doses higher than those recommended entail the risk of very serious liver damage. Use with caution in cases of: • Hepatocellular insufficiency • Severe renal insufficiency (Creatinine clearance < 30 mL/min) • Chronic alcoholism • Chronic malnutrition/low reserves of hepatic glutathione • Dehydration • Genetically caused G-6-PD deficiency (haemolytic anaemia possible). Contains less than 1 mmol sodium (23 mg) per container, i.e. essentially 'sodium-free'. **Interactions:** Probenecid, Salicyamide, Enzyme-inducing substances, Oral anticoagulants, when paracetamol is dosed 4 g per day for > 4 days. **Adverse reactions: Frequent:** Adverse reactions at injection site (pain and burning sensation). **Rare:** Malaise, increased levels of hepatic transaminases, hypotension. **Very rare:** Thrombocytopenia, leucopenia, neutropenia, hypersensitivity reaction, serious skin reactions. **Frequency not known:** Pruritus, erythema, flushing, tachycardia. **Presentation:** 50 mL bottle containing 500 mg paracetamol; 100 mL bottle containing 1,000 mg paracetamol.*

Refer to full packaging leaflet for complete information. Ref: 04/2019

Please refer to full prescribing information before prescribing.

B. Braun Medical (H.K.) Ltd.

Unit Nos. 13-18, Level 35, Tower 1, Millennium City 1, No. 388 Kwun Tong Road, Kwun Tong, Hong Kong
Tel: (852) 2277 6100 | Fax: (852) 2865 6095 | www.bbraun.com

B | BRAUN
SHARING EXPERTISE