Pain
NEWSLETTER
香 港 疼 痛 學 會
The Hong Kong Pain Society
December 2012

Say Goodbye to HEADACHE ...

Headache & Cephalgia

World Congress of Pain in Milan

Puzzles of Pain

Painful Apps

Innovative Partnership in Pain Management

原始的美

Pain Specialist-Patient's View

Message from the President

Dear colleagues and friends,

I hope you enjoy reading the series of electronic newsletter published since early this year. It would not be possible without the tremendous effort from members of the editorial board. I welcome you to share this environmental friendly means of communication with your colleagues and friends. This will further broaden the coverage of our newsletter and help attract more sponsorship from our industrial partners to keep this work going.

I attended the World Congress on Pain organized by the International Association for the Study of Pain (IASP) in August in Milan. It was the largest ever international pain conference with over 7,800 participants. Being a chapter of IASP, our Society shares the same vision and mission as that of the IASP, i.e. to promote multidisciplinary collaboration in the study and management of pain. I do encourage our members to join the IASP so as to strengthen our international network and assist in promoting pain education in less developed countries.

The Annual Scientific Meeting of our Society was held on 15th September 2012. The meeting was well attended by our members and the response was very favourable. We were also able to recruit a number of new members.

I am sure with your participation our Society will continue to sprout and grow, as symbolized by the logo of our Society.

Dr Steven Wong
President
Hong Kong Pain Society

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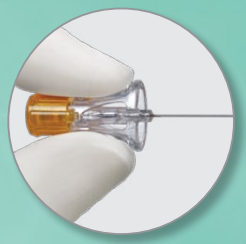

2. Crystal Prism

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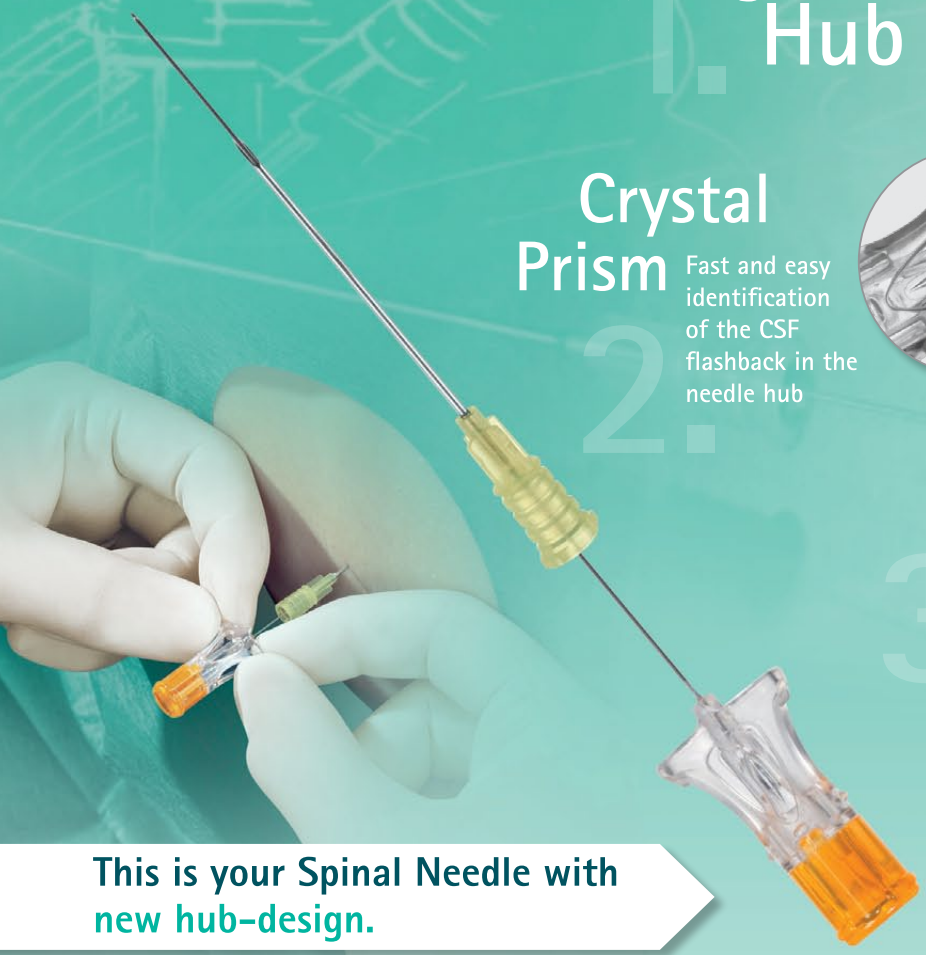

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	26G	88	0.45	3 1/2"	25	4502906-10
	26G	120	0.45	4 3/4"	25	4504917-13
	25G	75	0.50	3"	25	4505751-10
	25G	88	0.50	3 1/2"	25	4505905-10
	25G	120	0.50	4 3/4"	25	4505913-13
	22G	40	0.70	1 1/2"	25	4507401-13
	22G	75	0.70	3"	25	4507754-13
	22G	88	0.70	3 1/2"	25	4507908-10
	22G	120	0.70	4 3/4"	25	4506090-13
	20G	75	0.90	3"	25	4509757-13
	20G	88	0.90	3 1/2"	25	4509900-10
	19G	40	1.10	1 1/2"	25	4501144-13
	19G	88	1.10	3 1/2"	25	4501195-13
	18G	75	1.30	3"	25	4501373-13
	18G	88	1.30	3 1/2"	25	4501390-10

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	27G	88	0.40	3 1/2"	25	4502027-10
	27G	120	0.40	4 3/4"	25	4502132-13
	25G	25	0.50	1"	25	4502167-13
	25G	50	0.50	2"	25	4502159-13
	25G	88	0.50	3 1/2"	25	4502019-10
	25G	120	0.50	4 3/4"	25	4502120-13
	22G	88	0.70	3 1/2"	25	4502035-13
	27G	88*	0.40	3 1/2"	25	4502051-13
	27G	103*	0.40	4"	25	4502124-13
	25G	88*	0.50	3 1/2"	25	4502043-13
	25G	103*	0.50	4"	25	4502116-13

Guide needles	Size	Length ø (mm)	Needle ø (mm)	Length (inch)	Sales unit/ Pcs.	Code No. (REF)
	for spinal needles ■ 26G and ■ 25G					
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Editor's Note

In this issue of Hong Kong Pain Society Newsletter, we are pleased to say goodbye to the "Global Year against Headache" and welcome the "Global year against Visceral Pain". We have a chance to understand "pain" from different corners of the world. Neurologists Dr Raymond Chan from UK and Dr NG PW from HK gave us a comprehensive review on headache management. Dr Brenda Lau provided us an insight of pain service platform development in Canada. Dr Steven Wong, our president also shared with us his experience in the Hong Kong Pain Society Annual Scientific Meeting. Moreover we have input from an Aussie pain patient who live in Hong Kong. I am eager to learn from his local experience .You also will find Dr Law's documentary on "Missing Pieces of Pain Puzzle" and Miss Flori Lam's travel diary in Milan attractive. Hopefully our members can take a break from work, relax and enjoy this publication.

Last but not the least, let's welcome the the Global Year against Viseral Pain. http://www.iasp-pain.org/Content/NavigationMenu/GlobalYearAgainstPain/GlobalYearAgainstVisceralPain/PressRelease/default.htm Prevention is better than cure in pain management. Don't eat too much in order to be free from indigestion, which is a form of visceral pain during holidays. Wish you merry Christmas and happy new year.

Subeditor: **Dr Alice Man**
Private anaesthetist

Editor: **Dr Grace Hui Kit Man**
Associate Consultant, Anaes, QEH

Contents

Hong Kong Pain Newsletter is published quarterly. For advertising enquiries, please contact **Dr Grace Hui** at huikmg@ha.org.hk

The editor welcomes contributions including clinical reports, letters or news of interest to members. Please feel free to submit the material to **Dr Alice Man** at alicekyman@gmail.com

Tension-type headache Migraine and Trigeminal Autonomic Cephalgias : Total Strategy of Management

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Dr. NG, Ping Wing
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This is our pleasure to write up an article for the Hong Kong Pain Society concerning the management of primary headache disorders from the perspectives of a neurologist.

Tension-type headache (TTH) is the commonest primary headache and its lifetime prevalence is between 30% to 78% in population-based study. Most patients had infrequent episodic TTH without seeking medical attention, 24–37% had frequent episodic TTH and 2–3% had chronic TTH. Patients are usually able to manage their mild to moderate episodic TTH with simple analgesics, used alone or in combination, such as paracetamol, aspirin or non-steroidal anti-inflammatory drugs (NSAIDs)[1]. However in severe form or chronic TTH, simple analgesics alone seem do not help particularly when the headache is associated with other psychological comorbidities such as depression, stress and anxiety. In this situation, non-pharmacological treatments and other prophylactic pharmacotherapy should be emphasized such that pain can be adequately relieved without causing medications overuse. Amitriptyline

is the prophylactic drug of choice for chronic TTH[1]. Mirtazapine or venlafaxine are probably effective[1], whilst the other antidepressants, clomipramine, maprotiline and mianserin, may be effective[1]. Identification and avoidance of trigger factors, cognitive behavioural therapy, relaxation training and electromyography biofeedback constitute the important components of non-pharmacological treatments[1]. Physical therapy and

acupuncture certainly may help although there is no robust scientific evidence for its efficacy[1].

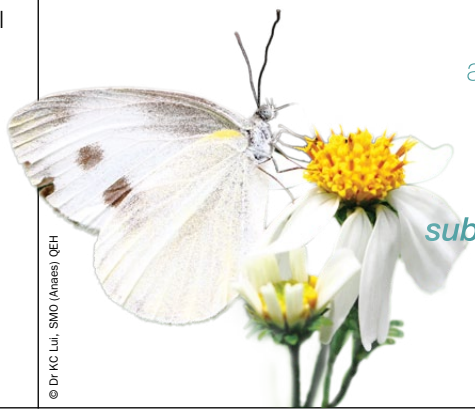
Migraine is one of the debilitating primary headaches that may bring patients to seek urgent attention. The principles of management consist of accurate diagnosis since migraine can mimic other types of headache disorders, avoidance of trigger factors as well as use of appropriate abortive and prophylactic treatments. Analgesics including paracetamol, aspirin or NSAIDS with or without antiemetics are the first drugs of choice for mild to moderate attack[2]. If they fail or headache is severe, one may consider triptans or ergot alkaloids provided that there are no contraindications such as ischemic heart disease, ischemic stroke, untreated arterial hypertension, Raynaud's disease, renal failure, pregnancy and lactation[2]. They should not be used together and should not exceed the recommended doses per month to avoid triptan- or ergotamine-overuse headache. When appropriate acute therapy cannot give adequate symptom control or there is over-frequent use of acute therapy, one should consider initiation of prophylactic treatment. Beta-blockers of metoprolol and propanolol, calcium channel blocker of flunarizine and anticonvulsants of valproic acid and topiramate are considered as first-line prophylactic treatment[2]. Other second-line drugs include amitriptyline and venlafaxine[2]. Now Onabotulinumtoxin A is also approved for preventive treatment of chronic migraine in the UK, Canada and United States after two large class I multicenter studies, PREEMPT 1 and PREEMPT 2, had been published[3-4].

Another important category is trigeminal autonomic cephalgias (TACs) consisting of cluster headache (episodic or chronic type), paroxysmal hemicrania, short-lasting unilateral neuralgiform headache attacks with conjunctival injection and tearing (SUNCT) or short-lasting unilateral neuralgiform headache attacks with cranial autonomic features (SUNA). Study showed that there was a mean of 6.6 years delay to diagnose cluster headache[5], suggesting that it was missed by general practitioner or less experienced general neurologist. TACs are characterized by prominent cranial autonomic features including conjunctival injection, lacrimation, ptosis, miosis, eyelid edema, forehead/facial sweating, rhinorrhoea and nasal congestion. Differentiation between TACs and migraine requires detailed history taking as autonomic features were reported to occur in some cases of migraine. In contrast to classical migraine, TACs are featured by excruciating unilateral stabbing pain leading to restlessness or agitation, multiple attacks per day with shorter duration ranging from few seconds to few hours depending on the subtype of TACs and presence of prominent cranial autonomic symptoms. Neuroimaging should be considered in all patients with TACs or TAC-like headaches with atypical presentation as studies showed that a portion of cases were due to secondary causes such as vascular lesions and tumors[6]. Table 1 showed the red flags suggesting the presence of secondary causes of headache which warrant further neuroimaging. In cluster headache, abortive

treatment is important to stop the devastating attack. Oxygen therapy, subcutaneous sumatriptan and nasal zolmitriptan are all considered effective in abortion of attack[7-8]. Verapamil is the drug of choice for long term prevention[7-8]. It was superior to placebo in randomized controlled trials and was considered to be more favourable than Lithium. It is suggested to escalate the dose every two weeks and the final effective dosage can be up to 960mg daily which is considered higher than its usage in cardiological indications and thus regular

ECG monitoring should be employed. Since it takes time to reach its maximal effect, therefore counseling and sometimes transitional treatment is required. Lithium is an effective agent although the response is less robust in episodic than chronic cluster headache[7-8]. Topiramate is another useful drug of frequent use in clinical practice[7-8]. Methysergide is a potent prophylactic agent but it is associated with small but significant risk of fibrotic complications and the continuous use of it should be limited to six months only[7-8]. Other drugs such as gabapentin, valproic acid, melatonin, and baclofen were reported helpful in some cases. Although there is no sufficient evidence to suggest the roles of steroid and ergotamines in long term prevention but they were often commenced as transitional treatment. Greater occipital nerve (GON) injection was considered a safe and useful procedure to reduce pain severity in short term and can be considered as a trial of bridging therapy. With advances in functional neuroimaging and more understanding about the pathophysiology of cluster headache, deep brain stimulation (DBS) targeting at posterior inferior hypothalamus seems to be an option for those with medically intractable cluster headache but more trials are warranted before it is conclusive[9]. Co mpared with DBS, occipital nerve stimulation (ONS) is less risky and there is evidence to suggest its efficacy[10-12]. For all new cases presented with TAC-like headache, it worths for a trial of Indomethacin since paroxysmal hemicrania is “Indomethacin-responsive headache” and this helps to nearly exclude cluster headache in which they share some overlapping features[8]. There is no abortive treatment for SUNCT/SUNA as the symptoms is so ultra-acute and therefore preventive treatment is more important and relevant. Lamotrigine was reported to have the highest efficacy although there was no randomized controlled trials[8].

In summary, it is important to accurately diagnose the subtype of headache as this determines the subsequent pathway of management. Management plan should be individualized and should take into account of headache frequency, patient comorbidities, and side effects. It is recommended to regularly keep a headache diary for all primary headache patients so as to evaluate the efficacy of treatment. If there is any doubt in diagnosis especially for those presented with multiple headache phenotypes, if the pain is refractory to treatment or if headache is associated with red flags and suspected due to secondary cause, referral to specialist is recommended.



© Dr KC Lui, SMO (Anaes) QEH

It is important to accurately diagnose the subtype of headache as this determines the ***subsequent pathway of management.***

Red flags to suggest secondary headache

- History of malignancy or immunodeficiency
- Sudden onset of (severe) headache
- Onset after age 50 years Progressive pattern
- Systemic symptoms or signs Focal neurological deficit
- Features of intracranial hypertension

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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
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AI-P233-L-298 Nov 2010

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A Promise for Life

Tackling the clinical and economic burden of disabling persistent pain through innovative partnerships-

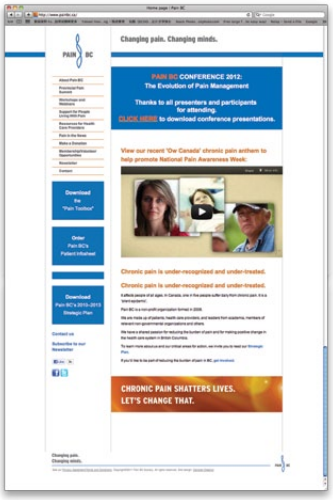
A Canadian Example

Dr. Brenda Lau
MD FRCPC FFPMANZCA MM
Clinical Assistant Professor, University of British Columbia, Advisor, PainBC Board of Directors

In Canada, much progress has been made to improve awareness and access to pain services in particular over the last 4 years. In the era of fiscal restraint and pressure on existing resources, it is indeed a challenge for pain providers to maintain let alone expand pain services. In this article, I summarize the innovative initiatives across the province of British Columbia in facilitating early access to resources in the community to reduce reliance on the few tertiary-level pain centers.

Prior to 2008, pain services in British Columbia had largely consisted of isolated centres of care be they tertiary level hospital based interdisciplinary pain clinics, focused single disease/syndrome specific services such as headache or fibromyalgia and numerous private based pain services involving services not currently funded by the medical services plan. GPs and other healthcare providers alike were frustrated with the inability to get help as the wait lists were 2-4 years. Due to this poor access, emergency departments became a refuge for not only acute but chronic pain and chronic disease management.

To improve linkages between previously isolated services and transfer of knowledge to patients and providers, a key grassroots organization, PainBC society, was formed in 2009. This group of health service providers, academics, administrators, patients and affiliated pain service organization representatives focused first on assisting both patients and providers in navigating the existing services through the web-based and social networking technologies. Resources are continuously being collated to make access easier. See www.painbc.ca.



The website also serves as a forum where concerns and issues can be discussed and allows for a platform through which innovative local and systems solutions can be explored. A second parallel objective was the organized dissemination of evidence-based and practical information in the current understanding and management of various pain conditions and pain-related disabilities. Lastly, it was focused on facilitating the processes in the development of the cross-system multi-level partnerships required to bring about truly accessible pain and disability management services.

Through the efforts of PainBC and the multiple partnerships developed, gradual progress is being made in the integration of previously fragmented services. Multiple province-wide initiatives have spawned and are leveraging each others' resources to bring about improved access for both patients and providers alike.

Since 2009, these initiatives have been derived from multiple stakeholders across the province and across the continuum of care. These include from the healthcare providers and all with pain care interests (non-profit organization PainBC society), from the health authorities (province-wide pain specialist hot line and the province-wide pelvic pain program), from the University of Victoria, department of Ageing (community based Pain Self-management programs), from the patient-led support network (People in Pain Network- PiPain), from the innovative projects committees of the BC medical association (province wide GP education initiative of the Practice Support Program launching programs on various chronic disease conditions most recently the musculoskeletal disorders), and from various community organizations (BC coalition for Persons with Disabilities, Organization For the Disabled Foundation, Arthritis society).

In June 2012, the work has begun on a province-wide Practice support Program (PSP) dedicated to pain management. This initiative is supported by tripartite funding and resources: BCMA via the innovation projects committees (specialist services, shared care and GP services committees), the Fraserhealth authority (one of five regional health authorities in BC) and the Simon Fraser University. This initiative is premised on community GP education via the PSP model and supported by on site preceptorships and ongoing support through mentor pain champions. The second major directive is tackling the pain management issues within the tertiary-hospitals via the resources of nurse pain champions.

PainBC's role in facilitating the partnerships and providing stewardship in various healthsystem redesign efforts has been the major success factor in aligning the work and resources of many initiatives. In challenging the traditional work silos of the above-mentioned stakeholders, the whole society benefits from creative and synergistic approaches in tackling the clinical and economic problems of disabling persistent pain.

Weblinks

Pain BC society:
www.painbc.ca

People in Pain Network:
www. Pipain.com

BC self-management programs in pain, arthritis and fibromyalgia:
www.selfmanagementbc.ca/upcomingworkshops

Practice support program:
www.practicesupport.bc.ca/psp/practice-support-program

Travel Diary of World Congress of Pain in Milan

Ms Flori Lam
APN (Anaes & OTS), Queen Elizabeth Hospital

Milan is the city of fashion, history and finance. This is the home city of Armani, Versace, Prada, Dolce & Gabbana, Gucci etc. The Duomo di Milano is the Gothic style cathedral that most Hong Kong people must be familiar with. The Teatro alla Scala is one of the most famous theatres. Leonardo da Vinci's *The Last Supper* is the world famous painting.

Luckily, I was able to visit such legendary tourists' spots eventually. But attending a conference is definitely different from an ordinary tour.

I took the Saturday mid-night flight from Hong Kong to Milan, Italy. After spending about 12 hours in the cabin, I was delighted to breathe in deeply the first fresh air at the Malpensa Airport around 7 am Sunday local time. But instead of catching up with some sleep in my hotel room, I chose to rush to attend the refresher course at the Pain Congress at 9am. Not a minute of this golden opportunity to learn should be wasted. I felt like a sponge, soaking in every bit of new information in pain medicine.

The 30-minutes walk from the hotel to the Congress venue became my daily morning exercise. The morning lectures helped to fight my jet lag and refreshed me. It was said the best way to tour around a city is by walking. Even when they are on the way to walk, Italians only stroll at half the speed of the Hong Kong people and they will never hesitate to stop by for a cup espresso at a coffee shop to start off their daily work. The Italian philosophy of life has inspired me a lot, who has been overwhelmed in the hassle of Hong Kong city life for a long time.

Basically the highly admired activity of shopping for fashion was out of the question. Let alone the monetary factor, the conference schedule was very tightly packed. Though not a shopaholic myself, I believe it is a sin to leave Milan empty-handed. A few pairs of new shoes and handbags, etc. were remedies to avoid the Post Milan Pain.

Lake Como is situated near the late district of northern Italy. This was the only discovery tour organized by the conference that I joined. It was not as spectacular as I imagined but was still a very enjoyable break between the busy schedules.

Milan is a city with a very efficient underground railway, not as convenient as in Hong Kong though. Exploring the city by your own was easy. The temptation to taste gelato at every street corner was simply irresistible.

The colourful mixes, the extraordinary flavours, the happy faces, the vibrant city – all magically came to life with a small bite of gelato.

While exploring the city, I very soon noticed that many people were walking around with the green conference souvenir bags. The red strap was especially unmistakable. With simple smile with a nod, we immediately greeted and recognized each other as the 'Pain People'. We were strangers from different parts of the world coming to attend the same Pain Congress in Milan, but we all share some common beliefs and aspiration in striving for better care pain patients. It was a wonderful feeling that our same missions are being carried out in so many different parts of the world for the benefit of so many people.

highlight : Painful Apps on iphone & Android

Health and fitness

You can try to install some of the apps below. The editor declares no conflict of interest!

Available on the iPhone App Store

Available on the Android Market

Paid >

Pain By Doctot

Clinician-administered assessment scales and lookup tables related to pain patients

Paid >

Pain Retreat

For parents with children suffering from abdominal pain and headache

Free >

Manage my Pain Lite

Clinician-administered assessment scales and lookup tables related to pain patients

Free >

Pain Scale

Simple VAS and smiley faces etc

Free >

PainWeek

Educational meetings

Free >

PainClinician

Medical resources and exchange ideas

Free >

Pain Care

Patients input their pain type, severity and the use of Medications to share with their clinicians through internet.

Free >

Pain log

To log pain details, colour the body map and take photo and share.

Paid >

Pain Killer 2.0

Uses binaural beat methodology to release endorphins for pain

Free >

Pain Guide

Quick reference for pain management for medical students and residents

Free >

Joint pain news

Articles on joint pain.

Free >

Muscle trigger point anatomy

Anatomy of muscle trigger points

Paid >

Pain Free back

Diagnose the type of back pain and graded exercise program

Free >

Pain Free back Lite

Same as above but free app with limited functions

Free >

Back pain

News on back pain

Free >

PM

Pain management e-pocket card

Free >

Pain Care

Patients input information to share their clinicans

Paid >

Pain Monitor Lite

Pain diary

Free >

Rheumatrack

To track the severity of rheumatic conditions

Paid >

Back pain guide

Information about back pain

Paid >

Pain Tracker

Pain diary

Free >

Pain Tracker Lite

Free version of same App

原始的美

“ **的士文**：*本土心肺麻醉科醫生，酷愛旅遊，交朋結友，學識廣博* ”

北疆。 深夜十一時多，喀納斯景區外的鴻福麗景酒店。

浴室裏突然傳來老婆的一聲慘叫，驚醒了處於半昏迷狀態、軟癱在床上的小弟 ...

「熱水沒有了！快點兒想個辦法！」老婆滿頭洗髮露，氣急敗壞地看著水龍頭流出來的水，由熱變暖，由暖變涼，由涼變冷，由冷變冰 ... 大驚失色之下，馬馬虎虎地沖去頭上的泡泡，跑了出來。時值金秋，喀納斯晚上只有兩度，自來水奇寒刺骨，無論如何洗不了澡。

怎辦？跑過隔鄰房間找救兵？一條腿剛踏出房門，才想起不知道團友們住哪房間，深夜裏萬籟俱寂，昏暗的走廊顯得異常平靜，猜想一眾團友可能已經好夢正酣，也不好意思打擾。想要打電話給前台，卻沒記下該撥甚麼號碼。沒辦法，打了電話給領隊。領隊告訴了我們前台號碼，前台派了一個中年漢過來看看。

「你們沒熱水嗎？」漢子邊說邊把電制拍拍拍地開了又關，不奈煩地說：「沒事呀，這會兒山間天氣冷，你等一個半小時水便會燒好，待熱水爐的指針停在紅格，就會有熱水呀。」這粗聲粗氣的漢子把話剛說完就轉身離開，檢查前後不夠兩分鐘，想不到夜深辦事效率仍是如斯的高。我和老婆面面相覷，一個半小時？不是開玩笑吧？

漢子一縷煙地跑了，我和老婆才又想起房間只有一條面巾，還是沒有乾透的。只好再電前台，想要多拿些乾毛巾。接電的女生語帶委婉，說：「不好意思，洗了的毛巾還未曬乾，剛才又有其他客人要毛巾，乾了的都給客人送過去了，現在已經沒有毛巾了。」「你是說全店的乾毛巾都已用光，一條都沒有了？」「對，不好意思 ...」

Well，沒有熱水，沒有毛巾，決定明早才來洗澡，先睡飽了才說。房間沒有空調，即使門窗緊閉也阻擋不住深秋的寒意，床上又沒電氈，躺在陰寒的被窩裏良久也未能入睡，索性翻起身把羽絨和襪子都穿上，管他三七二十一，蒙頭大睡 ...

只可惜小弟的肚子不爭氣，半夜竟然拉肚子。一輪舒解後，甚是暢快。回頭沖水，卻見坐廁去水不順，於是一沖再沖三沖，可是廁裏水漲便便高，再沖下去恐怕小弟的有機物會泛濫成災，惶恐之下只好把廁蓋翻下，眼不見為淨也。當然，也得先跟老婆報案，以免老婆嚇昏。這時是零晨四時半 ...

熬到早上六時，起來看看熱水爐的指針，還未到紅格，糟糕。行程前一天住禾木鄉的小木屋，熱水是滾燙的，可是只能從破爛的花灑頭一絲一絲地流出來，所以已經放棄了洗澡。這晚入住的酒店，外表相當不俗，可惜配套奇差，相當失望 ...

澡可以不洗，頭卻不能，總不成蓬頭垢面地在喀納斯湖畔拍照留念吧。動物的求生本能，讓老婆想出了燒水洗頭的好方法。一個電熱水壺，兩隻玻璃杯，成功地泡出了半盆水，貯在洗手盆裏。彎起腰來，閉上眼睛，一頭栽了進去，洗洗洗洗，雖然頗有難度，也不得不佩服老婆的急智 ...

對，美麗的地方，總帶點原始。城市人到鄉間，看村看人看風景看生活，看自己生命裏找不着的，這叫另類體驗。從香港出發，披星戴月，暴走三十六小時，跑到了北疆深山裏的禾木鄉。鄉間的路上，牛糞馬糞已和沙石泥土不可分離。怕髒，乾脆不要下鄉好了。路是人行的、車行的，也是牛行的、馬行的。可愛的牛兒，會排隊過橋，會避車，會讓人，這裏是牠們的家，我們是不請自來的客人，所以請別嫌這嫌那。再看馬兒，不知算不算老，但肯定都是識途的，自由在村裏走動。河邊兩匹馬兒在喝水，前面的主人口哨一吹，便乖乖地跟著前行，沒有策打，也不上韁，這叫做知心莫若馬 ...

晚上沒有看星，太累，想多點兒休息。早上也沒看日出，太冷，繾綣著暖暖的被窩。全團人算我們最懶惰 ...

晨曦之中，散步在村內，買了個燒餅吃，熱烘烘的，十分受用。10 RMB 一個，比香港 A1 還貴，客人卻多的是，這賣餅的嫂子該賺夠錢建一間豪華別墅了吧。走上觀景台，已是早上九時多，遠看炊煙晨霧蓋著的禾木，原始、簡樸、窮苦、卻自在。請別為這條美麗的村落排位，因為原始之美，在乎與世無爭 ...

Finding
Puzzles of Pain

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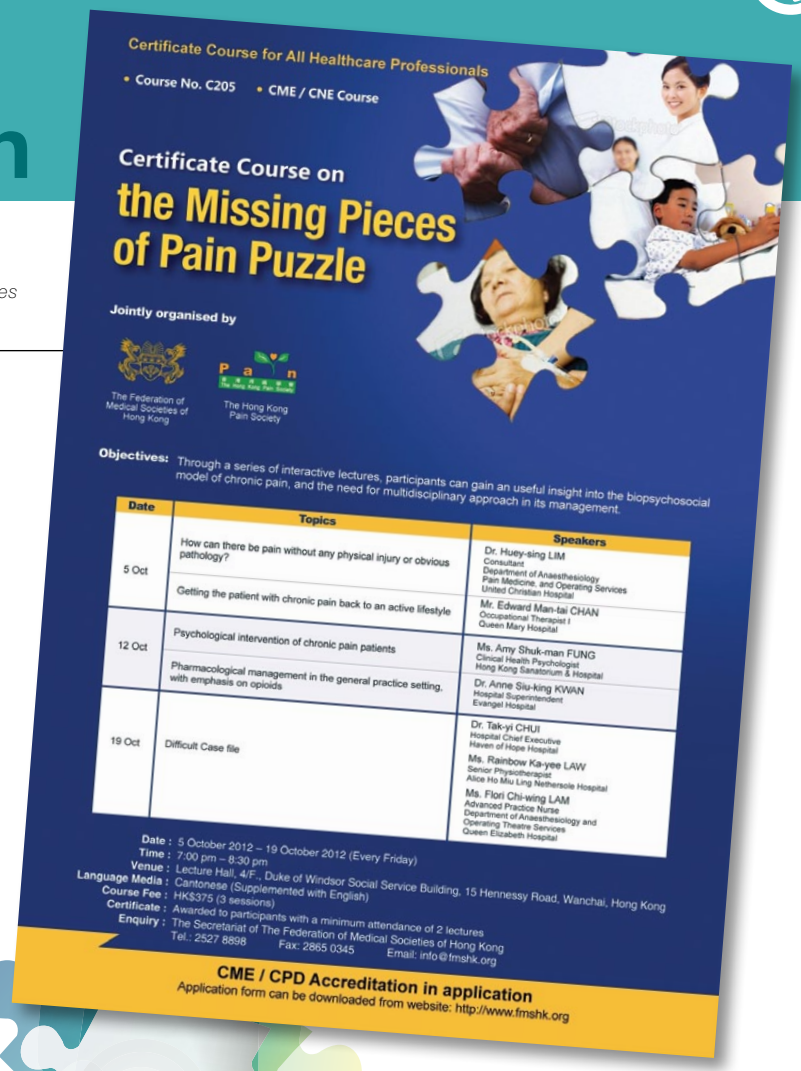


It is my pleasure to announce that the first collaboration, a three day lecture series title on "The Missing Pieces of Pain Puzzle", between Hong Kong Pain Society (HKPS) and the Federation of Medical Society of Hong Kong (FMSHK) had been successfully completed on 19 Oct 2012. I must take this opportunity to thank the organizing committee (HKPS), Ms Erica Hung (FMSHK) and all the speakers for their support in this function.

The objective of the course is to raise the concern among healthcare professionals in different discipline in their awareness on how to manage the patient with pain. We deliberately invite local speakers in different specialties as we believe pain is a multidisciplinary problem and by knowing each other on how their contributions in pain management, we can have a better overall care for our patient. In this event we have a nice overview on some of the classic myths in pain management. "Is it true you have pain? How come that there is no lesion?", "Is it a psychological problem?", "I'm not an addict how come you give me opioid?". And finally we have a fruitful share and discussion with the floor on the management of difficult cases we have been faced in clinical setting as therapist, as nurse and as doctor.

It attracted a total of 78 colleagues from various specialties to attend the course. Their feedback on the lecture series is excellent. This certainly confirms again our direction in the education series is correct. The only drawback I had received and it is always be the case is that there is not enough time for the speaker to share. On the coming 2013, we plan to have another collaboration with FMSHK. The area of interest will be on visceral pain – the year theme of ISAP. I'm looking forward to meet with you again hoping that you are not the "missing piece".

Is it true you have pain?

How come that there is no lesion?

Is it a psychological problem?

I'm not an addict how come you give me opioid?

Mr. Andrew Reid

Background

I first noticed quite severe left knee pain in or around early 2002. After spending a period of R.I.C.E and having no improvement in my condition, I was referred to an Orthopedic Surgeon. MRI showed significant inflammation of the quadriceps tendon, bursitis and edema.

I spent several months on medications and having physiotherapy but to no avail. It was finally decided that surgery was required and an open knee surgical procedure took place. Post op, I unfortunately had a build up of Synovial fluid, which despite several attempts to fully aspirate, formed a pseudo cyst on the quadriceps tendon and had to be removed. Post-Op I fell ill with a staph infection, which resulted in further surgery and the removal of the Bursa in the right knee.

Pain Specialist

After rehabilitation for the above procedures, I noticed an alarming number of new complaints, mainly around the lower back (L4-S1) and the lower limbs. I was referred to a pain specialist.

My first impressions were very mixed. Whilst being acknowledged that there was in fact significant pain, I was sent for x-rays and MRI's and put on regime of medications. MRI results were inconclusive and it was decided to keep me on medications for a prolonged period and to see what if any benefits I felt. Whilst this resulted in reduced pain levels, it completely altered my way of life and I did not enjoy this period at all. After several months, I was admitted to hospital for Sacroiliac and trigger point injections. During this time, I researched extensively my condition, so that I was in a better position to discuss with my physician.

The SI injections had no effect whatsoever, however, I did get some relief from the trigger point injections. Post treatment I was referred to a physiotherapist for rehab. My physio suggested that massage treatment would also benefit me and I had several successful treatments. I was then referred to both a knee and ankle/foot specialist. The long and short of this, was that I had symptomatic conditions in all three joints and these would only corrected by surgery. Accordingly I underwent several procedures for a meniscus tear, plus repair of the peronei tendons in both ankles. Postoperative I felt fine and my condition vastly improved.

Unfortunately, this only lasted for a year or so, and the joints regressed and in addition I had problems with my hips. I underwent a full multidiscipline appointment with orthopedics, physiotherapist and the pain specialist and effectively it was agreed to continue with pain medication and physiotherapy. This did not work and so I saw a new knee surgeon for as second opinion. He indicated arthroscopic surgery to check the knee out and to clean and debride any problems. Findings included grade II osteoarthritis throughout the knee. Corrective surgery improved the knee significantly and accordingly I had second opinions on my ankles and hips. Findings of all four indicated surgery was required and this took place over a couple of years. This treatment made a significant improvement in my condition and I was pretty much pain free for quite a long period. During the surgery, a new anesthetist was introduced to me and she in time became my pain specialist. In time, my ankle and especially my knee would deteriorate and I had to have a total knee replacement in February 2010, after a failed Tibial Tuberosity Osteotomy and subsequent Staph infection.

The new pain specialist listens very carefully to what I have to say and sets out a clear plan of what she believes needs to be done. My TKR has been in place for almost two years now and I have absolutely no pain from here at all. My ankle and Hip have both caused problems during this period, and after medications failed to give major improvements, I have had further ankle surgery and will require hip surgery next month. At all times, my pain specialist has updated the orthopedic surgeons of my progress and list of medications. She has additionally explained clearly that pain levels can go up and down and so medication levels require constant monitoring and revising when required.

Pain, whether symptomatic or complex, requires both diagnosis and treatment but also empathy with the patient, something I felt was missing. In addition, massage treatment for complex pain conditions is widely acknowledged in Canada, USA, Australia and UK, with some of these countries covering the treatment under private health care plans.

I believe that pain specialists will benefit from acknowledging the following:

- The patient's willingness to be on medications for long periods.
- The medical knowledge of the patient and consequently how they discuss and direct ongoing treatments.
- A view that they may not be able to cure and to explain this to the patient
- To explain that the patient may have to see several clinicians and the reasons behind this.
- Create a long term care plan with timelines for referrals' and reviews of mediations
- A full impact assessment of how certain treatments may affect an individual's lifestyle – both from a social and working viewpoint.
- Pain Specialists should liaise and have relationships with more physiotherapists and Registered Massage Therapists.

It is pleasing that all of the above bulleted points are taken into consideration by my existing clinicians. I feel on the whole that seeing a pain specialist is a positive move in improving and enhancing a patient lifestyle and condition if delivered in the correct and most appropriate manner.

Famous Quotes about Pain

1. The pain of the mind is worse than the pain of the body.

Publilius Syrus (1st Centry BC-?) Roman writer and poet.

2. Pain pays the income of each precious thing.

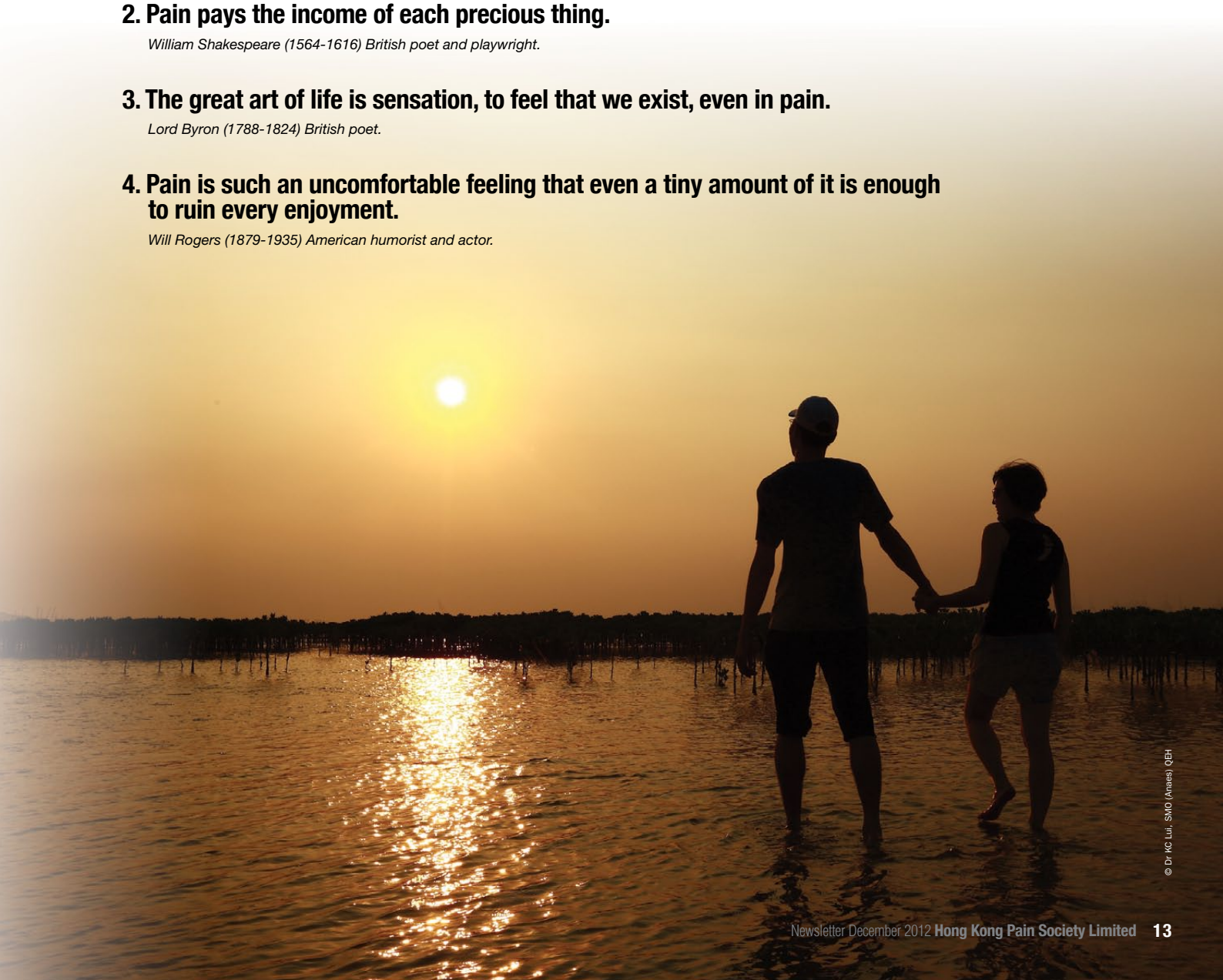
William Shakespeare (1564-1616) British poet and playwright.

3. The great art of life is sensation, to feel that we exist, even in pain.

Lord Byron (1788-1824) British poet.

4. Pain is such an uncomfortable feeling that even a tiny amount of it is enough to ruin every enjoyment.

Will Rogers (1879-1935) American humorist and actor.



Activity report 2012

1. **"Pain Genetics Symposium from basic science to clinical applications"**
   was welcomed by warm applause from audience on 9th June, 2012.

2. **The Pain Education Series 4 "Practical Management of Hip and Knee Pain"**
   on 28th April, 2012.

3. **Annual General Meeting The Pain Education Series**
   5 on 5th, 12th and 19th Oct., 2012

4. **The "Global Year against Visceral Pain" campaign was launched**
   on 15th Oct., 2012.
   http://www.iasp-pain.org/Content/NavigationMenu/GlobalYearAgainstPain/GlobalYearAgainstVisceralPain/default.htm

5. **Annual Scientific Meeting "New Light on Pain" was held successfully**
   on 15th Sep., 2012

Future Event

1. A public education talk jointly organized by HKPS and Health Action

will be held on 15 December 2012 at Duke of Windsor Social Service Building.

The topic will be Low Back Pain and Sciatica. We have invited Dr. KK Li, AC of Dept of O&T, QEH and Mr. Harry Choi, a physiotherapist as the guest speakers.

2. The HA Multidisciplinary Committee on Pain Medicine

will conduct the commissioned Programme on Vocational Rehabilitation in Chronic Pain *on 6-8 Dec 2012.*

Prof. Patrick Loisel from Toronto and Ms. Jain Holmes from London will be the guest speakers. A whole day seminar on Vocational Rehabilitation in Chronic Pain with local speakers will be conducted at CHP lecture theatre on 8 December. HKPS will be one of the supporters of the programme.

3. American Academy of Pain Medicine's 29th Annual Meeting

at Fort Lauderdale

April 11-14, 2013

http://www.painmed.org/annualmeeting/main.aspx

4. 8th International Conference on Pain Control and Regional Anaesthesia (IPCRA 2012) in Kochi, India

November 14th-17th, 2013

http://www.ipcra2012.com

5. "Persistent Pain: A National Challenge," 33rd Annual Scientific Meeting of the Australian Pain Society in Canberra, Australia

March 17th-20th, 2013

http://www.dcconferences.com.au/aps2013

6. IV Networking World Anesthesia Convention in Bangkok, Thailand

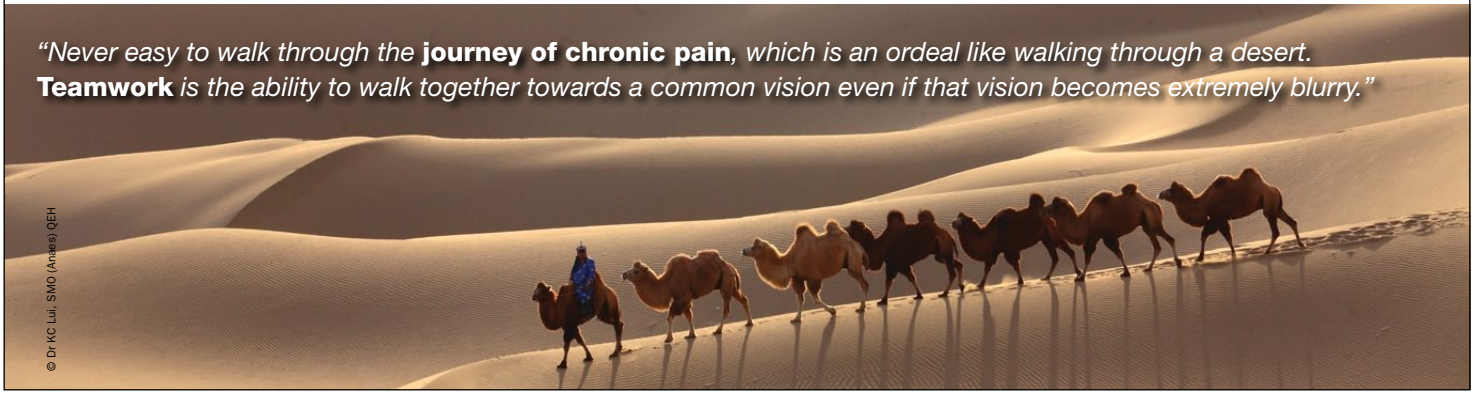
April 23-27th, 2013

http://www.nwac.org

7. The 5th Association of South-East Asian Pain Societies (ASEAPS) Conference in Singapore

April 28 - May 5, 2013

http://www.aseaps2013.org/



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