



Ngau Mamae

Quarterly Publication of the New Zealand Pain Society Inc.

Instructions to Authors

Ngau Mamae aims to keep clinicians up-to-date in regard to pain diagnosis and management. It will inform on NZ Pain Society (a Chapter of IASP – International Association for the Study of Pain) initiatives and activities. The Editor and Sub-editors seek contributions that will further these aims. Articles, reviews and letters should be submitted by email or supplied on disk to:

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Literature References

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Examples

Pennebaker JW. The psychology of physical symptoms. New York: Springer, 1982.

Philips H. Avoidance behaviour and its role in sustaining chronic pain. Behaviour Research Therapy 1987a; 4: 273-279.

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(Real Pain)

Ngau means to bite or engage in a very real way. Mamae means pain. In combination, the words describe a very real and deeply ingrained, gripping, biting pain.

— Merimeri Penfold

Of Ngati Kuri descent from the Far North. She was born in Te Hapua, educated at Queen Victoria College and qualified as a teacher working in education for many years. Moved to the Maori Studies Department at Auckland University. Was employed by Maori Studies Department at the University of Auckland to provide interpretations for University documents. Passed away in April, 2014.

Editorial

Dr Leinani Aiono-Le Tagaloa FANZCA FFPMANZCA

The Auckland Regional Pain Service

“She walks in beauty, like the night...” Lord Byron, George Gordon, 1813

For several more stanzas Lord Byron goes on to wax lyrical about his perfect woman, invoking the elements that make her so desirable, and finishing eloquently with “A mind at peace with all below, A heart whose love is innocent!” It is a beautiful poem, and resonates well with the picture of Perfect Womanhood, as depicted by the Botticelli Venus; rising fully formed from the ocean, perfect in pose and features, formed only of foam, and ready to fulfill all that a waiting world expects her to be. But like the images that modern media presents to young women to emulate, the perfection of Botticelli’s Venus is impossible to attain. The limbs are out of proportion, the neck impossibly long, the stance so far off centre that if one were to adopt it, it would throw one’s joints seriously out of alignment. And yet this image continues to populate the collective consciousness, as do so many other images calling women – especially young women – to conform to a certain weight, a certain look, a certain identity; and the mind is certainly not at peace with all below!

In every age there have been voices that dictate what it means to be Woman, but never have the voices been so loud or as insistent as in ours. Perhaps it is the ability to readily duplicate and multiply the images of perfection presented to us to emulate; the pressure of social media and the demands to conform to a certain image have only intensified in the past decade. Botticelli’s Venus has lost her safe ocean, the zephyrs that gently blew her to the shore and the motherly Ceres, the earth figure waiting to envelop her and is now afloat on a sea of blood, a plastic image with no connection to reality.

This issue will look at what truly is below, and explore the pain that exists for 25% of all New Zealand women between the ages of 18 and 60. Abdomino-pelvic pain in women is a complex issue, and the team at National Women’s Health have come together in true collaborative fashion to present their experience in identifying and managing female abdomino-pelvic pain. Their insights will be helpful for anyone seeking a better understanding of this complex and often emotionally challenging area. In addition we profile two amazing women who work in pain management: Sue King, recently retired from her post as Nurse

Practitioner in Waikato, a truly inspiring pioneer in the field; and Jane Suckling, Clinical Nurse Specialist and part of the National Women’s Health team.

Of note, this year Dr Richards will be retiring, after over 30 years of practise in the area of obstetric anaesthesia and abdomino-pelvic pain; this makes his contribution (see Aspects of Abdomino-pelvic Pain in Women) even more important.

With humble editorial apologies to our readership, in this issue we finally present you with the minutes from the AGM in Nelson. Having been reprised of my duties in that respect, I promise that next year the proceedings of our AGM will indeed be published in a more timely fashion!

In this issue also is a very entertaining and informative report from Tracy Pons (Physiotherapist), with highlights from her attendance at the Australian Pain Society ASM, made possible in part by a NZPS grant through the Broadfoot Trust. Again a friendly reminder to our members that there is funding available for endeavours such as this, as well as research that promotes and furthers our understanding of pain in New Zealand. Further details about grant rounds and application forms can be found on the NZPS website.

And finally, in true Samoan style, we end with the best: a warm welcome to Dr John Alchin for his first President’s Corner, which is no less entertaining and informative, along with a good dose of controversial. Our incumbent President has long been known not only as a strong advocate for pain patients and the field of pain medicine, but also for his brilliant mind and ability to interpret and comment on topical issues within both clinical practise and research. With a little arm-twisting we have been able to persuade him to share some of those pearls in a new column which shall be entitled ‘Pain Bytes’, and which aims to highlight particular aspects of pain medicine. Members are invited to comment, ask for the original papers, contribute and debate, as they feel led!

Nga mihi nui and here’s to a warm winter’s read!

Nani

Leinani Aiono-Le Tagaloa

The comments in this Editorial do not necessarily reflect those of the New Zealand Pain Society or its Executive, nor The Auckland Regional Pain Service.

NZPS Member Profile

Jane Suckling, RN

Clinical Nurse Specialist in Pain, National Women's Health, Level 9, Auckland City Hospital



After training as a registered nurse in Southampton, UK and working in Intensive Care in the UK and NZ for 8 years, I decided to train as a midwife. Upon completing my midwifery training, I worked in women's health research with the University of Auckland as trial co-coordinator for 3 clinical trials, and then worked for the Cochrane collaboration writing systematic reviews. I realised I missed clinical work at this point, and applied for a position as a Clinical Nurse Specialist in Pain for women's health at National Women's, Level 9, Auckland City Hospital. This combined my passions of working with women in a clinical role and being involved in research. During this time I completed my Master of Health Science at the University of Auckland with a focus on Public Health.

I have worked in my current role with an amazing group of other professionals for the last 12 years. We cover the acute pain round on Level 9, providing a

7 day week nurse led service. We also run two complex pain outpatient clinics every week. Our clinics are modeled on a multidisciplinary team approach, and we work closely with psychologists and physiotherapists. To further expand my skills within the clinic based setting I completed a post-graduate diploma in counselling in 2016.

All my nursing and counselling roles have required me to quickly build rapport, develop trust and communicate effectively in unpredictable, complex and sometimes emotionally charged situations. This was no less so than when I started out overseas in the USA as the nurse at a children's outdoor education camp. Here, I also learned the importance of viewing individuals within the broader context of their lives, including friends, family and culture. All of these skills I feel I have transferred to my current position.

I am currently enjoying the challenges and rewards of clinic-based counselling with women of all ages and backgrounds, who present with anxiety, depression, addiction and pain. Whilst narrative, acceptance commitment, and solution focused therapies are effective, I am having the most success by teaching natural, holistic approaches such as mindfulness, which empower women to take ownership of their situation. My depth of experience in a range of disciplines helps me to achieve outcomes that meet individuals' needs and aspirations.

My teaching abilities have been extended through my lecturing at Auckland University, in which I have planned, delivered and evaluated post-graduate health courses, such as the pain management paper run by the University.

With two children of my own, I am inspired to help young people (women especially!) to learn abilities and attitudes for social, emotional and physical well-being, and thus to succeed in their increasingly complex lives. I try to model balance in my own life, spending time gardening, doing yoga, and walking some of New Zealand's amazing tracks as a family with my husband and children.

President's Corner

Dr John Alchin,

FFPMANZCA, FAFOEM(RACP), President, NZPS

I took over as President of the New Zealand Pain Society at our Annual Scientific Meeting in Nelson, held from 2nd – 4th March 2017. So my thanks go to my predecessor, Dr Fran James, who now becomes our Immediate Past-President, and, ipso facto, my virtual god-mother. Or patron saint. Or guardian angel. Trying to keep me out of trouble, whispering in my ear sage words of advice, hints that now might be a propitious time for such-and-such course of action, etc; tasks that, by the way, she shares with my wife Lee. For Fran, though, as Lee points out to me, the term is for a year or so, rather than a life sentence.

Scientific Pain Conferences

The theme of the Nelson Conference, "Active & Able: Independent with Pain", accurately reflected the presentations. Special thanks on behalf of our membership goes to all who made this conference such a success: to the Local Organising Committee (convened by Dr Elena Moran, ably assisted by Stephanie Windsor and Dr Nikola Huntingford), the Scientific Committee (Malcolm Johnson, and Drs Lorna Fox and Gwyn Lewis) and also to our professional conference organiser (WORKZ4U), who we were delighted to re-appoint to be our conference organiser for the next triennium. Special thanks also to the speakers, both overseas and local; and finally to all the attendees, without whom the conference would be, well, a flop. (How much of a flop? Imagine an aged-care facility if the supply of PDE5I's ran out.) There were 285 registrations, and it turned a profit of \$ NZ 6,320. Quite an achievement. So thanks again to all involved.

I have been fortunate enough to attend two subsequent pain conferences. I was the guest of the Australian Pain Society at their ASM in Adelaide in April, (reciprocally, Dr Geoff Speldewinde, the then-President of the Australian Pain Society, was our guest in Nelson). I represented the NZ Pain Society (oh, such strenuous work on your behalf!) at a combined breakfast meeting of the NZ and Australian Pain Societies, the *Faculty of Pain Medicine* (FPM) of the Australian & NZ College of Anaesthetists (ANZCA), and *PainAustralia*, to discuss matters of mutual interest, and to maintain relationships.

Then in May I attended the FPM's Refresher Day in Brisbane, attached to ANZCA's Annual Scientific Meeting. In my capacity as President, I was part of the official stage party of the annual ANZCA College Ceremony, where successful candidates were awarded their Fellowships in ANZCA or FPM. On stage I was next to local anaesthetist (not that she gives only local anaesthetics, but that she comes from Brisbane) Dr Bridget Effeney, who headed the local organising committee for the ANZCA conference. We discovered that she was about 2 years old the last time we met: in 1978, at her parents' home in inner Sydney. Her father, Dr David Effeney, was the senior surgical registrar, and our surgical tutor, at St Vincents Hospital. I was able to pass on to her some memorable lessons from her father that I have managed to adhere to for 4 decades: "*Effeney's 3 laws for the examination of the abdomen*" (don't forget the scrotal contents, rectum, and hernial orifices); and "*3 squirts before breakfast, think of alcoholism*".

A session entitled "Medicinal cannabis for chronic non-cancer pain: promise or pothole?" was organised and chaired by Prof Milton Cohen. Related to this, Milton Cohen was interviewed on Radio NZ ("*Jesse Mulligan, 1-4pm*") on 15th May 2017. That interview is worth listening to, and can be found on the Radio NZ website. Jesse Mulligan sounded surprised that Prof Cohen was not enthusiastically pro "medicinal cannabinoids". This is indicative of the favourable bias of the media towards cannabis, and the gap between popular perception, and the state of the scientific evidence.

As I write I am preparing to fly to Kuala Lumpur for the 11th International Symposium on Paediatric Pain, organised by the Pain in Childhood Special Interest Group of the *International Association for the Study of Pain*. At Burwood Hospital we have been receiving an increasing number of paediatric referrals, mostly from the Paediatric Department at Christchurch Hospital, reflecting the increase in paediatric health care needs, including mental health, following the 2010 – 2011 Christchurch earthquakes. So I will be attending this meeting, along with two of our clinical psychologists (Jess Mills, Bron Trewin) to help us address this need.

“Better Pain Management”

Also at the May Brisbane FPM/ANZCA meeting, the FPM released its on-line pain e-learning resource, “Better Pain Management”. It is designed for all health care professionals working with patients with chronic non-malignant pain. It consists of 12 on-line learning modules focussed on developing skills and knowledge, each designed to be completed in an hour. They can be used to put together a self-directed learning program to suit the clinician’s specific needs. So they can be bought individually, although so far they have mostly been purchased as a set. Paid-up members of the Australian and NZ Pain Societies are entitled to a 20% discount in fees for all modules. Details on how to access this, and the discount for our members, will be made available in our monthly newsletter, and quarterly Ngau Mamae, courtesy of our wonderfully efficient secretary (Sarah Maley), and Ngau Mamae editor (Dr Leinani Aiono-Le Tagaloa (Nani)).

ACC’s New Pain Contracts

In 2015, ACC started a service redesign project with a view to making improvements to pain management services and service delivery. More specifically their goals were:

- to improve access to pain management services,
- to establish a more straightforward, easy to understand service,
- to ensure pain management fits better with our other rehabilitation services,
- to establish a way of measuring results to make sure pain management services are consistent and sustainable,
- to build capability in the pain management sector.

However, there was widespread dismay (replaced over time by unhappiness!) when the new ACC pain contracts were released (and almost simultaneously came into force) in late 2016, as they appeared to bear little resemblance to those stated goals. On behalf of the *NZ Pain Society* membership, I need some feedback from our members on this topic: what would you like the *NZ Pain Society* to do about this? I would be grateful to hear your comments. In fact, we need such input, to know what course of action we should take on your behalf.

Due to the clear indications of widespread strong dissatisfaction with the new ACC contracts, evident in both community levels and tertiary level providers, it was discussed on 1st March at the joint meeting of the NZPS and FPM (NZ National Committee) in Nelson. The minutes from that meeting state:

“ACC contracts

“Feedback from many providers is that the redesigned ACC pain management contracts are difficult to use. This is most disappointing to NZPS, as it endorsed the consultation and development stages of the proposed new ACC pain contract. It was recommended that feedback about the ACC contract is sought, with the option of potentially developing a joint NZPS/FPM response to ACC.”

Ted Shipton (as Chair of the NZ National Committee of the FPM) subsequently drafted a letter for discussion, but was later informed by ANZCA headquarters in Melbourne that such advocacy was outside the remit, the “job description”, of ANZCA. So, if the letter is to be sent, it needs to be sent from the NZ Pain Society.

Over to you. Comments would be appreciated. Would you like us, on your behalf, to express in writing to ACC the dissatisfaction of the *NZ Pain Society* membership at the new ACC chronic pain contracts?

Some history (which can be omitted, dear reader, if you find such strongly worded, unambiguous expression odious).

The first ACC pain contracts came into force in 1998. They were benign, and from memory effected no real changes to practice, at least in the public hospital pain service in which I worked, and for which I was at the time Clinical Director (CD).

But the second iteration of the ACC chronic pain contract, in the early 2000s (from memory, about 2002), was quite different. It was presented to us with 3 weeks to comment on. As I was still the CD, I worked with our service manager and our senior clinical psychologist to develop a submission on this contract, as we thought we had been invited by ACC to do so. There were many points on which we disagreed with the new “proposed” contract, generally concerning matters of professional integrity and practice, so we developed quite a detailed and well-argued case. To

our surprise, ACC's response to our submission was: "It's a non-negotiable package deal; take it or leave it." In other words, it was not really a discussion document at all; and the call for submissions was a chimera. Burwood Hospital management listened to their clinicians, accepted our advice that the ACC contract was at odds with professional standards, and thus could not be signed; and made an appointment to fly to Wellington to present our case to ACC. The Burwood Hospital General Manager, accompanied by our Service Manager, did so, with their prepared presentation to make our case to ACC.

By their subsequent account to me, at the meeting with ACC in Wellington they were subjected to a prolonged and intemperate tirade from an ACC medical manager of dubious personality characteristics, such that at least one of our managers was reduced to tears in the meeting. The rest of the ACC staff in attendance looked down in silence and evident embarrassment during his performance. In their defence, I assume that his reputation within ACC was such that none dared question his behaviour in his presence.

As we had failed to persuade ACC to change the contract, the Burwood Hospital Pain Management service now had to make a choice: either to sign a contract with ACC that we disagreed with ethically and professionally; or to decline to sign it. A meeting of our medical staff was unanimous in deciding that we should not, could not, sign it. However, our non-medical colleagues were concerned that their jobs may be at risk, if we did not sign it. So I made the decision to sign it, against the unanimous wishes of my medical colleagues, out of respect for the wishes of our non-medical colleagues. We signed ACC contract v 2.0, a decision that I have frequently regretted since, as it has never lost its malodorous scent, no doubt augmented by my vivid memory of, and anger at, the scandalous behaviour of ACC in general, and to our managers in particular.

So now to ACC chronic pain contracts v 3.0 (2016) ...

Dr John Alchin
FFPMANZCA, FAFOEM(RACP)
President,
New Zealand Pain Society

All comments in this article are the President's reflections, and are not necessarily those of the New Zealand Pain Society or its Executive, nor the Pain Management Service of Burwood Hospital, or its management.

The Role of Physiotherapy in the Management of Chronic Pelvic Pain (CPP)

Nicol Ranger

Physiotherapist, National Women's Health, Auckland City Hospital.

Chronic Pelvic Pain (CPP) is thought to have a prevalence of 1 in 4 women worldwide(1). There is often no known pathology. It is complex, associated with physiological, psychological and social challenges, and is frequently a multi system presentation. In addition, there is a high prevalence of sexual abuse (up to 50%) among patients suffering from CPP. Patients presenting with CPP frequently complain of multiple symptoms, which may include dysfunction of one or more of the pelvic organs. This creates much confusion. Proposed explanations for this multisystem presentation include viscerovisceral convergence; viscerosomatic convergence; hyper tonicity of the pelvic floor muscles creating visceral symptoms along with somatovisceral convergence; and central sensitization with expansion of receptive fields(4).

Traditionally, women's physiotherapy has involved the management of urinary and faecal incontinence, urgency of the bowel and bladder, and pelvic organ prolapse. Treatments focused on pelvic strengthening. Over the last 20 years internationally, (and over the last 15 years within NZ), skills have grown to accommodate increasing awareness of CPP. EMG studies have highlighted that increased pelvic floor muscle activity is part of the body's natural defense response to threatening situations(7). Research has begun to demonstrate relationships between muscle, skin, internal organs, and the central and peripheral nervous systems.

Due to the complexity of CPP, physiotherapy cannot be carried out without the support of psychology services. A bio-psycho-social approach is essential, ideally within a multidisciplinary setting.

Breathing and CPP

The sympathetic nervous system response to pain often creates a pattern of apical breathing or hyperventilation(8). Hyperventilation uses 23% more energy than diaphragmatic breathing(3) and creates chronic muscle tension, myofascial trigger points, hypoxia(6), and a heightened sense of anxiety, thus increasing perceived pain thresholds(8).

Control of breathing dampens the 'flight and flight response'. Diaphragmatic breathing facilitates abdominal and pelvic floor muscle relaxation(3). Because of the biomechanical relationship between the diaphragm, the abdominal wall and the pelvic floor muscles, dysfunction in one will likely create dysfunction in another. For example, diaphragmatic breathing encourages a simultaneous rise and fall within the pelvic floor. Losing this pattern of breathing reduces the natural rhythm of the pelvic floor muscles. Diaphragmatic breathing also promotes internal massage to the viscera, which may be important for normal pelvic circulation.

Pelvic Floor Dysfunction

Common symptoms include:

- Generalized pain throughout the pelvis
- Dyspareunia (deep and/or superficial)
- Dyschezia/Anismus
- Bladder pain, urgency and/or frequency
- Altered flow of micturition
- End of void pain

These symptoms largely result from a hypertonic pelvic floor, rather than the hypotonic pelvic floor which may be encountered in a patient with incontinence or pelvic organ prolapse (although these symptoms may be concurrent). As physiotherapists, it is important for us to differentiate between a *hypotonic* and a *hypertonic* pelvic floor; and in the case of the hypertonic pelvic floor, the focus should be on

relaxation and down-training prior to strengthening. The pelvic floor muscles have two layers. The superficial muscles primarily have a role in sexual function. The deeper levator ani muscles provide stability for the pelvic joints and pelvic organs, as well as playing a significant role in maintaining urinary continence.

Bladder Pain Syndrome

Bladder Pain Syndrome (BPS) is defined as:

'The complaint of suprapubic pain related to bladder filling, accompanied by other symptoms such as frequency and nocturia in the absence of proven pathologies' (International Continence society ICS 2002)

A study revealed that 78.3% of patients with BPS demonstrated at least one pelvic floor or rectus abdominus myofascial trigger point, and that 67.9% of patients demonstrated six or more separately identifiable trigger points(2). The American Urological association guideline for BPS and interstitial cystitis (IC) now recommends appropriate manual therapy techniques (for the pelvic floor) as a second line treatment for BPS and IC. It also states pelvic floor strengthening should be avoided (17). Bladder retraining is felt to be less effective for BPS than for bladder over-activity.

Bowel Symptoms

Irritable Bowel Syndrome (IBS) is commonly associated with CPP. Advice is often required regarding basic dietary modifications and fluid intake, and avoiding stimulants such as coffee and energy drinks (e.g. Red Bull). Stool management may require medication or more specialist help such as a referral to a dietician or nutritionist. Dyschezia and constipation can also arise as a result of a hypertonic pelvic floor muscles and the functional inability to relax sufficiently to defecate. Most importantly the puborectalis muscle needs to relax to widen the anal canal. Physiotherapy interventions include pelvic floor release or down training. Optimizing toileting technique assists with pelvic floor relaxation and discourages bearing down. There is some evidence that abdominal massage can stimulate the Enteric Nervous System and increase peristalsis(10,11).

Vulvodynia

Vulvodynia is defined as:

'Vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable neurological disorder'(14).

Provoked vulvodynia is the most common form of vulvodynia with a prevalence of 3-18%(14). Pinpoint tenderness of the vestibular area is evident even on light touch, causing pain on penetration with intercourse or superficial dyspareunia. Unprovoked vulvodynia is less common and presents as a more generalized vulval pain. Vulvodynia has the characteristics of a chronic neuropathic pain condition(15). Most women with vulvodynia exhibit pelvic floor abnormalities. Pelvic floor performance is significantly lower in terms of contractile and resting ability and efficacy of contraction(5,15). Because vulvodynia primarily affects the superficial pelvic floor, most women do not report bladder disturbance.

Vaginismus

Vaginismus is defined as:

'Recurrent or persistent involuntary tightening of muscles around the outer third of the vagina whenever penetration is attempted'(13).

Vaginismus may develop insidiously, often in the teenage years, or may develop as the result of a specific event such as trauma, childbirth or a medical procedure. Fear and anxiety will often escalate if not addressed. Vaginismus usually affects just the superficial pelvic floor and generally, bladder disturbance is not reported.

Treatment approaches

I feel very privileged to work with this group of patients; despite the challenges it is an extremely rewarding area of physiotherapy. Patients often suffer for several years before attending physiotherapy with CPP, many are frustrated by the health system and often there is a sense that they don't feel believed. Gaining their trust is essential, and it is important to listen to their story and acknowledge their symptoms. Most patients have little understanding of their condition; therefore explaining anatomy and pain helps to empower them towards self-management.

Breathing and relaxation are the corner stones of treatment with an emphasis on tuning down the sympathetic nervous system response.

Musculoskeletal and postural issues should be addressed. Up to 85% of CPP patients have musculoskeletal problems(9) and 75% of women with CPP have been found to have typical patterns of faulty posture(16). An injury to the sacroiliac joint or coccyx can be sufficient to create increased tone in the pelvic

floor. It is less threatening to address musculoskeletal issues externally, before addressing internally.

Sensitive questioning of their bladder, bowel and sexual history provides much insight into pelvic floor dysfunction. Pelvic floor rehabilitation should begin with education, so the patient understands the relationship between their breathing and their pelvic floor. Manual therapy can include therapist or patient led techniques, being mindful of each patient's history. The use of hold/relax techniques, a Therawand or biofeedback can allow patients to work independently. The use of vaginal dilators provides a graded exposure to those with increased anxiety or more centralized pain, particularly useful for those with superficial dyspareunia.

Exercise should become part of their self-management. General pelvic stretches should be encouraged. Exercises that promote relaxation of the core muscles are preferential to exercises which promote strengthening. There is evidence that Yin or restorative yoga decreases sympathetic nervous system activity(12). Patients with hypertonic pelvic floor muscles should avoid Pilates and strong abdominal strengthening until their tone has normalized.

Above all patients should feel respected, validated and safe. Patience is required to allow them time to respond to treatment, as progress is often slow. Continuous informed consent is vital to ensure they are actively in control of their own pain management.

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Pain Bytes

Dr John Alchin, FFPMANZCA, Pain Medicine Specialist, Burwood Hospital, Christchurch.

Some Interesting Recent Medical Journal items

The following selection illustrates, among other things, that one of the best sources of up-to-date authoritative information on pain is not necessarily from the specialised pain journals, but from the world's leading weekly general medical journals – the *New England Journal of Medicine (NEJM)*, the *Lancet*, the *British Medical Journal (BMJ)*, and the *Journal of the American Medical Association (JAMA)*.

... on back pain

The *BMJ* (2017;357:j2725 doi: 10.1136/bmj.j2725; published 5 June 2017) reported that the *Medical Defence Union*, which claims to be Britain's largest provider of medical indemnity cover to doctors, is withdrawing support for spinal surgery in private hospitals, blaming the prohibitive cost of claims. But surgeons operating in the *NHS*, and those covered by the *Medical Protection Society* and the *Medical and Dental Defence Union of Scotland*, the other two major players in the medical indemnity market, are still covered for spinal surgery. Data from the British spine registry shows that by far the biggest proportion of spinal operations are to correct degenerative changes. For lumbar decompressions (for neural compression, and including discectomy in about half of cases) the complication rate is 15%. But a report from Salford Royal NHS Foundation Trust presented at the *British Association of Spinal Surgery* conference in March found marked differences between patients and surgeons regarding the success of operations. The complication rate reported by surgeons was 4.6%, and by patients 25%. The true complication rate, the report said, was 15.2%.

JAMA (13 June 2017, Volume 317, Number 22, pp 2327-28) summarised a Cochrane review on NSAIDs in chronic low back pain (CLBP) (*Cochrane Database Syst Rev.* 2016;2: CD012087). It found that, "Compared with placebo, NSAIDs are associated with a small but significant improvement in pain and disability in patients with chronic low back pain, although this difference became non-significant when studies with high risk for bias were excluded. The associated benefits were smaller than the minimal clinically important difference... the magnitude of the association was small, the quality of the evidence was low, and the statistical heterogeneity was high."

The *BMJ* (2017;357:j2938 doi: 10.1136/bmj.j2938 (Published 23 June 2017) had an obituary on "*Gordon Waddell*, *Orthopaedic surgeon who reformed the treatment of lower back pain*". He died on 20 April 2017 aged 75 of mesothelioma. His work has profoundly affected the way we all work (or should work!) in chronic pain: "As an orthopaedic surgeon in the 1970s Gordon Waddell realised that the current model for treating back pain was not working. He identified three main problems: the standard advice of bed rest was incorrect, there was an over-reliance on surgery as a treatment, and the message that anything that causes pain must be avoided was wrong—"hurt does not mean harm" was his mantra." All sounds very familiar? In an "Ah ha!" moment that sounds strikingly similar to that later recounted by US Rheumatologist Nordin Hadler ("*Occupational Musculoskeletal Disorders*", 1st ed, 1993), "Waddell was running a clinic in Glasgow and wondered why some patients were far more disabled by back pain than others. In what was a highly unusual move at the time, he formed a partnership with a young clinical psychology researcher, Chris Main, and together they investigated why some patients could barely walk, while others were moving reasonably well, despite looking the same on physical examination ... he and Main realised that much of the medical assessment of back pain was unreliable ... found that psychological factors were just as important as physical factors in terms of a patient's disability: what a patient believed or had been told had an influence on how he or she responded to treatment ... Some also believed that his discussion of some of the psychological aspects of back pain – or the non-organic signs, as Waddell called them – meant that patients were malingering. Waddell and Main later said: "Despite clear caveats about the interpretation of the signs, they have been misinterpreted and misused both clinically and medicolegally" ... Much of his work culminated in "*The Back Pain Revolution*", a medical textbook whose central message was that back pain had become overmedicalised ... In his later career, Waddell became interested in the world of work and health, contributing to the development of occupational health guidelines on back pain, published in 2000 by the Faculty of Occupational Medicine. He also became an adviser to the Department of Work and Pensions ... a major policy review by Waddell and Kim Burton concluded that work was good

for health, but some misconstrued his message, believing that the focus was to force disabled people into work. In fact, the review found that good work was good for health – not just any work – and that good work can be therapeutic.”

And finally, *JAMA* has just published (4th July 2017, pages 68-81) a 14-page paper reporting on 3 randomised clinical trials in 16 multidisciplinary pain clinics in The Netherlands of radiofrequency neurotomy (RFN) in 681 patients with CLBP (mean age, 52.2 years; 62% women, mean baseline pain intensity, 7.1). Eligible participants had CLBP; a positive diagnostic block at the facet joints (*facet joint trial*, 251 participants), sacroiliac joints (*sacroiliac joint trial*, 228 participants), or a combination of facet joints, sacroiliac joints, or intervertebral discs (*combination trial*, 202 participants); were unresponsive to conservative care, and had no excluding co-morbidities (severe psychological problems, determined by psychological questionnaires, involvement in work-related conflicts or claims; body mass index over 35; on anticoagulant drug therapy or coagulopathy). They all received a 3-month standardized exercise program and psychological support if needed. Those randomised to the intervention group also received RFN, usually once, but up to 3 times. 599 (88%) completed the 3-month follow-up, and 521 (77%) completed the 12-month follow-up. The mean difference in pain intensity between the RFN and control groups at 3 months was -0.18 in the facet joint trial; -0.71 in the sacroiliac joint trial; and -0.99 in the combination trial. At 12 months, the results were: $+0.47$ in the facet joint trial; -0.07 in the sacroiliac joint trial; and $+0.69$ in the combination trial. They concluded that adding RFN to a standardized exercise program in CLBP resulted in either no improvement, or no clinically important improvement, compared to the standardized exercise program alone. “*The findings do not support the use of*

radiofrequency denervation to treat chronic low back pain from these sources ... Based on this study, radiofrequency denervation is not recommended, and should be performed only in a research setting”. I doubt that this is the last word on the question of RFN. But it is a large study, published in a high ranking medical journal, and cannot be summarily dismissed simply because it does not agree with either strongly held beliefs or current practice. My guess is that issue will be taken with the specific methodologies of the diagnostic and interventional procedures used in the study.

Also on low back pain (LBP), there was another excellent recent interview on *Radio NZ National*, again by Jesse Mulligan (“*Jesse Mulligan, 1-4pm*”) on 20th June 2017. It was with Cathryn Ramin, a US investigative journalist, focussed on her book about her personal, over-40-year history of LBP: “*Crooked: outwitting the back pain industry, and getting on the road to recovery*”. It is also well worth listening to. She reports accurately on many of the myths around LBP. For example, I cheered when she correctly stated that there is no such thing as “Degenerative Disc Disease”, whose function seems to be mainly to push US patients towards expensive, unnecessary, useless, and potentially harmful surgical procedures. She mentioned that, of 100 US spinal surgeons asked if they would themselves undergo spinal fusion, only one said “yes”, although they all did this procedure on their patients routinely. She correctly notes that most other offered treatments for chronic spinal pain lack any robust evidence of efficacy, including epidural steroid injections for spinal pain, and manipulation. What does work is the less headline grabbing, slow and difficult process of guided rehabilitation and exercise, for which she recommends a “back whisperer”: a wise, informed and conservative clinician, who will guide the patient along the correct path, and help them avoid the temptation to rush after non-existent quick fixes.

To be continued...

NZPS Life Member – Ms Sue King

Janet McAllister



Ms Sue King, Nurse Practitioner in Pain Medicine
Photo courtesy of Waikato DHB News Room

Sue King was the inaugural Clinical Nurse Specialist at the Waikato Pain Service from 1995 to 2016, and Secretary of the New Zealand Pain Society from 2006 to 2012. She became New Zealand's first Nurse Practitioner in Pain Management with Prescribing Rights in 2010 and led the development of the NZ Pain and Knowledge and Skills Framework for Registered Nurses, launched in 2013.

Ms King's interest in pain grew out of her oncology work: in the late 1970s and early 1980s, she cared for a number of people with cancer who suffered horrendous, harrowing pain. Due to the time nurses spend observing and monitoring the patient, she notes that "it is the nurse who sees the pain patterns and behaviour."

Ms King was born in Timaru and did her initial nursing training in Christchurch. Keen to travel, she booked tickets to England even before she knew she had passed her State finals, in 1977. She ended up working at the Royal Marsden Cancer Hospital and Research Centre, and obtained a Postgraduate Certificate in Oncological Nursing.

She came home in 1982, to an oncological nursing job at Waikato Hospital, and worked her way to becoming Clinical Resource Nurse for the General Surgery/Urology Service. In 1994, she was invited to

apply to set up the nursing aspect of a new acute pain management service being established at the hospital by anaesthetist Steve Jones.

There were concerns that the fledgling service – which at first was a surgical service, treating only acute pain problems – would be disestablished due to fiscal restraints. "We didn't think you'd be one to take a risk!" some of Ms King's colleagues told her, after she had successfully applied.

However, the Waikato pain service became respected and well-utilised, and has been thriving now for over 20 years. Whereas once it only cared for post-operative patients briefly, it now offers an in-patient pain service. As the length of contact with any one patient grew, Ms King found that case managing – including care planning to minimise harm that might lead to readmissions – was a privilege. She found it satisfying to get to know her patients and their friends and family, and address all components of the bio-psycho-social chronic pain model.

By the time she took early retirement as a nurse practitioner in 2016, she was running her own outpatient clinic for former inpatients who needed oversight going home; this involved building relationships with GPs and outside services. Ms King considers becoming a nurse practitioner as the pinnacle of

her career: she was the second nurse practitioner in New Zealand in pain management and the first with prescribing rights, ensuring her patients could get the medication they required without delay.

Among the many facets of pain management nursing, Ms King emphasises education and expectation management: pain nurses explain to patients and their families why pain relief is important, and explain non-pharmacological strategies – such as distraction, positioning, sleep and diet – as well as any drugs the person may be offered.

As a member of the New Zealand Pain Society Ms King became very active in the establishment and work of the Nursing Interest Group, under the auspices of the society. In 2006, she became society secretary, in order to contribute to the work of the Society at a national and international level. Ms King appreciates that nurses have always played

significant roles in the multi-disciplinary society – her predecessor as Secretary was Jenny Sandom, while Julia Barton and Judy Leader have both served as presidents of the society. In the absence of society position descriptions, Ms King developed a framework for council positions roles and responsibilities so that people interested in running for a leadership position could have a sense of what would be required. “I like to get things done,” she says.

Ms King also developed and co-ordinated pain management education for Waikato District Health Board nurses and midwives, and drove the development of the New Zealand Pain and Knowledge and Skills Framework for Registered Nurses, helping to ensure standards of care are consistent around the country.

In retirement, she is working on her lifestyle block in the Waikato, beekeeping, gardening and teaching herself the piano.

Aspects of Abdomino-pelvic Pain in Women

Dr Glynn Richards

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Abdomino-pelvic pain is a very common presenting symptom in gynaecological circles: twenty to twenty five percent of all gynaecological outpatient consultations include some aspect of chronic pain, roughly five percent of all new patients. From this group, thirty to thirty five percent of all diagnostic laparoscopies are for pain, as are five to ten percent of hysterectomies.

To fully categorise all causes of abdomino-pelvic pain would be beyond the scope of this publication, so I have chosen to outline our experience of two of the most common types presenting to our clinic; chronic pelvic pain associated with endometriosis, and pelvic pain due to pregnancy. A more extensive report can be found in the European Association of Urology document "Guidelines on Chronic Pelvic Pain".

Chronic Pelvic Pain

The World Health Organisation (WHO) performed a systematic review, The Prevalence Of Chronic Pelvic Pain (CPP) in 2006, describing this as "a neglected reproductive health morbidity."⁽¹⁾ The incidence was noted to be higher in more developed countries, no doubt influenced by more reliable rates of reporting, as well as ethnic, genetic and social factors. Reported incidences include 15% of 18-50 year old women (Mathias 1996) in the United States; 24% in the UK and 25% in New Zealand.

Our clinical experience is focussed mostly around women suffering from endometriosis. It has been estimated that endometriosis afflicts in excess of 176 million women in the 15 to 45 year age group world wide. The cost of caring for women in this group is quite substantial. One of the most informative and analytical appraisals of the problem in recent times on the extent and proposed remedies is "The 6 Billion Dollar Woman, 600 Million Dollar Girl". This was prepared by Pain Australia in conjunction with the Faculty of Pain Medicine of the Australia and New Zealand College of Anaesthetists (FPANZCA) and Endometriosis New Zealand. Their estimates of treatment costs for endometriosis in Australia are summarised as follows:

Australia: (based on prevalence of 1:10 women)
Annual cost: \$6 billion (excludes adolescents)
\$600 million (adolescents only)
\$12,000 per girl

The above costings are for treatment only! If one takes into account the more personal costs to patients and their carers, it is estimated the total cost would be doubled. Moreover, these costs should be considered within the broader context of the estimated incidence of chronic pain in the Australian population; in 2001 epidemiologist Professor Fiona Blyth ⁽²⁾ published a paper estimating 1:5 people in Australia suffer from chronic pain ⁽⁴⁾.

Despite the above, Professor Cindy Farquhar, in a presentation to the European Society of Human Reproduction and Embryology (ESHRE) Pre Congress course in London (July 2013), highlighted the relative paucity of published research on female abdomino pelvic pain as compared to two other medical complaints, asthma and low back pain: this being despite the similar presentation rates of the three complaints. Her figures are taken from Medline, Cochrane Foundation and Embase databases (see Fig 1).

It is of interest that in one of its clinical letters, the International Association for the Study of Pain (IASP) reported that women were often excluded from trials of new analgesics or regimes, because of the sometimes erratic or cyclical nature of their pain. Indeed the current definition of abdomino-pelvic pain is not helpful. IASP defines abdomino-pelvic pain as "abdominal pain occurring below the umbilicus." A more inclusive definition is "abdominal pain occurring below the umbilicus lasting more than three months". The problem with these definitions is that the symptoms are multifaceted, and the definitions do not reflect the cyclical nature of the pain.

So, what can be done? Optimal results of treatment can only be achieved by a good multidisciplinary approach. There should be seamless communication between all

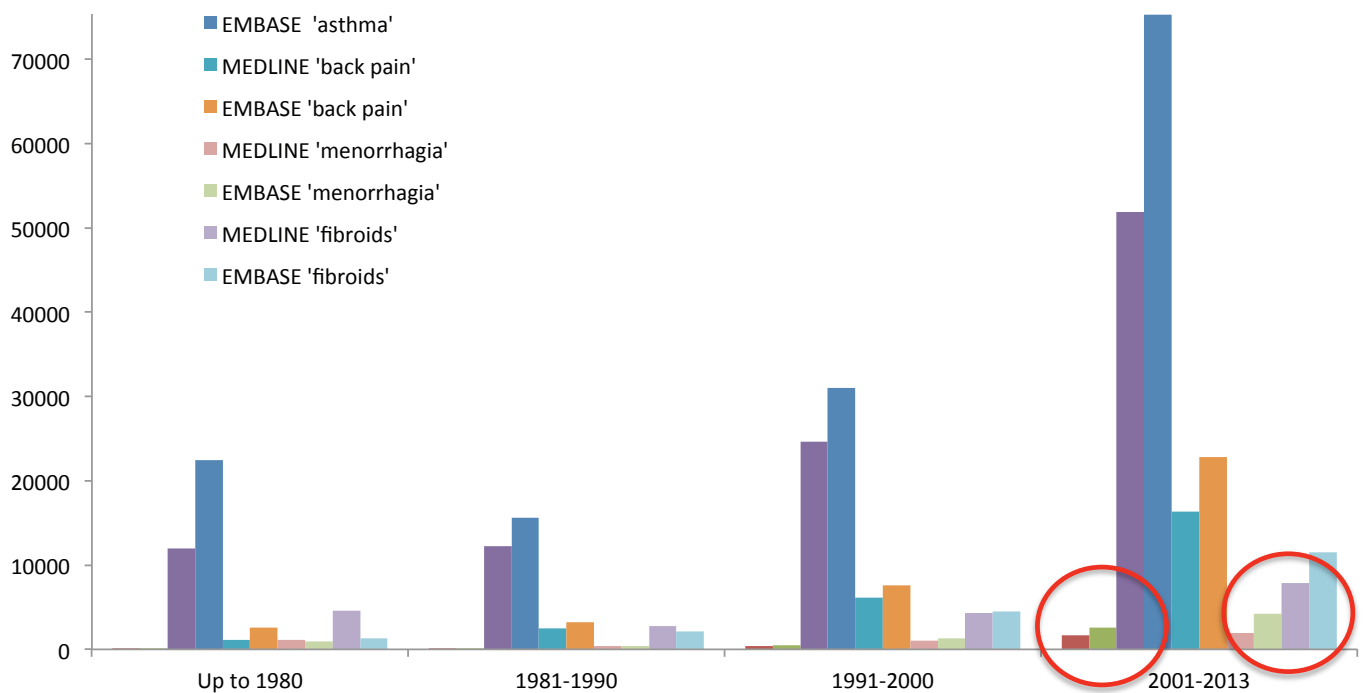


Figure 1: A comparison of the number of publications per annum for chronic pelvic pain versus asthma, back pain, menorrhagia and fibroids

involved members of the team. Corridor consultations, texting, letters or hurried phone calls between cases on a busy operating list detract from the value of head to head discussion. "He who would do good-----"!

A good team would be as in the table below:

Pain Specialist; +/-	Gynaecologist
	(General surgeon)
	Psychologist
	Physiotherapist
	Pain Nurse
	"Empathy"

Whist most of the above will be self explanatory, some will be the subject of the accompanying papers in this issue. Tantamount to success is sufficient empathy and understanding to enable the patient to fully express their complaint and validate themselves.

I believe the Pain Nurses are the "glue" which holds the system together, especially in this all female treatment group. Pain nurses form a valuable contact person for these patients and are able to less formally advise on helpful resources and counselling.

The Pain Specialist (PS) functions as the initial assessor and coordinator of all relevant information and formulates the most useful regime for management. The PS can then initiate any appropriate medication.

The initial approach is usually in the form of the traditional analgesic pyramid: paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs) and low dose tricyclic antidepressants (TCA). Both TCAs and NSAIDs may have individual variations and warrant trials of differing types of either one, depending on the individual pain practitioner's experience. Should this prove inadequate, any ongoing pain should be assessed as organic or neuropathic, and there may be a combination of both elements. For organic pain we routinely advise low dose methadone, with the assumption that those patients requiring methadone will only need it for a limited time whilst they wait to be scheduled for surgery. For neuropathic pain we advise anti-arrhythmic (mexiletine) or anti-epileptic (gabapentin) medications. It is well to remember that there is evidence of new nerve growth into endometrial lesions, which is the basis for the use of these drugs. The current all round favourite in New Zealand is gabapentin. It seems to have a limited side effect profile, but even so some young women find it unsatisfactory. Complaints of sedation, memory loss, weight gain and constriction of mood often lead to its abandonment. It is then that we consider mexiletine, which is often much better tolerated, sometimes securing clinical improvement when reasonable dosages of gabapentin have failed. Both mexiletine and methadone tend to cause S-T prolongation, therefore patients should have ECG screening prior to commencing treatment.

Pelvic Pain Due To Pregnancy

This too is a very common presenting complaint to our clinic. Often severe, it is, thankfully, often rapidly resolved following delivery, if appropriate treatment measures are adopted. The presentations we see are a consequence of the relaxation and stretching of (mainly) the sacro iliac and pubic symphysis ligaments, complicated by inputs from the lumbar spine and hip joints. This relaxation coincides with a sharp rise in relaxin levels, which are mirrored by rises in oestrogen and progesterone. Yes there is relaxation, distraction, instability and insufficiency but no clear evidence of arthropathy or inflammatory joint disease.

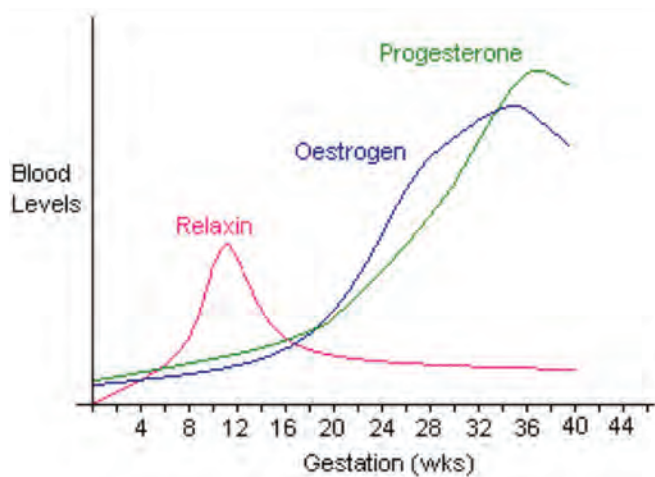


Figure 2: Hormone levels in pregnancy

The mixture of the various components of the pain leads to difficulty in assigning a meaningful descriptive title. Attempts have been made in terms of radiological appearances, physical signs and physiotherapy findings. Wu et al (3) summarised these descriptive attempts as below, and finally came up with the somewhat unwieldy title of Pregnancy-Related Lumbo-Pelvic Pain (PLBP). For greater ease we use the term Pelvic Arthropathy of Pregnancy .

- Posterior Pelvic Pain (Ostgard)
- Pregnancy -Related Pelvic Girdle Pain – PPP
- Pregnancy-Related Low Back Pain –PBLP
- Pregnancy -Related Lumbo-Pelvic Pain -PLBP

Serious pain is estimated to occur in twenty five percent of all pregnancies, causing severe disability in eight percent. PPP +/- PBLP is demonstrable in forty five percent of pregnancies, and this persists in up to twenty five percent postpartum. How much this is due to the continued presence of relaxin is debatable, as it is said to persist in significant levels until approximately three months after the cessation of breastfeeding.

Severe pelvic pain has significant implications for the mother. There is clearly a deterioration of mobility with its related consequences, and significant losses due to the impairment of enjoyment of private life, career and interaction with partner and any young children. The inactivity leads to significant deconditioning. The increased pain commonly noted at night contributes to chronic tiredness and accompanying diminution of pain tolerance, and at times depression and anxiety. The above may be compounded by lack of empathy on the part of professional carers, family and “friends”. In addition, there is the risk and worry of chronicity, and concern for recurrence in ensuing pregnancies. The pubic symphysis is a relatively small joint, but particularly prone to cause chronic post partum pain if not adequately protected.

The risks of severe maternal pelvic pain to the foetus are also considerable, though theoretically reduced by avoiding medication in the first trimester. Untreated pain in the mother with associated stress can impinge on placental function and consequently reduce foetal well being and growth. Ongoing inadequately treated pain may lead to attempts or requests for early induction or surgical delivery with all of the attendant short term and long term risks of prematurity.

This can all be minimised with optimal care. The pain team aims to support the patient, and facilitate the pregnancy to progress as near to full term as possible. Best results once again are the product of good multidisciplinary team work, with seamless levels of communication. The initial approach is usually and most appropriately to the physiotherapy team. Amongst other modalities they provide massage, exercises, belts, supports, acupuncture, TENS, reassurance and empathy. They also take the patient through the first trimester and period of organogenesis, when medication can pose a higher risk. The psychological needs of the woman who approached pregnancy expecting a natural and trouble free process, and who now is debilitated by pain, need to be professionally addressed. Nurses and midwives need to fully understand the causes of the pain and the necessary treatment, and at all times be empathetic and supportive. Likewise the obstetrician needs to be on board with the team’s objectives, to attain as near as possible a full term pregnancy.

Finally, the pain specialist can assist with medication regimes and at times appropriate use of local anaesthetic and steroid injections. Ligament injections, carpal tunnel injections and lumbar epidural injections can be most helpful. Generally women are reticent to

take medications in pregnancy although some do resort to self medication, which can be potentially risky to foetal development. Martha Werler (4) surveyed an American population of women who self medicated in pregnancy, where over the counter medications are more freely available. She was not able to show any increased level of problems than one might expect from random teratogenic medications in the first trimester.

In medicating the pregnant mother we must be careful to minimise risk to the foetus. We avoid medication in the first trimester, and it is not until this time that the effects of relaxin become fully evident. It would be unethical to conduct pain drug trials in pregnancy, so we rely on knowledge gleaned from reports on drugs used for coincidental purposes during pregnancy, drug registries, anecdotal reports, animal studies, and risk classification compendia such as the admirable "Drugs in Pregnancy and Lactation" by Briggs et al (5). More general summaries of clinical management are valuable to those working in less clinically endowed units.

Our approach to medication once again starts with the basic analgesic pyramid, beginning with time based paracetamol and usually adding low dose tricyclic at night (the latter both for analgesia and as an aid to sleep.) To this is added clonidine TTS patches if a clearly defined tender focal point of pain can be demonstrated. This may be all that is necessary, and may give adequate relief for several weeks. NSAIDs have only a very limited and very short term use in the second trimester, and only with full acquiescence of the obstetrician.

If the pain becomes more severe, once again it is necessary to delineate the relative contributions of organic and neuropathic pain. If the pain is aching in quality, aggravated by moving and associated with prolonged periods of immobility, then methadone is added to the mix. We usually commence with 2.5mg three times daily. In pregnancy, due to the marked changes in maternal physiology, it is necessary to give small doses more frequently than in the non pregnant state and we sometimes increase the frequency to four times daily. This minimises the risks of abrupt peaks and troughs. In our experience this does not lead to greater doses, and the total dose usually readily stays below the recommended 20 mg per day. This dose cutoff is said to reduce the risk of foetal abstinence syndrome. Medicating the mother with methadone has given rise to concerns regarding the risk of foetal abstinence syndrome. Carl Kuschel (6) studied the babies of women in our treatment

group and compared them with those of women on high dose methadone maintenance for the treatment of addiction. The former group showed virtually no adverse effects from the methadone while the latter were significantly affected.

Should the pain seem to be neuropathic, and described as burning, stabbing or shooting, our drug of choice is mexilitine, often with good result. According to Briggs et al (5), based on the limited information available in humans, mexilitine is reasonably favourable and does not pose a significant risk to the foetus. By contrast, studies have demonstrated suppression of synaptogenesis in the brains of mice treated with gabapentin, and it has been recommended that gabapentin not be used in pregnant women. Sometimes both mexilitine and methadone will be required, and baseline ECG screening prior to commencement of therapy would again be advisable.

Both mexilitine and methadone daily doses are halved on delivery, and rapidly tailed off over the ensuing few days.

The above measures aim to minimise the risks of treatment and balance advantage against risk. The one major deficiency is the paucity of accurate knowledge of the effects of maternal medication on the foetus as measured in the longer term into childhood.

The overall results are very rewarding.

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Broadfoot Trust Travel Grant Report

Australian Pain Society 37th ASM 9–12 April 2017

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Introduction

I would like to give my heartfelt and grateful thanks to the New Zealand Pain Society for your funding towards my attendance at the Australian Pain conference in April 2017. I submitted a poster presentation on my research into Physiotherapy and Complex Regional Pain Syndrome (CRPS). I was also invited to present a one minute rapid communication slide to the plenary session, something that not all poster presenters were invited to do.

The conference opening ceremony featured two Aboriginal men performing a selection of dances and music that showed their joy and holistic view of life. The dances continued throughout the generations, showing how the reality of today and the present is connected to those of our family who have already passed, as well as the land around us. Since the Aboriginal culture is the oldest known human culture still practiced in the modern world, I feel that their heritage is important to embrace as they provide a tangible link to our past that history books cannot provide, to other cultures that no longer exist.

David Butler also provided an entertaining welcome to the audience. He pointed to how valuable pain research and clinical understanding about pain is to Australia and the world. He had participated in the "Pain Revolution Bicycle Ride" from Melbourne to Adelaide, and told of how a group of clinicians and researchers had participated, stopping in each small centre along the road to provide hope about pain management being possible for those who suffer.

I was able to chat informally with passers-by who looked at my poster as well as other clinicians and researchers from all around the world. This opportunity was for me a

valuable treasure, and something I can keep; the tangible sense of not being alone in that demanding world I work in, as a solo practitioner and relatively isolated clinical researcher in my field. I discovered that those who work at the coal face full-time and are also active in research are few and far between; but that we are all connected. We all share a passion for active and relevant research about what constitutes excellent as well as satisfying care for those in our communities who experience significant pain-related disability.



Figure 1 My poster presentation

On Sunday 9th April I attended the Physiotherapy Sub Group meeting. This was arranged by the Australian Pain Society (APS) to engage with physiotherapists and discuss how they can encourage and support physiotherapists in the clinical setting. I discovered that Australian physiotherapists who work in pain as I do, do not have supervision in place (as psychologists do) to help them with cope with patients that have complex needs and are potentially emotionally draining.

I also attended a Meet The Speakers Breakfast Session and joined a lively debate about the struggle clinicians have to integrate the scientific research knowledge they glean from conferences like this into everyday clinical practice. The real world of working "at the coal face" with complex patients presenting with persistent pain is quite a different place to the research lab! Sleep was identified in this debate as possibly the most prominent and difficult problem to manage effectively.

Some of the other presentations that were of note for me:

1. *Prof Steve Hunt* **There is no pain site in the somato-sensory cortex** Pain travels via a pathway activated in the spinal cord and then links from the thalamus to many other areas of the brain. The development of a non-paralysing Botox injection shows potential to provide pain relief for up to a 9 month period.
2. *Dr Alexandra Farlane* **The Patient Dilemma: The intertwined nature of chronic pain and post-traumatic stress disorder. Post-traumatic stress disorder** is under diagnosed and overlooked. It is a common problem however, for those presenting with persistent pain. Management is multi-dimensional, aimed towards modulating the upregulated hyper reactivity to environmental stresses. Managing acute pain episodes associated with trauma is important to reduce the possibility of neural upregulation.
3. *Dr Sean Mackey* **Learning health systems: A new dawn in personalised pain care and real-world discovery research.** He described CHOIR; a large data set at Stanford used to describe patients. Their huge data bases collect all the data about the patients (similar to ePPOC) and the respective treatment for all patients. Their biggest barrier is the "buy in" by clinicians. In this context I feel a potential problem with ePPOC is that different centres are being compared by ACC.
4. *Dr Judith Turner* **Opioids, chronic pain and function: Recent findings and clinical perspective.** Opioid prescription is not helpful for pain management. Opioid reduction following dependence takes time. Mindfulness based stress reduction is similar to CBT for positive outcomes with pain management programmes.
5. *Prof Mark Hutchinson.* **The "toll" of knowing you are sick: Implications for acute pain management and consequences for chronic agony.**
6. *Prof Stuart Brierly* **NaV1.1 and its contribution to chronic visceral pain.** Irritable Bowel Syndrome research shows evidence of neuronal hypersensitivity (sensitisation) of the gut. Management involves a biopsychosocial approach identifying triggers e.g. stress and developing a self-management approach
7. *Haley O'Sullivan* presented about how Royal Melbourne hospital has reduced CRPS incidence in the fracture clinic to zero, with an algorithm of early referral to the hand therapist and pain service.
8. *Dr Clare Ashton-Jones* **In (certain) clinicians we trust** showed that warmth and perceptions of competence (which is associated with trust worthiness) are associated with improved outcomes for patients. She showed how clinician's level of fatigue, frustration, anger and body language impact on the patient's trust in the clinician. She showed that trustworthiness component can be facilitated by
 - Being relaxed and confident
 - Smiling
 - Empathising
 - Demonstrating knowledge and skill
 - Being certain and positive
 - Managing our own frustration and anger (stress)
9. Pain in childhood: Free papers: Assisting self-management with parent delivered input is key to managing paediatric persistent pain. Parent's distress significantly affects children's poorer ability to cope with burns procedures.

10. PTSD and pain: Free papers. Inherent association between pain and cognitive function as cognitive function is embodied in movement. It is associated with both the “limited resource” and “neuroplasticity theory” in central processing. In trauma the immune system with the neuroglial components are also involved with up-regulation of neural hyper excitability.

I was not able to attend the third and last morning of the conference due to my early morning flight connections. Topics included:

- Epigenetics: Research is beginning to understand how early experience can be mapped onto our genes and influence how proteins are expressed
- Psychological management of persistent pain: There are many psychological variables associated with persistent pain and it is not feasible to target them all in an intervention
- Myths about musculoskeletal pain in Aboriginal Australians: Myths are debunked and the issue around access to and quality of care; disparity in prevalence and the steps needed to better manage musculoskeletal pain for Aboriginal Australians
- Bonica Lecture – Pain and analgesia in the era of genetics: Genetics can now explain a considerable proportion of the variability in efficiency and toxicity of opioid analgesic requirements.
- Teaching medical students pain management in difficult end of life situations using simulation: The use of a clinical simulation lab is shown to be an effective method of teaching palliative care and end of life skills to medical students in the later years of their training.

In conclusion, I wish to express how grateful I am to the New Zealand Pain Society for supporting my travel and enabling me to attend. I have acquired real treasures to take home back to New Zealand with me. I have gained more practical and theoretical knowledge and I know we are not isolated. Also, I am not alone; although what I do every day in my pain management work and research is unusual in a classic model, there are many out there across the globe who share and practice a similar vision to mine.

I would encourage anyone reading this to seriously consider planning to attend the combined Pain Societies of Australia and New Zealand Conference in Sydney from 8–11 April 2018.

The New Zealand Pain Society Inc.

Annual General Meeting Friday, 3 March 2017

17:00 – 18:00 The Rutherford Hotel, Nelson

Present:

Frances James, John Alchin, Sarah Maley, Jaap Rigtering, Nani Aiono-Le Tagaloa, Brigitte Gertoberens, Erica Gleeson, Leena St Martin, Louise Sheppard, Luciana Blaga, Wei Chung Tong, Jenny Hunt, David Jones, Jenny Sandom, Ross Drake, Lee Gardiner, Tom Nesar, Jan Haraldsson, Jessica Hows, Paul Vroegop, Helen Macdonald, Tara Birch, Neil Micklewood, Chris Rumball, Glyn Richards, Dagmar Hempel, Edward Shipton, Joanne Walker, Elspeth Shipton, Ramakrishnan Mani, Frances Beswick.

Apologies for absence:

Cat Swift, Barbara Barwick, Kathryn Russell and Jim Olson

The AGM commenced at:

4.45pm

Minutes from the AGM held on 8 April 2016 at the Devon Hotel, New Plymouth were tabled.

It was moved by Brigitte Gertoberens and seconded by Jaap Rigtering to accept the minutes of 8 April 2016.

Carried

1. President's report

- Fran spoke to her report.
- The New Zealand Pain Society (NZPS) constitution details the key aspirations of the society; to promote high quality pain work in clinical, research and education practice in NZ. The constitution also emphasises the importance of collaboration and information sharing. Fran's report was structured in line with the NZPS Strategic Plan, which references the key aims of the NZPS constitution:

Strategic Aim 1: Advocacy

- There has been considerable media coverage around medicinal cannabinoids for chronic pain. The NZPS exchanged correspondence with the Ministry of Health regarding media reporting noting potential errors in the presentation of information (e.g. differentiating cannabis and medicinal cannabinoids) and noting the current evidence base does not support the use of cannabinoids for persistent pain.
- Another key focus area has been providing feedback on the ACC Pain Management Services Redesign project. We were asked to contribute a professional review of the consultation process for the redesign work and to advocate for best practise in the resulting framework.
- Correspondence with Ministry of Health regarding considerable media coverage on medicinal cannabinoids for persistent pain. NZPS exchanged correspondence with the MOH, Peter Dunn responded that he fully agreed with NZPS input. Ted Shipton has also been interviewed.
- Consultation on ACC's Pain Management Services Redesign project.

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- Jaap Rigtering attended workshop “Live a Good Life: Join the Conversation. A focus group event to start developing a new disability strategy for New Zealand”. Further written correspondence on the draft strategy noted that persistent pain meets the criteria for disability.
 - John Alchin attended the preliminary Choose Wisely workshop looking at introducing this framework to facilitate patients to understand medical treatment decision making.

Strategic Aim 2: Networking

- Regular discussions with the Australian Pain Society (APS)/Faculty of Pain Medicine (FPM). Key points from these discussions are reported in Ngau Mamae.
- NZPS/APS Combined Annual Scientific Meeting scheduled for Sydney in 2018.
- NZPS Pain in Childhood Special Interest Group (SIG) and Paediatric Society Pain SIG merger documented in a memorandum of understanding (MOU). The MOU ensures the SIG functions in line with NZPS constitutional requirements and financial safeguards are in place.
- NZPS congratulated the Physiotherapy Board on the development of a new Pain specialist scope of practice and offered to be a resource if applications to this scope are received.
- John Alchin presented at the Pain@Otago research symposium on the role of the NZ Pain Society, and its relationship to IASP

Strategic Aim 3: Information Sharing

- The council recognises that our internet presence is a key point of engagement with NZPS members and the general public. There has been increasing engagement with the Facebook page.
- We feel the key function of the website is as a resource for health professionals. We would like to redesign the website and see this as a high priority for 2017.
- Updating the website will require commitment from NZPS members with an interest in contributing to the website development and maintenance. Over the last two years there has been a Social Media representative present at council meetings and we would like to develop this as a permanent council role with associated voting rights. NZPS has tenders but what we lack is someone to drive this. We believe it is a reasonable investment of Society monies so we have sourced quotes for re-development of website. We also need to formalise correspondence to include Treasurer/Secretary and President email address. We have been very lucky that Louise Sheppard has been involved and done an incredible job in the social media role of late.
- Archive project on hold, all the boxes are now in one place.
- Sue King has accepted Lifetime membership and will formally accept this in Christchurch in 2019. We are now publishing biographies for lifetime members. Ian Broadfoot was our first lifetime member.
- We have been very lucky to have Dr Leinani Aiono-Le Tagaloa step in as Editor for Ngau Mamae. We hope that you find Ngau Mamae useful and interesting and we welcome contributions and comments.
- Each year the NZPS/APS/FPM group produce a Global Year against Pain (GYAP) poster. This year is the GYAP After Surgery and the poster was prepared by FPM

and available to NZPS members via the website. Our APS colleagues questioned if the poster is useful to membership. There were suggestions of discontinuing the poster. The council would like to know if the membership would like us to advocate for continuing the production of a GYAP poster. A large number of members identified with the GYAP poster and reported using it.

Strategic Aim 4: Education

- The Annual Scientific Meetings remain a focus of education and networking within the NZPS. We are impressed by the high calibre of speakers presenting. Networking is always recognised as a positive outcome from delegates. We continue to minimise the costs
- of attending the meeting as many members note it is difficult to source continuing education funding.
- Successful 2016 Annual Scientific Meeting: “Surfing the pain wave”, held in New Plymouth.
- 2017 meeting: Active and Able. Nelson.
- 2018 meeting: Educate, Collaborate, Disseminate. Combined with APS, Sydney.
- Paediatric pain half day symposium offered in conjunction with the NZ Paediatric Society meeting. Symposium was well received.
- The FPM has developed online Better Pain Management education modules which will be available at a discounted rate to NZPS members. Release is expected in April this year. We also have promoted the Sick Kids web based education package which is an IASP endorsed free resource.
- Global Year against Pain After Surgery poster prepared by FPM and available to NZPS members via the website.
- The NZPS has contracted with ACC to develop a resource for patients with persistent pain. ACC requested NZPS involvement as a recognised body of health professionals with expertise in the management of pain.
- The NZPS had no applicants to the first grant round this year, or an extra round offered for World Congress travel funding. In the final grant round for the year we approved three travel and/or education grants. We need to get the word out there that money is available.

Strategic Aim 5: Research

- The NZPS currently has two sources of funding to support researchers in New Zealand.
- We were disappointed to receive no applications for the Broadfoot Trust Prize for NZ peer reviewed published research and have decided to move the closing date to mid-year. Fran recommended that everyone discuss this prize with students. Broadfoot applications to close on 1 June 2017 in line with the June grant round
- Cynthia Mary Miller bequest funding awarded to Dr M. Kluger’s research group towards the cost of the candidate gene association studies in a prospective observational research study examining the predictors and mechanisms of persistent pain after breast cancer surgery.

Strategic Aim 6: Sustainability

- With multiple changes of council members at the last AGM this has been an opportune time to consider the underlying processes and legal obligations of NZPS as a charitable society. As Treasurer,
- Jaap has undertaken work to transfer our financial systems to Xero which has been of considerable benefit to NZPS.
- Accounts transferred to Xero accounting system with significant savings on auditing costs.
- Financial accountability process continued (charitable society status, companies' office, audited accounts).
- Secretarial role scoped and hours increased to match required work. The costs are covered by income from membership fees.
- New council members in key roles were asked to help document the roles and create a foundation for future handovers.
- Website/Social Media representative on council to be a permanent position as this is a critical role.
- Social media rep, Louise Sheppard has come along to all Council discussions which allows us to look at how we communicate to members and where we are going to in the future. We would like the social media rep to become a member of the Council. This fits in our Society documentation.

It was carried unanimously that the social media representative will become a member of the Council.

- Fran reported that it has been a privilege to give back to the NZPS as an organisation. She stated that as a student, attending her first meeting, she felt celebrated by colleagues and she hopes we continue to provide this warm welcome to new members. Fran believes the strength of the NZPS will always be the people and the community we create. Fran recognised the wonderful support from the council and thanked the members of the council for their enthusiasm and commitment.
- Fran welcomed John Alchin as incoming President, John brings a wealth of experience as a clinician and an academic, and from his previous roles with NZPS. Fran expressed her confidence in John being a most excellent President.

Discussion points:

- Lee Gardiner asked for NZPS position statement documentation relating to the ACC project and also the stance on cannabinoid use in New Zealand. Louise and Fran identified that we supported FPM's stance on cannabinoids. Fran also said we were involved in teleconferences with ACC so we don't have any position statements in regards to this.
- Fran reported that we took on a contract with ACC to create good educational resources. They are paying NZPS \$12,500 to complete this work.

It was moved by Fran James and seconded by Nani Aiono-Le Tagaloa to accept the President's Report

Carried

2. Treasurer's report

- Jaap spoke to the Financial report provided by an external accountant, Byron Pearson, Chartered Accountant, from Veritas Accounting and Auditing.
- Jaap reports that during his time as Treasurer he has focused on the modernisation of accounting processes and increasing transparency to include:
 - Reduced use of paper records where possible.
 - Use of secure cloud based storage of Treasurers digital records.
 - Use of Xero for all bookkeeping to reduce cost in accounting fees, and in the hope that NZPS can move into digitally generating all invoices. NZPS can then track who has or hasn't paid. However, this has required a very manual process of entering all current members.

Discussion points:

- David Jones queried where the assets are currently and Jaap reported that monies have been invested across two accounts.

It was moved by Jaap Rigtering and seconded by Brigitte Gertoberens to accept the Treasurer's report.

Carried

3. Membership report

- Fran spoke to Sarah Maley's membership report. Statistics show an increase in members for 2016 possibly secondary to new ACC contract. Fran said it is hoped that with automated invoicing we will improve the membership payment process.
- During 2016 members received initial invoice and two reminders thereafter i.e. in July and September. All invoicing will be transferred onto the Xero system for 2017. As at 31 December 2016, the 75 unpaid memberships have been suspended. Their details remain open on our data base should they choose to return to the NZPS in the next 12 months.
- New members for 2016 = 139 compared to 60 new members in 2015.
- Resignations/archived members to date = 20 compared to 52 in 2015.
- 75 members suspended in 2016 due to unpaid subs
- Membership Tiers as at 31 December 2016 are as follows:
 - Affiliates: 13
 - Tier 1: 325
 - Tier 2: 104
 - Students: 10
 - Retirees: 6
 - Life Members: 7 to include APS Secretariat

It was moved by Frances James and seconded by Jenny Hunt to accept the Membership Report

Carried

4. Editor-in-Chief, Ngau Mamae report

- Nani identified to the members that as a chapter of IASP, it is mandatory that we have a journal, in keeping with the mission statement of the International Association for the Study of Pain. Ngau Mamae was given its name by a kuia of Ngati Kuri descent, and means to bite, to engage with (Ngau) pain (Mamae).
- Nani identified that her particular focus and passion is to highlight and publish the wealth of knowledge and wisdom that exists within our own clinical practice in New Zealand, and make it available to our members; sometimes the solution to a challenging patient or situation has already been thought of, and these are gems that need to be shared. Networking is also important for a small society, and so a very integral part of our journal is the Member's profile, where we get the chance to learn more about each other: not only our clinical skillset, but also the very human elements that make us all unique and interesting.
- Nani reports that she has struggled with meeting official seasonal start dates with the knock-on effect of delaying the publication dates for each issue, and ultimately resulting in having to miss out on Summer 2017. However, to avoid having to ask people to produce something so close to the Christmas and New Year period, themes have been set for each issue, in line with the current Global Year Against Pain theme set by IASP and the formulated projected deadlines and publication dates for the coming year are as follows:
 - Autumn 2017: Deadline 28 February, Publication date 6 March
 - Winter 2017: Deadline 26 May, Publication date 5 June
 - Spring 2017: Deadline 25 August, Publication date 4 September
 - Summer 2017: Deadline 24 November, Publication date 4 December
- Nani reports that she has discovered the same challenges when collating an issue as have been expressed by her predecessors. It is a struggle not only to persuade people to contribute to our journal, but also to get contributions back in a timely fashion. In addition to this, there is a very low response rate to emails inviting members to send in a profile of themselves to be published. This feature of the journal is often the most popular one, and we have a team of editors ready and willing to edit and/or ghost-write if necessary.
- Nani asked everyone to go to their colleagues and speak to their places of work and encourage people to contribute to the journal.
- Nani also discussed the proposal of an Editors section to include letters to the editor. It was suggested that letters written by the President as part of NZPS business e.g. Ministry of Health letters regarding cannabinoids debate, could be included in this section.

It was moved by Nani Aiono-Le Tagaloa and seconded by Jaap Rigtering to accept the Ngau Mamae Report

Carried

5. Correspondence

- Fran stated that written communication to the Ministry of Health re NZPS' stance on cannabinoids will be advertised to all members on the website and in Ngau Mamae.
- No other correspondence of note.

6. Election of Officers

- Fran welcomed John Alchin into his new role as NZPS President. Fran will become immediate Past President.
- Fran identified no other Council changes which means that next year NZPS will have a few roles to fill. She recommended that members find out more information about the roles in advance.
- Fran informed members that NZPS want to formally elect a social media representative on Council. John Alchin and Sarah Maley reported that Bronnie Thompson had identified some interest. Louise Sheppard to hold further discussions with Bronnie. Jaap Rigtering also recommended a colleague, who has a history of graphic design. Fran reports that members need to remember that there is the support of a social media team. Louise said there is also a role description which she is happy to email to people considering the role. Ramakrishnan Mani also expressed an interest in the social media role and Louise agreed to forward him and Bronnie the role description.
- Brigitte and John thanked Fran for all her input during her term of Presidency. Fran and John thanked Sarah, Jaap and Nani for their hard work in their specific Council positions.

7. Working Groups:

Pain in Childhood Special Interest Group

- Paul Vroegop presented report on behalf of Kathryn Russell and identified the very impressive year the SIG has had.
- The goals of the SIG are to:
 - Support a multidisciplinary approach to the field of pain management in children and adolescents
 - Encourage education and research in paediatric pain (acute pain, procedural and iatrogenic pain, and persistent/chronic pain).
 - Support health professionals within New Zealand to improve child and adolescent pain management through advocacy, strategy, and planning.
 - Provide advice to the Pain Society on current issues in the field of pain affecting the health and well-being of children and young people.
 - Collaborate with the Paediatric Society of NZ Pain in Children and Adolescents SIG, to best achieve joint goals.
- Activities of the last 12 months have included:
 - The Memorandum of Understanding between NZ Pain Society and Paediatric Society of NZ was finalised and signed off by both Presidents.
 - Teleconferences in March, October, plus contributions to the NZ and Australian Pain society executive meetings (2 teleconferences) – Kathryn Russell and Ross Drake
 - Communications on the list servers
 - Half day Symposium in November 2016 – over 40 registrations.
 - A member of the group (Ross Drake) has liaised with the Faculty of Pain Medicine to produce the application to the National Health Committee to support the development of 3 specialist chronic pain services for children in NZ as part of their process for appraisal of proposals for the NHC's assessment work programme. Unfortunately, this was declined and it is unlikely that further specialist services in paediatric chronic pain will be driven at the national level in the short term.

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- Educational teleconferences were not seen as possible to sustain, however case discussion forums/journal club were considered more likely. Hope to begin on the Telepaeds network 2017.
 - Youth health survey delayed (no longer 2017), however a pain question was developed for when this occurs
 - Investigating feasibility of hosting the International Symposium for Pediatric Pain in NZ in 2021 – however a change in format has meant bids to host will no longer be accepted and conferences will be organised and funded centrally by the ISSP. However promotional material about New Zealand will be sent to the committee.
- Paul thanked Kathryn for her role as a President and said she has done a fantastic role. Her term finished in November 2017 and Sarah Thompson, Nurse Specialist at Starship, has taken over Presidency.
 - Fran reports that it has also been formally agreed that NZPS ASM will have a Paediatric focus symposium every 3 years.

It was moved by Paul Vroegop and seconded by Ross Drake to accept the Pain in Childhood Special Interest Group report

Carried

Nurses Special Interest Group

- Jenny Hunt spoke to her report. She reports that there are approximately 80 members in the Nursing SIG.
- Nursing AGM was also held in Nelson on 2 March 2017.
- Volunteers are to get project underway to update The Nursing Knowledge and Skills Framework which is due for review by 2018. This is an important and comprehensive document developed by the NZPS NSIG and accredited by National Nursing Consortium NZ as a summary of pain knowledge and skills for nurses in NZ. Susie O'Connor and Erica Gleeson have offered to lead this. The Document has been recognised by the Royal College of Nursing and accredited by the British Nursing Society which they have streamlined for their purposes.

It was moved by Jenny Hunt and seconded by John Alchin to accept the Nursing Special Interest Group report

Carried

Social Media Group

- Louise spoke to her report.
- On average NZPS site receives 817 visitors per month (range 669 – 1089). Use seems to peak around the time of ASM each year. 80% of the visitors our site gets are from first time visitors. 44% of visits are from New Zealand. People stay on the site an average of 1¼ minutes and visit an average of 2 pages. 19% of visits in the last year were on a mobile device. 60% of new visits found the site through an organic search. Overall, user behaviour on the site hasn't changed over the past 2 years
- During the second half of 2016, discussions were held around the possibility of rebuilding the website to provide additional functionality and future proof the site. In late August, Council developed a 'wish list' for the website. Two quotes were sourced to get an indication of the potential costs involved in a redesign/rebuild - these

quotes ranged from \$13,377.50 + GST to \$15,150 + GST. Based on these prices a decision was made at the October Council meeting to go ahead and investigate a redesign further and it was decided to establish a separate Website Redesign Working Party to progress this. An article was published in the Spring issue of Ngau Mamae advertising for volunteers to be part of this working party and to date we have 1 volunteer. It is intended that this project will be progressed through 2017.

- Our Facebook page now has 329 'likes' – growth has been steady over last year with accelerated growth in past 3-4 months. The majority (67%) of the Facebook audience are female with 57% being between 25 and 54 years of age. 7 people visit our website directly from our Facebook page each month. Our Twitter account is currently not active.
- The Website 'Wish List' included:
 - ____@nzps emails (<10)
 - Online membership renewal - possibly Xero compatible
 - At least 1000MB of storage
 - Unmetered traffic.
 - Clean, professional and modern appearance (similar to www.americanpainsociety.org)
 - Ability to maintain and update the site ourselves
 - Integration of our social media accounts
 - Mobile device compatible
 - Integration with cloud storage
 - Possibly: ability for members to search the membership for other members and 'request' a contact from a specific member

It was moved by Louise Sheppard and seconded by Sarah Maley to accept Social Media Report

Carried

8. Broadfoot Trust

- Fran discussed the Trust fund that NZPS has access to which is used to promote best practice in pain medicine. This is awarded to the best peer reviewed NZ publication. Unfortunately, no applications were made in 2016. The funds were left to the NZPS by Ian Broadfoot and are managed by Guardian Trust.
- The NZPS is responsible for providing two trustees. The Guardian Trust lawyers have agreed that if NZPS make a specific statement and name their current President and Treasurer in the AGM minutes as trustees then this can be accepted as a legal statement of responsibility as the current Broadfoot Trustees.
- Fran has identified that the Broadfoot prize will now be awarded in June (rather than November) to coincide with other grant round and allows prize winners to prepare for the ASM the year after.
- As at 3/3/2017, John Alchin becomes the President of NZPS and Jaap Rigtering remains as Treasurer thus becoming the two Trustees for the Broadfoot Trust for 2017.

9. Conference Calendar

- 2018 Conjoint Australian Pain Society and NZPS Annual Scientific Meeting will be held April 8-11 in Sydney. Kate McCallum is co-convenor and Fran James and Ross Drake are on the organising committee.
- 2019 ASM will be held in Christchurch. John Alchin is currently leading the organisation of this meeting.

10. Corporate Membership

- Fran presented a discussion document including the terms of corporate membership and asked members their opinions on whether corporate membership is of value to the NZ Pain Society and should the council review the criteria and benefits for corporate membership of the NZPS?
- There was insufficient time to fully discuss this issue during the AGM. 16 members agreed there is a role for Corporate members in NZPS and 9 members expressed concern with having Corporate membership.
- Fran James suggested the discussion paper is put to membership and that a position statement is brought back to the next AGM.
- David Jones suggested that the advantages and disadvantages of corporate membership be included in a summary document of position statement.

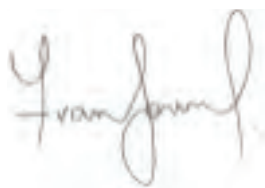
It was moved by Frances James and seconded by Jenny Hunt to review the role of corporate membership in the society. A Position Statement to be brought back to membership to discuss.

Carried

Meeting adjourned at 6:10 pm

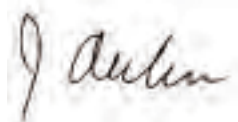
Signed Chair: Frances James

Dated: 30 March 2017



Signed President Elect: John Alchin

Dated: 30 March 2017



The Role of a Psychologist In the Multidisciplinary Management of Chronic Pelvic Pain

Leena St Martin

Clinical Psychologist, Gynaecology Outpatients Department, National Women's Health, Auckland District Health Board

Introduction

An earlier version of this article was published in *Ngau Mamae* over a decade ago (St Martin 2006) and now it seems timely to consider the challenges and insights gained from our work with women with chronic pelvic pain at National Women's Health, Auckland District Health Board.

Approximately 25% of women in New Zealand suffer from chronic pelvic pain, similar to the rate in the United Kingdom of 24% (Grace, Zondervan 2004). There has been no significant update to this statistic over the past decade. Around 10% are likely to have the diagnosis of endometriosis which is the most widely recognised pelvic pain condition. Although endometriosis was previously regarded as a 'working women's disease' reflective of upwardly mobile professionals who delay child-bearing, presentations at our clinic are reflective of our increasingly multicultural and socio-economically diverse population in Auckland.

Chronic pelvic pain in women is defined as pain in the pelvic region that has persisted for at least six months and is considered gynaecological in origin. Forms of chronic pelvic pain include endometriosis, pelvic congestion syndrome, surgery-related tissue adhesions and scarring, chronic pelvic pain without clear pathology, and neuropathic pain. Associated problems include irritable bowel syndrome, interstitial cystitis, and painful bladder syndrome. Common verbal descriptors of pelvic pain are that it drags, stabs, radiates down the legs, and can come in waves with such intensity that it is likened to labour contractions during childbirth. Pain may be accompanied by vomiting, diarrhoea and fainting and is often made worse by movement, sexual activity, and bowel motions. In addition to these symptoms, sufferers often have painful menstruation (dysmenorrhoea), menstrual bleeding irregularities, and dyspareunia (pain with sexual intercourse).

Contributing factors are hormonal, immunological (auto-immune), familial, genetic, and environmental.

Stressful life events have been noted as higher among women with chronic pelvic pain with consequent dysregulation of the hypothalamic-pituitary-adrenal axis (Heim et al, 1998). As one example of a predisposing factor, childhood abuse was examined in the earlier literature with reports ranging from 19-67% for childhood sexual abuse, and 39-60% for childhood physical abuse. Women with chronic pelvic pain have also been noted to have higher rates of dissociation, post traumatic stress symptoms, emotional regulation difficulties, and other common abuse-related sequelae (Heim et al 1998, Walker et al 1995). More contemporarily, there is an acknowledgement that some of these sequelae can also result from a variety of experiences constituting emotional abuse or neglect rather than overt physical or sexual abuse. This reflects our increasingly complex social environment with changing family configurations and approaches to parenting, including parental loss or loss of primary attachment figure, which may result in similar outcomes for young women. The neurobiological and psychiatric consequences of these various childhood experiences and recommendations for treatment have been usefully described (Heim et al 2010). However regarding pain behaviours, the presence of these social or cultural variables may result in minimal pain behaviours being demonstrated in the presence of major trauma, and the opposite may also be evident. Thus we must take care not to make pathologising inferences based on observed pain behaviours.

Historically there was little knowledge of pelvic pain conditions and a seven year delay was typical between onset of symptoms and eventual diagnosis. In New Zealand this diagnostic delay has been addressed through better clinician education and via the efforts of consumer advocacy groups such as NZ Endometriosis Foundation (www.nzendo.org.nz) who conduct educational campaigns in order to reach young school-age women, and by public access to information on social media. However the gain of earlier diagnosis has brought with it the dilemma

of exposure to surgery at increasingly younger ages and the prospect of repetitive surgeries to address persistent symptoms.

Diagnosis is by laparoscopy, with concurrent treatment via excision of any implicated tissue. Ongoing medical management often involves the use of estrogen-suppressing hormones orally or via intrauterine contraceptive device (e.g. Mirena) although this can sometimes increase pelvic pain and some women request to have the device removed prematurely. Hormonal options which induce temporary menopause to provide symptom relief (e.g. Zoladex) can result in unacceptable side-effects such as hirsutism, weight gain, and depressed mood.

Laparoscopy may provide an inconclusive diagnosis or simply an absence of observed tissue pathology. In the case of endometriosis, even where endometrial deposits are found and excised, it may still be coincidental rather than the cause of the pain. Although many women experience marked pain relief following excision of endometriosis, approximately 20% have a return of pain despite surgery. At this point, the psychological consequences of chronic pelvic pain are usually apparent as the woman contemplates a future filled with pain and disability and the implications of having a condition which does not clearly fit within a biomedical paradigm.

The functional and psychosocial impact of chronic pelvic pain is significant. Women commonly report global loss of functioning – pain affects their ability to function at home and at work, relationships suffer, and there is resulting mood deterioration. Further problems can develop from reliance on opioid analgesics to control pain and from infertility, or early termination of fertility, by hysterectomy in an attempt to control pain. These effects can compromise a woman's sense of femininity and result in a loss of social confidence. The situation is more challenging for those with an inconclusive diagnosis as described above. These women are more likely to conclude that the pain must be "all in their head" as at this point, they are usually unaware of the part central sensitisation plays in their ongoing pain symptoms.

It is therefore not unusual for women to seek several medical opinions and undergo multiple laparoscopies in their quest to achieve a conclusive diagnosis which makes sense to them and to seek relief from

pain. The relationship that the women have with their Gynaecologist takes on a greater significance as they tend to invest in that person to provide these answers (Warwick et al, 2005). The significance of this relationship may be underestimated by medical professionals, resulting in frustration and anxiety for both parties (Grace 1995, Elliot 1996).

The importance of patient experience as a variable which influences health outcomes has been recognised. Doyle et al (2013) conducted a systematic review of the literature and found evidence of positive associations between patient experience, patient safety and clinical effectiveness, which are regarded as the three pillars of quality in healthcare. They note that "clear information, empathic, two-way communication and respect for patients' beliefs and concerns could lead to patients being more informed and involved in decision-making and create an environment where patients are more willing to disclose information" (Doyle et al 2013, p.2). These comments seem to reflect the New Zealand context where the principles of the Treaty of Waitangi as they apply to healthcare state that partnership, participation and protection should be evident at all levels of our clinical practice (Ministry of Health, www.health.govt.nz). A more local development within Auckland DHB has been a revision of organisational values following an extensive survey of patients regarding their healthcare experiences, and staff regarding their work satisfaction. Interestingly there was a reasonable match between the factors which patients and staff considered important for good outcome. The provision of information, organisation, and confidence in care were identified as very important dimensions (ADHB 2016). Values and their related behaviours have been translated into te reo maori, and include the importance of patients feeling welcome ("Haere Mai"), showing respect ("Manaaki"), a team approach ("Tuhono") and aspiration towards excellence ("Angamua").

At National Women's Health, a multidisciplinary service comprising physiotherapists, anaesthetic pain team, and a psychologist, is available to assist women with chronic pelvic pain following gynaecological intervention. Routine outpatient psychological interventions include emotional support with illness adjustment, behavioural pain management (including relaxation training, mindfulness techniques, pacing

and goal-setting), coaching on optimising contacts with other health professionals and services, and sometimes couples therapy to improve understandings of the impact of pain on the sexual relationship. Therapeutic treatment modalities have been refined via the contribution of third wave CBT approaches such as ACT.

If targeted treatment of mood symptoms is indicated, concurrent community mental health referral usually occurs as this service is not equipped to prescribe psychotropic medication. Patients may utilise the psychology service for anything from a single session up to several years, often supplemented by attendance at other relevant services such as The Auckland Regional Pain Service (TARPS).

Inspired by the successes of our Australian colleagues with pre-clinic interventions (Davies et al, 2010), we trialled a pre-clinic short pain group which aimed to provide psycho-education about chronic pelvic pain and hopefully reduce pressure on clinic time and tailor patient expectations in a helpful direction. After several rounds, these groups were discontinued due to high levels of staff hours required for teaching sessions and due to the relatively low numbers of patients attending due to the usual barriers of transportation, childcare, and time needed off work to attend. We concluded that the group format was not a replacement for the actual clinic and that patients valued their individual relationship with the pain consultant and other members of the treatment team for the reasons described above.

Management of Behavioural Complexities

Within the chronic pelvic pain population we have noted a small subgroup of inpatients who pose a significant cost by virtue of frequency and length of hospital stay, behavioural interactions with nursing staff resulting in a negative impact on staff morale, and high use of costly analgesia. This pattern seems to have its parallel across other medical specialties (Kenedi et al, 2015).

These patients commonly report an all-or-nothing experience of pain as measured on a visual analogue scale (0/10 or 8-10/10). This may reflect a lack of effective behavioural coping strategies for lower levels of pain and may also indicate that they have altered autonomic arousal systems, as previously described, due to past traumatic experiences. The level of

analgesia required in order to achieve a window free from intense pain is observed to often exceed that used by cancer patients. In addition, these patients do not exhibit consistency of pain behaviours (e.g. bodily protection). A typical example would be someone who can be seen freely moving about the hospital, socially engaging with other patients during cigarette breaks, alternating with being curled up in a foetal position crying, or repeatedly bell-pressing for medication when back on the ward. Not surprisingly, staff tend to regard these patients with some suspicion. For the woman in question, this may result in delayed access to adequate pain control medications, thus increasing her emotional distress and disruptive behaviour on the ward.

To address these problems, I introduced aspects of an evidence-based treatment model known as Dialectical Behaviour Therapy (Linehan 1993). DBT is a comprehensive team-based treatment model originally developed to address the needs of people diagnosed with borderline personality disorder and has also been used in the treatment of eating disorders and substance abuse. Whilst chronic pelvic pain has not been addressed in the DBT literature, I observed similarities between the two patient groups. For example, both are viewed as labour intensive, long-term, complex, and demanding to work with. A philosophy of patient validation balanced with an expectation of behavioural change underpins the DBT approach. DBT also addresses the needs of staff also by encouraging a coordinated team approach to support staff in their work. This can minimise professional burnout and thus reduce the possibility of unhelpful or damaging behaviour towards patients.

As a result of describing this approach over the years at pain education forums, other medical specialties ranging from emergency department to organ transplant units have expressed interest in improving their management of patients who fit a similar behavioural profile. A further development was a project to consider the utility of treating these patients under the umbrella of a Medically Unexplained Symptoms (MUS) clinic. The treatment of functional disorders or MUS has gained traction in the northern hemisphere as it is considered a means of diverting complex patients away from unnecessary and expensive medical treatments and encouraging more adaptive coping with chronic symptomatology (Kenedi et al 2015). However

the question remains as to whether this terminology and treatment approach is acceptable to patients. Due to funding constraints at this stage the MUS project remains on hold at ADHB so 'business as usual' continues with these patient groups being managed within their specific medical specialties.

What is validation?

Validation, as it is used in DBT, is a broad concept which applies at the systemic as well as individual levels. At the individual level, validation is about communicating acceptance and unconditional positive regard through techniques such as reflective listening. When we validate, we reflect back to the person their communication and confirm our understanding of that person's experience. The emotional effect of validation is that it can reduce defensiveness and anxiety in the patient, resulting in improved information processing and improved interpersonal dynamics. This effect is important in the case of chronic pelvic pain as, like the borderline, these patients have heard a strong message that their pain and presentation are unacceptable to others.

In the chronic pelvic pain literature two aspects of prior validation have been identified as important for patients:

1. The initial medical consultation – a favourable assessment of the medical consultation by the patient predicted recovery at six months follow-up as measured by pain scores (Selfe et al, 1998).
2. The role of a diagnostic laparoscopy – although patients can be hard to treat medically, yet are defensive about psychosocial components of their pain, there can be a positive psychological effect of laparoscopy. Pain improvements after laparoscopy were predicted by beliefs about pain and a change in evaluation of the seriousness of the condition (Elcombe et al 1997).

At the systemic level, validation can increase a patient's sense of control and thereby reduce anxiety. By working collaboratively with the patient to design a multidisciplinary management plan, she is given a message that the hospital has recognised her needs and is attempting to meet these needs. Ultimately this can increase compliance with the treatment regime. Management plans should include mention of the current diagnosis or working formulation, along with a multidisciplinary treatment plan, identifying all stakeholders and their roles, treatment steps the patient is expected to undertake for each part

of the service, and steps the patient should take if requiring access to acute services. Management plans are regularly reviewed upon request by the patient or stakeholders.

Although treatment compliance, reduction in lengthy hospitalisations and use of costly analgesia, make up the ultimate goal of such initiatives, it is important to note that these aspects of service provision are not denied or terminated prematurely. Rather, the patient maintains control over her use of services, through negotiation with staff. Knowing that she can access acute services may provide something of an 'insurance policy' and may even encourage more independent problem-solving around pain management. If the patient determines that she requires urgent inpatient review, she follows a clear admission pathway to access this, ideally starting with a GP referral. Following acute gynaecological review, she is either discharged or transferred to the gynaecology ward. If behaviour management issues have previously been identified, the multidisciplinary team is notified, usually within 24 hours.

It is important to note that within DBT, validation is balanced with an expectation of behaviour change and therefore standard behavioural principles of reinforcement and punishment apply. The patient is advised of any behaviour contract in a compassionate yet straightforward manner. Staff are required to uphold their part of the plan by adhering to charted analgesia regardless of observed behavioural inconsistencies. The patient is reviewed daily at hand-over meeting and the behaviour management approach is described in the patient record so that new staff can adhere to the plan. Ideally staff would have the opportunity to debrief any difficulties faced and receive support and advice from their peers. Upon discharge from the ward, outpatient follow-up is confirmed so the patient again has a clear sense of service continuity. It is desirable that she sees the same consultant regularly to ensure consistency.

In summary, this approach involves operationalising a multidimensional pain model and incorporating organizational values by applying the following:

3. Validation – from individual to systemic levels
4. Working as a team respectfully
5. Developing multidisciplinary management plans in partnership with patient

6. Staying within the plan
7. Observing your limits - maintain appropriate professional boundaries and self-expectations
8. Input from a psychologist or other professional skilled in behaviour management.

Discussion

This paper has provided the opportunity to review our approach towards caring for patients with chronic pelvic pain. Multidisciplinary care for both routine and complex presentations remains best practice. Greater awareness of the role that central sensitisation mechanisms play in pain perception and symptom reporting amongst referring medical colleagues has resulted in earlier referral to our service and recognition that repetitive pelvic surgery should be avoided where possible.

The validation-balanced-with-change equation still applies for a small sub-group of patients, and in staff responses to caring for them. Developments in the field of neurobiology have improved understandings of the precise mechanisms which result in desired behavioural outcomes in patients. Related concepts such as 'patient experience' and 'staff engagement' are increasingly being recognised as important for achieving overall quality of care. At a local level these concepts have led to revised organisational values and invite consideration of the extent to which our service delivery reflects the healthcare principles of the Treaty of Waitangi. Other hospital services have developed a curiosity about the approach taken and are considering how these principles might apply with their complex patient groups.

Acknowledgements: The author wishes to thank staff from the Acute Pain Service, National Women's Health for their ongoing interest in this model

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Professor Liesbet Goubert



Prof Goubert works in the Department of Experimental Clinical and Health Psychology at Ghent University, Belgium. Her

research focus is on the interpersonal dynamics of (chronic) pain and chronic illness. More recently she has become interested in the study of psychosocial resilience mechanisms that may account for the sustainment of adaptive functioning and well-being in the presence of pain.

Professor Stephen McMahon



Prof McMahon is Sherrington Professor of Physiology at King's College London and a Fellow of the Academy of Medical Sciences.

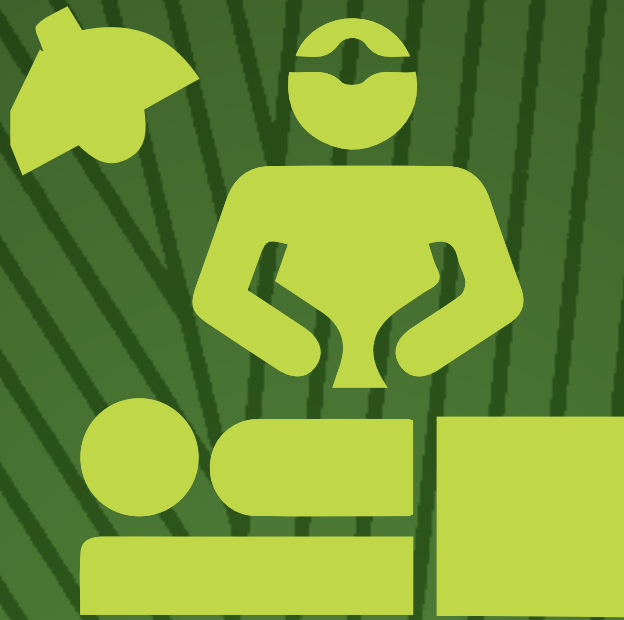
His major research interest is pain mechanisms - identifying pain mediators and studying their neurobiological actions. His current research is focused on neuro-immune interactions, particularly the neurobiology of chemokines, and the genetics and epigenetics of pain.

Dr Tonya Palermo



Dr Palermo is a pediatric psychologist and Professor of Anesthesiology & Pain Medicine at University of Washington with adjunct

appointments in Pediatrics and Psychiatry. She also directs the Pediatric Pain & Sleep Innovations Lab that aims to improve the lives of children with pain and their families by developing, evaluating, and disseminating innovative treatments that can be delivered at low cost.



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NOTE:

Modality-oriented Clinic

- Provides specific type of treatment, eg. nerve blocks, TENS acupuncture, etc
- May have one or more health care disciplines.
- Does not provide an integrated, comprehensive approach.

Pain Clinic

- Focuses on the diagnosis and management of patients with chronic pain, or may specialise in specific
- diagnoses of pain related to a specific region of the body.
- Does not provide comprehensive assessment or treatment.
- A single physician functioning within a complex healthcare institution which offers appropriate consultative and therapeutic services would qualify, but not an isolated solo practitioner.

Multidisciplinary Pain Clinic

- Specialises in the multidisciplinary diagnosis and management of patients with chronic pain.
- Staffed by physicians of different specialities and other healthcare providers.
- May have facilities that are inpatient, outpatient or both.
- Differs from a Multidisciplinary Pain Centre only because it does not include research and teaching.

Multidisciplinary Pain Centre

- An organisation of healthcare professionals and basic scientists that includes research, teaching, and patient care in acute and chronic pain.
- Typically a component of a medical school or a teaching hospital.
- Clinical programmes supervised by an appropriately trained and licensed Director.
- Staffed by a minimum of physician, clinical psychologist or psychiatrist, occupational therapist, physiotherapist, and registered nurse.
- Services provided must be integrated and based upon interdisciplinary assessment and management.
- Offers both inpatient and outpatient programmes.