CANADIAN ACADEMY OF PAIN MANAGEMENT

CAPM NEWSLETTER

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At the recent monthly information session sponsored by the Inter-disciplinary Pain Program, at the University of Western Ontario (UWO), we heard from a retired but very active Dr. Don Ranney.

Don is an orthopaedic surgeon who continues to do research as well as 'Independent Medical Evaluations' (IME) for plaintiff insurance companies and lawyers.

For those of you who work and communicate via your research laboratories and meeting rooms, you are now entering the real world of 'treating the post-traumatic persistent pain person' in the community.

Don discussed some of the challenges in being able to provide accurate and good information for the patients he 'assessed'. He also **emphasized** the fact that he is no longer being asked to do IMEs for defense insurance companies. Evidently the insurers 'didn't like his recommendations' since they often including more treatment suggestions!

And soon after that discussion, this health provider received a copy of one of those IMEs that was conducted by a physiatrist who also works in a Pain Clinic.

The physician commented in this 'examination' that physiotherapy services, which s/he described as only manual therapy, were not 'reasonable and necessary'. S/he based this opinion on the fact that the patient did not /could not tell the physician whether she was feeling **"significantly"** better.

This very experienced physiatrist did not appear to have read the complete physiotherapy report which stated that the patient had symptoms suggestive of a post traumatic vision injury and was being referred for additional assessment; and that the patient had requested massage therapy even though when initially seen by this health provider, the patient could not tolerate being touched! Neither did this examiner comment of the fact that the patient had a team of very experienced health professionals (names noted on the physio report) working with her – including her family physician, OT, psychologist, psychiatrist, optometrist, and case manager (oh yes, the patient had already been deemed catastrophic - allowing her access to more funds needed for her recovery/rehabilitation.)

Nor did the physiatrist comment on the possible effect that this trauma may have had on this young woman's life - including the fact that at the time of the MVA, she was pregnant and had to be hospitalized for 2 months before the birth, that the patient sustained a serious orthopaedic hip injury, which necessitated 'pins and screws' surgery (and that in spite of this surgery, the hip remains unstable). Also unreported was the fact that this health provider was the third physiotherapist working with this patient and (according to the patient), extremely helpful (but maybe not yet measurably so) for her progress (which she could not verbalize well).

The physiatrist did approve the mattress and pool membership. Because physiotherapy services were denied, it is questioned how the patient was to implement the pool program since also recommended was supervised in pool sessions with the physiotherapist.

So—what has happened to some of us? Have we sold our souls to the insurance industry because it is financially more lucrative than dealing with chronic pain patients 1-1? Do we have one set of 'opinions' when the patient is referred by a family physician and another 'opinion' when the same question is asked by an insurance company?

Wouldn't it be nice to just be an excellent health provider - knowledgeable about the complexity of pain and the importance of multi-disciplinary management? We could then truly 'work as a team' with our patients and their families to provide the best care they need.

CAPM can be this vehicle by which health providers of all disciplines work together to provide excellent patient care!

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INSIDE THIS ISSUE:

Editor's Letter cont'd

The current newsletter will highlight the presentation by Dr. David Rosenbloom, D.Pharm. McMaster University on Analgesia During Pregnancy and Breast Feeding. This presentation was part of the recent CAPM course held at the end of January 2011 on 'Inter-disciplinary Pain Management' in Hamilton.

Dr. Rosenbloom's slides are re-printed in the newsletter. They are also available as an attachment of this newsletter.

Information on NORA (The Neuro-optometric Rehabilitation Association' and the possible relationship between persistent pain, 'post trauma vision syndrome (PTVS)' and 'visual mid line shift syndrome (VMSS)' will be introduced by your editor.

All members of CAPM are reminded to notify your Editor about 'updates in your professions' concerning pain management initiatives and courses.

You may also want to consider reviewing a book or article, presenting your own article for publication in this newsletter or comment on an important meeting/conference to have attended.

Respectfully submitted,

Gloria Gilbert, PT, M.Sc.
Secretary CAPM
Fellow, CAPM
Member and Fellow AAPM

Update from the Executive

Continued networking in the pain community, outreach to pharmaceutical companies and health providers, and our first Clinical Skills Workshop have kept your Executive Committee busy over the last few months, CAPM and the Canadian Chapter of the American Academy of Craniofacial Pain are 'in discussion'. We hope to collaborate with some mutually important educational and clinical endeavours.

Our first Inter-disciplinary Pain Management 2 day Course held in Hamilton at the end of January 2011 was a huge success. The course was fully subscribed and well received by the attendees. Plans remain to develop a series of informative and inter-active workshops of this type in different regions across the country (volunteers needed!)

In November 2010, members of CAPM including Howie Vernon, chiropractor, Eleni Hapidou, psychologist, Gloria Gilbert, physiotherapist and myself (psychiatrist) did a combined seminar at the Annual Meeting of the Canadian Chiropractic Association held in Toronto on Multi-disciplinary Pain Management.

This inter-active workshop was a good forum to also highlight the important multi-disciplinary orientation of CAPM and the benefits to membership.

Hope you will be able to join CAPM at our Annual Meeting: Marriott Gateway on the Falls, April 14, 2011 at 7:30 am during the Canadian Pain Society Meeting to be held in April in Niagara.

Yours sincerely,

Eldon Tunks MD FRCPC
CAPM President
Diplomate of CAPM
Member and Diplomate of AAPM

Update from the Professions

Gloria Gilbert, M.Sc.PT, Fellow, CAPM

(i) Chronic Pain and Mild Traumatic Brain Injury (mTBI): Is there more of a link then we realize? Are pain symptoms masking symptoms related to TBI?

In my relatively specialized physiotherapy practice, I have listened to many patients describe their challenges and obstacles during their rehabilitation process.

For many years, a question I have often asked (myself) was 'is it possible that something else has happened (at the time of this trauma) - besides the more obvious injury to bones and soft tissue?'

Why do some post traumatic neck pain patients have prolonged symptoms - even though they have been compliant with all treatment recommendations, have no significant psychological distress, love their job and their family, and have successfully adjusted to a 'changed' lifestyle.

Over the past three years, I have attended the annual conferences sponsored by Toronto Rehab on 'Mild Traumatic Brain Injury": Challenges and Controversies in Diagnosis'.

This is a clinical meeting, which is attracting a growing number of health providers, lawyers, researchers and case managers.

Perhaps we have to 'look again' at our post traumatic patients (especially when they injured their neck).

Have they sustained an as yet 'undiagnosed' mTBI, specifically one that affects the vision system (and therefore also balance, proprioception, spatial awareness and possibly the ability to progress their exercise programs?).

Because many 'whiplash' patients do not know whether or not they have lost consciousness and may suggest that they are only 'dazed', the significance of their injuries may be overlooked.

Most patients will only answer questions asked of them. They do not always report other than pain symptoms – unless they **are** asked. Only then do you they mention 'feelings' that they were either embarrassed or worried about, or maybe just thought were unrelated to the accident. So now we hear different words: dizziness, nausea, light-headedness, spinning, blurred vision, ringing in the ears, change in hearing, clumsiness).

And many will go for a check-up with their optometrist who does a vision test (in sitting and not in an ambient environment). S/he then tells them that their vision is fine and maybe their prescription needs a little adjustment.

And even the audiologist may not appreciate the effects of a concussion - often telling the patient that tests, which may or not demonstrate a hearing loss, are probably due to age!

The words post concussive symptoms are more and more in the news today. The high cost and liability of a star football or hockey player sitting on the bench for a lengthy period of time (because of a concussion? mTBI?), is funding more research.

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Update from the Professions cont'd

So, it is possible that the persistent pain symptoms are also masking the effects of a mTBI?
Is it additionally probable that our patients sustained both a whiplash-type injury AND a mTBI at the time of the accident?

For more important information on the possible effects of a mTBI, please review the website of NORA- The Neuro-optometric Rehabilitation Association at www.nora.cc/

Founded by Dr. William Padula, who I refer to as an 'observant and caring optometrist', the site is an important site to obtain information that may assist in better assessing/ treating /managing our patients.

Once you are on the NORA website, click PATIENTS: and you will be provided with a list of topics.

Of particular interest to pain professionals, is PTVS (Post Trauma Vision Syndrome and VMSS (Visual Mid-line Shift Syndrome).

(i) Podcast of Persistent Pain and mTBI: On December 19, 2010 I was the guest speaker on the radio program 'Brainwaves' sponsored by The Brain Injury Association of London & Region. The topic was Pain and Brain Injury. You can hear this dialogue (with the commercials) by going onto the website of the BIA www.braininjuyrlondon.on.ca. Check out podcasts Radio 980 AM December 19, 2010 (The topic title is not noted- the radio station will start doing this is in 2011!

My patients have found this information helpful- and re-assuring (they also have their family and friends listen as well!)

(ii) Integrating Pain Management Principles into your Physiotherapy Practice: is another initiative of this health provider. On April 2, 2011, a full day workshop will be held in the Hanover/Stratford area. If you are a PT or know of a PT who may be interested in attending, please have them contact me.

Your additional thoughts and ideas on the subject of mTBI and chronic pain are most appreciative.
Please email me at : gloria@downtownclinic.ca

Upcoming Meeting Notices

Canadian Pain Society Annual Conference
April 13-16, 2011
Marriott Gateway on the Falls
Niagara Falls, ON
For more information, visit www.canadianpainsociety.ca or view the attached Registration and Program Guide

Canadian Academy of Pain Management Annual General Meeting
Thursday April 14, 2011 at 7:30 am
Marriott Gateway on the Falls
Niagara Falls, ON

2011 Canadian Pain Society/British Pain Society Joint Conference
June 21-24, 2011
Edinburgh International Conference Centre
Edinburgh, Scotland
For more information, visit www.britishpainsociety.org

Lead Article: Pain Analgesia During Pregnancy and Breast-Feeding

David Rosenbloon, D.Pharm.
Professor of Medicine, McMaster University (Neurology & Associate Member, Psychiatry)

Pain Analgesia During Pregnancy and Breast-Feeding

Analgesia during pregnancy and breastfeeding

- 50% of pregnant women will experience low back pain during pregnancy: less often neck pain
- Address problems of weight and core fitness before conception. During pregnancy, recommend walking and modified exercise, and advise on body mechanics
- Aquatic exercise may be helpful

TNS

- TNS may be used over a limb but not over low back or abdomen (can precipitate labor)

Medication in pregnancy

- Acetaminophen OK in appropriate dose
- NSAID short-term only in the second trimester, but topical diclofenac with DMSO not recommended (first trimester NSAID use associated with spontaneous abortion and structural defects, and third trimester use associated with premature closure of ductus arteriosus and neonatal pulmonary hypertension)

Opioid in pregnancy

- Avoid opioid during pregnancy if possible (opioid at term risks withdrawal syndrome and respiratory depression in neonate)

With caution in pregnancy

- TCAs if essential for migraine or neuralgia control
- Lidocaine for regional anesthesia judiciously and occasionally, but can be toxic to newborn

Avoid

- Insufficient data on: Muscle relaxants (baclofen, cyclobenzaprine, methocarbamol, orphenadrine), anticonvulsants (Gabapentin or pregabalin)
- Diazepam risks congenital malformations, diazepam withdrawal, floppy infant syndrome

Advice during lactation

- In postpartum and lactation, about 1/3 of women have low back pain. Risk factors—weight gain, lifting and carrying infant, ergonomics of child care.
- Continue walking, modified exercise to strengthen abdomen and back, good body mechanics, appropriate diet

TNS

- No contraindication for TNS during lactation

Analgesic during lactation

- Acetaminophen and ibuprofen and most NSAIDs are safe in appropriate doses
- Avoid codeine products if possible or very brief use—can risk high morphine level in breast milk
- Tramadol and metabolites are secreted into breast milk
- Tricyclic antidepressant can cause sedation in newborn
- Diazepam accumulates in milk—risks sedation
- Gabapentin may appear in infants' serum—no adverse effects noted so far

References

- Motherisk [www.motherisk.org/women/drugs.jsp]
- Briggs GG, Freeman RK, Yaffe SJ. Drugs in Pregnancy and Lactation 2008; LactMed [toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT]
- Hale T. Medications and Mothers' Milk, 2008