FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

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TRANSMITTER

THE MEMBERSHIP MAGAZINE FOR THE FACULTY OF PAIN MEDICINE ISSUE 23

Spotlight on: Use of Analogies and Pictures in Patient Consultation

The four pillars of pain management

PAIN PATHWAY FOR PELVIC MESH

COVID VACCINE AND STEROIDS

PALLIATIVE CARE AND PAIN COLLABORATION

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Use of analogies and pictures in consultations

Enhancing the understanding of pain management principles to patients and health care professionals.

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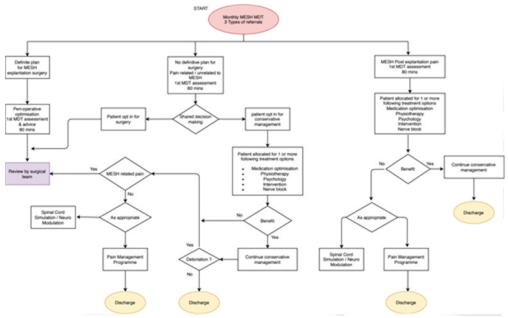

Pain pathway for pelvic mesh

The Manchester Foundation Trust Experience of managing mesh pain complications.

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Dr Manohar Sharma
Clinical Editor

WELCOME

Welcome to Transmitter — Spring 2021 Edition!
With Spring upon us and gradually coming out of the third national lockdown, there is increased hope of a return to some form of a new normal. We probably will have to evolve and live with this virus and get used to these mixed emotions.

We are all keen to restart pain clinic work as waiting lists have grown significantly over the last year and are challenging in terms of prioritisation. We are getting used to remote working where possible and some of this will continue as there are advantages afforded by flexibility for both healthcare professionals and patients. In Liverpool, we generally had a positive experience of assessing palliative medicine cases remotely requiring pain medicine input (P8). There has been added advantage that referring teams could attend the virtual video assessment and thus facilitating the managment plan. So, there is some positive evolution already happening for many of us.

The FFPMRCA written and oral examinations have moved online and have received good feedback. There has been a significant impact on chronic pain training. To help minimise this impact, the FPMLearning hub is now live, with valuable pain training and examination resources: www.fpm.ac.uk/fpmlearning.

Consent and shared decision making, as in the new guidance on decision making and consent published by the GMC in 2020, has implications for our practice as highlighted in this edition. The GMC first wave credential programme is progressing with the Pain Credential now moving forward through the various stages of development. The process is not yet complete and there remain several steps before we will know the final outcome.

Chronic pain: assessment and management guideline from NICE has been just published and FPM has published a response. This guideline, I am sure will have implications for future pain services landscape. The Faculty is very aware and work is being undertaken proactively on this. A key priority has also been to update *Core Standards for Pain Management Services in the UK* (CPMS UK) 2nd edition document on which much of our wider pain work relies. This is progressing well and should be published this year.

There is an important update on steroid use and implication of covid vaccination for steroid pain interventions in this edition. I am sure understanding on this will only improve as we learn more with time. I anticipate new challenges unique to us all individually, for the multidisciplinary pain teams and the specific components of pain services in getting back to full flow and pace as pre-pandemic. I urge you to continue to look after yourself and your families, reach out to support friends, colleagues and vulnerable members of society, and to play your role in helping those around you to move forward to a new normal. There is certainly more hope now than a year ago!

Manohar Sharma

Dr John Hughes
FPM Dean

MESSAGE FROM THE DEAN

I sit watching the seasons turn as if all is well with the world. For us COVID remains — as we come out of the latest wave, we look forward to reaping the benefits of the vaccination programme and hopefully the planned lifting of current restrictions.

The Faculty continues to monitor the situation and provide guidance and updates. The focus is moving towards restoration of services but time will have to be given to ensure staff have been able to recover and rest from the effects of the last year. The latest update is an addendum to the *Improving the Lives of People with Complex Chronic Pain and how to Commission Effective Pain Management Services in England* document. Published last June but produced prior to the COVID pandemic, this addendum highlights some of the key challenges and themes that need to be considered when commissioning pain services and taking into account COVID. This links with the *Core Standards for Pain Management Services in the UK* (CPMS UK) 2nd edition that has undergone open consultation and is now being reviewed prior to publication later in the year.

Credentials and curricula

There are a number of areas that the Faculty has been engaged with that have real potential for progress. The GMC first wave credential programme is progressing with the Pain Credential now moving forward through the various stages of development. This has been a new experience on both sides, allowing for discussions to ensure the finished product will deliver a standards and quality assured output that is equitable to the current advanced pain training, but with access to a broader number of specialties. The process is not yet complete and there remain several steps before we will know the final outcome.

> The Faculty has launched the FPMLearning Hub, a new open resource for all trainees providing a variety of Pain Medicine Teaching Materials.

There is the new 2021 anaesthetic curriculum that will soon be going live. The pain management elements remain throughout all stages of the curriculum. A pain medicine module is now mandatory in all three stages of the curriculum but there are also more advanced modules for those wishing to specialise in in-patient pain and outpatient chronic pain. The philosophy and reasoning behind the 2021 curriculum can be found on the RCoA website (2021 Anaesthetics curriculum).

Re-establishing services

The FPM and BPS attend regular meetings of the NHSE MSK COVID group which has allowed us to highlight issues relating to chronic pain in the musculoskeletal arena at the same time as pointing out that not all pain is musculoskeletal. There are developments within the Elective Care Transformation Programme producing a specification for a MSK clinical triage services. Clearly the focus initially will be on re-establishing services notably around orthopaedics and rheumatology but we continue to press the importance for pain management. It is clear that a significant number of patients with persistent pain can and should be managed in a community or primary care setting but there is also a need for

specialist services providing a broad biopsychosocial range of strategies and interventions for the more complex patients. There is also a requirement for much better links across the boundaries of primary and secondary care.

It has always been difficult to gain traction for pain management amongst all the other calls on the healthcare system. That said the Faculty and its committees continue to call for the realisation that good pain management is of positive benefit to patients and also society as a whole. The Faculty will continue to argue in favour for this, whilst maintaining quality and standards.

There is potential with the recent white paper *Integration and Innovation: working together to improve health and social care for all* alongside the NHS Long Term Plan coupled with changes already been seen as a result of the COVID pandemic that pain medicine may be taken more seriously in some areas. There is no panacea but we will continue to find ways to improve pain management for all.

Opioids and cannabinoids

Looking at the inpatient activity the FPM alongside the RCoA have produced a collaborative document with representation form the RCGP, RCS, RCN, RCP and BPS, endorsed by CPOC and the Royal Pharmaceutical Society Surgery and *Opioids: Best Practice Guidelines 2021*. This is a significant document providing the first national guidance on perioperative opioid prescribing.

As I finish writing this update the International Association for the Study of Pain has just published a position statement on the use of *Cannabinoids to treat Pain* alongside a comprehensive review of the research. It does not endorse the general use of cannabinoids to treat pain but has published a list of research questions that need to be addressed in order to assess the potential efficacy, safety and role of cannabinoids in treating pain.

Exams and education

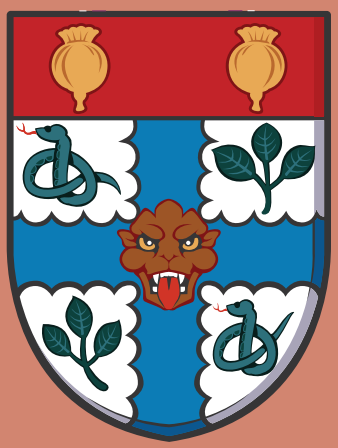
I would also like to congratulate the exams team and court of examiners in bringing virtual exams to fruition whilst maintaining standards. Also, to the examinees who have managed to prepare themselves, cope with the new exam whilst also facing the rigors of the pandemic. A credit to you all.

On a parallel note, the Faculty has launched the FPMLearning Hub that is a new open resource for all trainees providing a variety of Pain Medicine teaching materials including case reports, journal club, recommended reading, webinars, podcasts, and other resources. It will continue to grow.

Welcome new Board members

Finally, it gave me great pleasure to welcome Dr Shiva Tripathi for his first term alongside Dr Ganesan Baranidharan and Dr Barry Miller back for second terms on the Board of the Faculty at the March Board Meeting and look forward to working and continue to work with them. It did mean that we said farewell to Dr Carol McCartney and Dr Andy Nicolaou at the December meeting and thanked them for their significant contributions over recent years.

Faculty Update



New Fellows by Examination and Assessment

Mahmoud Alkholany
Deepika Arora
Sunil Jeevan Dasari
Andrew Grant
Andy Kwok
Mohammad Misurati
Manish Mittal
Lisa Molus
Saurabh Nagpaul
David Radley
Anita Thoppil
Therese Walsh
Paul Watson
Andy Whelan

New Affiliate Members

Joseph Palumbo
Ahmed Shahin
Martina Rekatsina

New Affiliate Fellows

Jayne Halcrow
Anthony Gubbay

New Fellow ad Eundem

Somnath Bagchi

New Assocaite Fellows

Kate Marley

Dr Emma Baird
Inpatient Pain
Medicine Lead

ACUTE/INPATIENT PAIN AND THE PANDEMIC

COVID-19's impact on the NHS has been vast and wide-reaching. Inpatient pain services have long been under-resourced and underfunded. Professor Rockett's 2017 survey of acute pain services in the UK showed that 83% of UK hospitals had an inpatient pain service but only 20% had outside daylight hours cover and most did not meet FPM *Core Standards*[1].

The additional funding pressures to the health service during the pandemic are around £40billion or 2% GDP pre-COVID-19. By 2023/24 this is predicted to be around a further £10 billion or 0.5% GDP[2]. COVID-19 reduced the NHS's ability to offer routine care and as a result waiting times have increased. Addressing this will require significant funding. We have a lot of lost ground to make up.

With the delay in national planning guidance due to COVID-19 it is expected budgets will roll over to 21/22. More detailed planning guidance is not expected until April at the earliest. Funding for service development is not expected to be available until late 2021/early 2022. In order to meet core standards the majority of inpatient pain services in the UK need to get funding to develop their services. Proving our worth in order to justify funding has always been one of inpatients pain's biggest problems.

The Faculty of Pain Medicine, during the first and second waves of the pandemic, carried out two surveys of its members. After the 23rd March, 20% of in patient pain services stopped all together and 50% offered a reduced service. Full inpatient pain service provision was rare. Nursing staff were deployed to other areas, usually CrCU, and Inpatient pain consultants were deployed to anaesthetics and/or CrCU. There were more agency staff working on the wards and wards were configured differently, often cohorting patients by COVID-19 status rather than surgical specialty. Epidural safety was highlighted as particularly challenging.

Changes to the service

COVID-19 changed the way many services practiced. Many offered more telephone advice; some even did this from home. A smaller number of trusts suspended all epidural and nerve catheter services. With reduced staffing numbers the ability to train and educated ward staff was lost. We have all found the pandemic hard, stressful and at times scary. The initial months were marred by PPE shortages and regularly changing guidance.

There has been a major issue getting redeployed staff back into inpatient pain. Either they were retained on Critical Care

or were absent through sickness/ burnout. The problem with the second wave was that trusts tried to keep as much urgent elective surgery going as possible. We have all seen how easy it is to stop a service but how hard it is to get it going again.

I have discussed the 'patient experience' with many of the patients I saw during the COVID-19 surges. The surgical patients with concurrent COVID-19 seem to have the worse experience. Unsurprisingly medical and nursing staff were more reluctant to go into the ward red bays leaving patients isolated and afraid. They had difficulty communicating with nurses and doctors in PPE and difficult conversations were conducted without family present.

Going into red bays on ward rounds I saw this clearly. Patients were struggling to get their prescribed PRN analgesia and basic nursing care with some senior consultants sending in their juniors rather than expose themselves to the risk of COVID-19. I saw patients helping each other out. The most able in the bay helping those that needed it. I even witnessed patients help feed other patients in the COVID bays which was both heart-warming and harrowing.

Redeployment of staff

When I asked locally what people would do differently there were several responses of "retire/leave". Others mentioned improved departmental communication and better support networks.

Many trusts redeployed staff for fixed blocks and shorter time periods of time during the second wave which helped keep services running and reduced the risk of burn out and fatigue.

One major improvement would have been for chronic pain services to continue. We cannot operate a good inpatient service without the back-up of the outpatient team. We found that the longer the pandemic went on, the more chronic pain patients attended hospital with uncontrolled pain.

> "I even witnessed patients help feed other patients in COVID bays which was both heart-warming and harrowing.

We have to acknowledge that the pandemic may have highlighted better, more effective, ways of working. Teams have found innovative ways to incorporate remote working, training and teaching.

The future is all about getting our service back to normal and getting funding to provide the type of care we all want to be able to provide. It would be nice if when the Faculty next survey inpatient pain services, we have all secured the funding we need to meet FPMs core standards.

I think we all need to congratulate ourselves with what we have managed to achieve. We have kept going, whether that has been in our redeployed roles or in inpatient pain, in the face of great adversity. My worry is that the financial impact of COVID-19 will decimate our services long after the pandemic fizzles out.

One of the main goals for 2021 is to improve opioid stewardship nationally. As part of this goal, and on the back of the publication of the Surgery and Opioids: Best Practice Guidelines[3] we plan to carry out a national survey of perioperative opioid usage. The aim will be to get an overview of current practice and form a national strategy going forward. There is overwhelming international evidence of perioperative opioids causing harm, including persistent opioid use[4].

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Dr Kate Marley
Consultant in
Palliative Medicine

COLLABORATIVE WORKING BETWEEN PAIN AND PALLIATIVE MEDICINE TO IMPROVE CANCER PAIN

I rejoined Aintree Palliative Medicine department Liverpool in 2014 as a consultant, having been fortunate enough to do two years of my Palliative Medicine training there. I was to take over as Palliative Medicine Lead and truly I had big shoes to fill.

Our Joint Pain and Palliative Care service in Liverpool was started in the 1990s by Dr Tim Nash and Dr Ged Corcoran and further developed by Dr Heino Hugel from Palliative Medicine and Dr Manohar Sharma from Pain Medicine. I knew that patients came from far and wide to avail themselves of procedures such as cordotomy, intrathecal pumps and spinal neurolytic blocks and suddenly colleagues were phoning me for advice about advanced pain management as a recently qualified consultant and some of these people had trained me – no pressure!

Working across services

Thankfully, I have the benefit of working with excellent colleagues from the Walton Centre Liverpool as Dr Sharma and Dr Gupta assess patients with me, review scans with me and explain to me which procedures are possible and why. I brought lots of patients to clinic early on for their expert opinion and gradually I began to find I started to develop expertise of my own.

I feel strongly that seeing patients together is much better than me just sending my patients to Manish and Manohar for their opinion. I know they would agree. For one thing, my idea of who is 'well' and who is frail is quite different from their judgement of the same. It means that they feel a bit more confident about performing procedures on people who are incredibly unwell, and more patients therefore benefit from their input.

Sometimes people come to clinic look like they might die very soon, and I can intervene when I can see that the focus of care should be on pharmacological management and preparation for the end of life. I can liaise easily with local palliative care services to make this happen which would be harder for the pain doctors to do in their busy clinics.

I am also well placed to liaise with local Oncology teams to discuss the prognosis, timing of anticancer therapy and pain management procedures and negotiating treatment breaks where needed.

A resource for patients

Having a full range of options for management of pain is also an amazing resource for our patients. We can offer intrathecal neurolysis, epidural catheters, cordotomies (both percutaneous and open), vertebroplasty, capsaicin patching, and implanted intrathecal drug delivery. I rarely escalate opioid doses to very high levels because I consider procedures early on and often this allows patients to manage on much lower doses of medication and suffer fewer side effects.

It is nice to get a different perspective on pain management from colleagues in Pain Medicine and in Neurosurgery. I am incredibly lucky to work with such a supportive team who are all interested in helping my patients. Obtaining good pain relief for a cancer patient is very satisfying for the treating team. Cancer pain is challenging in that it is dynamic and there are other factors such as illness stage, performance status of the patient and concurrent treatments they are receiving. Hearing a husband say that he's "got his wife back now her medications have

been reduced" or receiving a postcard from a patient who has managed to go on holiday or seeing a patient doing a little dance in the sunshine in the hospice garden with his newly sited epidural catheter is beyond priceless.

Being able to assess patients away from the hustle and bustle of the hospital in the hospice outpatient department means that we have more time to do an assessment and we also have the facilities for people to lie down on a bed whilst they are being seen or recline in a soft chair if that means they can tolerate the assessment. The hospice is often a better place for post-procedure management for these patients also.

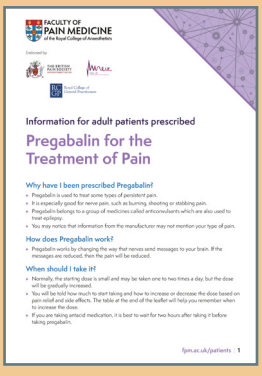
We know that severe chronic pain is overwhelming and exhausting. It becomes all-consuming for our patients and may distract patients from addressing the other issues life-limiting illness. They can focus on little else but the pain and often have high hopes that an injection will take it all away and everything can go back to normal. Careful communication with patients is needed as well as a sense of when not to do something. It can be hard to say to someone who has travelled a long distance that unfortunately there is not a procedure that will help. The COVID-19 pandemic has brought additional challenges in arranging theatre time and postoperative care but has also brought the benefit of the video consultation. This has reduced the need for patients to travel to appointments and has enabled their referring physicians to attend the assessments where we have patients referred from the inpatient setting. This brings with it the added advantage of a medical perspective on what has been tried before and the referrers we have spoken to have felt that it has improved their knowledge and confidence in referring for procedures.

> “Seeing a patient doing a little dance in the sunshine in the hospice garden with his newly sited epidural catheter is beyond priceless.

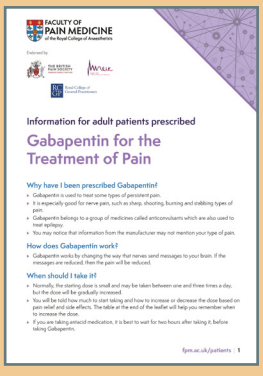
Thus, our cancer pain service has run relatively near normal during pandemic.

We hope that in time patients will have easy access to advanced pain management options in their local area and referrals regionally and nationally will only be necessary for procedures such as cordotomy and intrathecal pumps which are best delivered in specialist centres. We try to offer as much education as possible and this has been well supported by the Pain Relief Foundation and EFIC.

Proving the value of this work is challenging due to the heterogeneity of the patient group and the confounding factors from disease burden when trying to assess such things as quality-of-life following procedures. We have been able to contribute to the Cordotomy Registry and the outcomes have been published in peer reviewed journals including our own prospective series published in 2020. Thankfully both hospital trusts are incredibly supportive of our work and we can work as flexibly as needed to provide the service in a timely way. I am excited to see what the next 25 years brings…



Pregabalin for the treatment of pain



Gabapentin for the treatment of pain

Cannabis and cannabis related substances

Newly updated FPM patient information leaflets available to download now

www.fpm.ac.uk/patients/patient-info

STEROID USE IN THE COVID PANDEMIC

Professor Sam Eldabe
Dept of Pain Medicine
James Cook University Hospital

Dr Kapil Arora
Advanced Pain Trainee
Northern Deanery

Corticosteroids are synthetic derivatives of the endogenous adrenal cortex hormones. Two main classes of corticosteroids; glucocorticoids and mineralocorticoids, are involved in a wide range of physiological processes, including stress response, immune response, and regulation of inflammation, metabolism and electrolyte levels.

Injectable steroid preparations can be broadly classified into two groups: particulate (methylprednisolone, triamcinolone and prednisolone) and non-particulate (betamethasone and dexamethasone).

Glucocorticoids effects result from inhibition of phospholipase, alterations in lymphocytes, inhibition of cytokine expression and stabilization of the cellular membrane[1]. Chronic pain patients may be prescribed oral or injectable steroids for a wide variety of musculoskeletal or neurological conditions[2]. Steroids administration may lead to secondary adrenal insufficiency, alteration of the immune response[3], along with several other adverse effects including myopathy, hyperglycaemia and osteoporosis [4]. In addition, concerns have arisen involving rare but serious neurologic injuries after epidural corticosteroid injection of particulate steroids compared to non-particulate steroids[5].

Sustained systemic absorption

Among available steroids, the depot form of methylprednisolone is most frequently used for chronic pain. Secondary adrenal insufficiency with 80 mg methylprednisolone can last up to 4 weeks; however, for a small proportion it could be up to 2 months[6]. Friedly et al. randomised 400 spinal stenosis patients to receive epidural injections of either local anaesthetic (LA) with one of four corticosteroids preparations or local anaesthetic only. At 3 weeks post-injection, those treated with methylprednisolone or triamcinolone had a significant reduction of morning serum cortisol levels compared to baseline, whereas patients treated with betamethasone or dexamethasone were not significantly different than the LA arm. These findings confirm that after a single particulate corticosteroid injection, there is evidence of sustained systemic absorption of the steroid with

associated cortisol suppression[7]. In a large retrospective study, the injection of corticosteroids into joints was shown to be associated with a higher risk of influenza[8].

Incubation and effectiveness

The incubation period for coronavirus can be up to 14 days with a median time of 5.1 days. Therefore the administration of a steroid injection to an asymptomatic carrier of the virus could potentially put them at an increased risk of an adverse outcome from the virus, although the level of any potential increased risk has not been quantified[9,10]. However the 'RECOVERY' trial has shown that in patients hospitalised with COVID-19, the addition of dexamethasone at admission resulted in a significantly lower 28-day mortality among those who were receiving either invasive mechanical ventilation or oxygen alone at randomisation but not among those receiving no respiratory support[11]. Current evidence is not sufficient to allow quantification of the immunosuppression risk associated with steroid use for pain interventions, should a patient come into contact with COVID-19. The Faculty of Pain Medicines' position statement urges caution on the safety of steroids injected during the current COVID-19 pandemic[12].

> Do not delay vaccination for someone who is taking, has received or is soon to receive steroids in any form.

Furthermore, the effectiveness of steroids in spinal pain is less clear. A recent systematic review and meta-analysis of 15 studies reported a lack of superiority of epidural injections with lidocaine with steroids compared to without steroids in spinal pain[13]. Also, in an RCT comparing transforaminal epidural clonidine versus corticosteroid for acute lumbosacral radiculopathy found corticosteroids resulted in greater functional improvement with unclear differences in analgesia[14]. While the biological rationale behind steroid injections is clear it is uncertain whether the addition of steroids offers any additional clinical benefits over injection of LA alone. There are a number of procedures where the evidence does not support the use of steroids[13,14,15]. Therefore, clinicians should consider alternatives to steroids where appropriate like LA, clonidine, pulsed radiofrequency and radiofrequency.

Benefits must outweigh risks

If steroids are needed, use a lowest possible dose for the shortest possible time. The benefits must outweigh the risks. Starting oral prednisolone at more than 5mg per day for more than a month could move an adult into the clinically extremely vulnerable (CEV) group. Steroid injection should be only be considered if a patient has failed first line measures, has high levels of pain and disability, and continuation of symptoms will have a significant negative effect on their

KEY POINTS

- **Explain to patient risk of steroids not known and difficult to put numbers on**
- **Evaluate and discuss their personal COVID risks (gender, age, comorbidity, ethnicity etc.)**
- **Evaluate benefit/risk from steroid**
- **Discuss alternatives to steroid and their potential outcomes**
- **Consider local virus prevalence**
- **Assist patient with decision making based on their personal condition circumstances**
- **Document the above**

PRINCIPLES OF USING STEROIDS

- **Steroids increase potential for adrenal insufficiency and altered immune response**
- **Intra-articular steroid injections could increase the risk of viral infection**
- **Duration of immune suppression could be less with the use of dexamethasone and betamethasone**
- **Consider evaluating risks and benefits of steroid injections and use a decreased dose**
- **Only give a steroid injection if a patient has significant disease activity and/or intrusive and persisting symptoms, and there are no appropriate alternatives**
- **COVID-19 vaccination and steroid injection: patient may not mount an appropriate immune response and potential of reduction in efficacy of COVID vaccine**

health and wellbeing. Therefore, an individual COVID risk assessment (gender, age, comorbidity, ethnicity etc.) should take place and clinician should discuss the risk and benefits of steroid administration with the patient to allow them to make an informed decision.

COVID-19 vaccination

None of the current UK approved vaccines are considered to be 'live' vaccines. The vaccines are considered safe for use in immunosuppressed patients but the patient may not mount an appropriate immune response with legitimate concerns over the potential for reduction in vaccine efficacy.

Specialists may advise their patients based on their knowledge and understanding of their immune status and likely immune response to vaccination, but should also consider the risk from COVID-19 and the patient's likelihood of exposure.

Do not delay

Do not delay vaccination for someone who is taking, has received or is soon to receive steroids in any form. For a patient who is on an elective waiting list for a steroid injection of up to 80mg methylprednisolone or 80mg triamcinolone, the administration of the COVID-19 vaccine is the priority if the vaccine has been offered to the patient.

In this scenario, the steroid injection should be deferred by two weeks after the vaccine, to enable the patient to mount the best response to the COVID-19 vaccine.

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USING PICTURES AND ANALOGIES TO ENHANCE THE UNDERSTANDING OF PAIN MANAGEMENT PRINCIPLES

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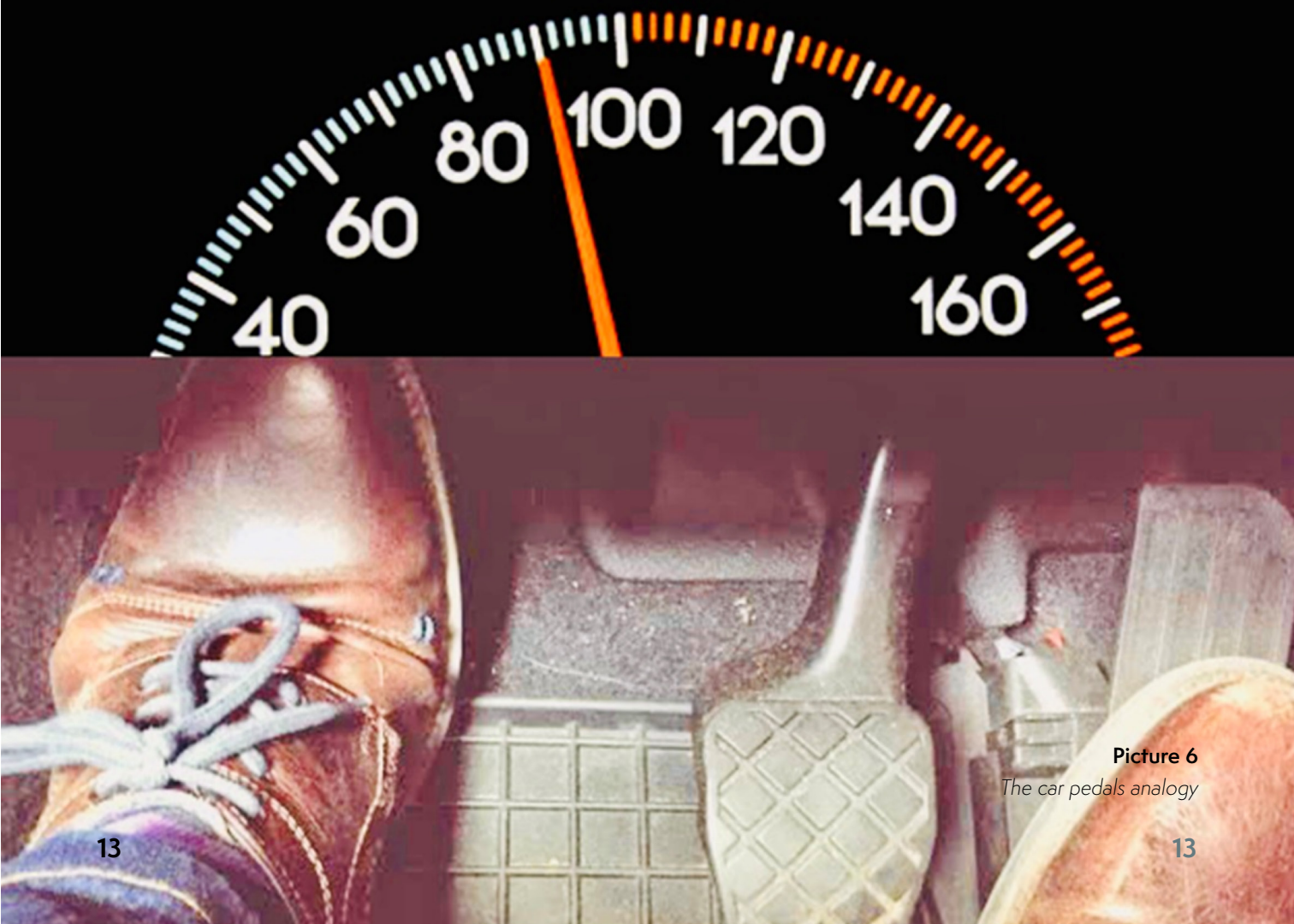
The use of metaphors and analogies in pain management literature is well known for explaining key principles to students, health care professionals and both adult and paediatric pain patients[1]. Metaphors and analogies have been shown to be useful even in palliative care practice in effectively communicating in challenging clinical scenarios[2].



Picture 6
The car pedals analogy

13

In these COVID times, remote patient consultations and online education have become a common practice. In such scenario, explaining some key concepts with use of pictures and analogies helps in effectively communicating with patients and enhancing the learning experiences in education. The use of metaphors and analogies however has also been reviewed to be potentially detrimental at times with risks of oversimplification and even misinformation[3].

The following are some examples of use of pictures and analogies used in patient consultations and pain education sessions.

The Burning Candles Analogy of Acute and Chronic Pain (Picture 1)

This picture helps in understanding the difference between acute and chronic pain. Acute pain serves as a warning signal, has a protective function and is may be uninfluenced by background biopsychosocial functions. In contrast, the biopsychosocial functions are distorted in chronic pain and then the pain no longer serves as a warning signal or as a protective function. Crucially, as we understand with increasing evidences, a badly managed acute pain can lead to development of chronic pain.

The Four Pillars of Pain Management (see front cover)

The Four Pillars (Ps) of pain management are Pills, Procedures, Physiotherapy and Psychology. This concept highlights the need to explore all these key aspects, reinforces self-management strategies through physiotherapy, psychology and discourages overreliance on 'Pills' alone. This analogy serves as a useful starting point of discussion with the patient to engage with pain management programme.

The Olympic Rings of Pain Relief Pills (Picture 3)

I use this analogy to group pain medications as paracetamol, NSAIDs, anti-neuropathics, opioids and others. This model helps in understanding the difference between different types of pain medications, considers optimising NSAIDs in acute and nociceptive pain, improves understanding of additive effects of paracetamol with NSAIDS and Opioids and also the raises awareness of coprescription risks of high doses of opioids and gabapentinoids. It serves as a useful tool to guide discussions around opioid reduction, discouraging over reliance on opioid group of medication.

In an observational patient feedback collection exercise over three years in face-to-face consultations before the pandemic and in subsequent remote consultations during the pandemic, I have found this analogy facilitating patient education during the consultation, engaging and empowering them towards shared decision making.

Picture 1 *Burning candles analogy*

Picture 3 *Olympic rings of pain relief pills*

The Coffee Mug Analogy of Opioid Receptors (Picture 4)

This analogy helps in understanding opioid polypharmacy and guides a discussion about dose limitation of opioids. Codeine, Tramadol, Tapentadol, Oxycodone Morphine, Fentanyl and Buprenorphine are the commonly used opioids in the UK and at times patients may be on three or more of these preparations simultaneously. In such scenario, the coffee mug analogy talks about these opioid molecules competing among each other to occupy the same cup (receptor) to exert their action. Beyond a certain dose, all available cups are full (receptor saturation) and a higher dose is unlikely to give additional pain relief.

The Coins & Bank Notes Analogy of Immediate Release and Long-acting Opioids (Picture 5)

This analogy helps in understanding the difference between immediate release (IR) and sustained release (SR) opioids. The rational use of opioids in chronic non cancer pain has gone through a paradigm shift, moving away from long-acting preparations and patches and using immediate release preparations for management of acute flare ups and activity related pain management as per the CDC guidance from USA in 2016[4].

Consider the opioids as money. The immediate release preparations are like coins and the sustained release preparations are like Bank notes. A £10 Bank note and 10 coins of £1 are worth (work) exactly the same. The newer scientific evidence suggests using coins (IR Opioids) as needed rather than Bank notes (SR Pills and Transdermal Patches) for effective chronic pain management.

The Car Pedals Analogy of Pain Pathways (Picture 6 — see previous page)

This analogy helps in understanding how the Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin and Noradrenaline Reuptake Inhibitors (SNRIs) work in neuropathic pain management.

Consider this in a manual transmission model car. The intensity of pain shooting up to the brain in the ascending pain pathway is like the acceleration pedal; the descending pain modulating pathway is the clutch pedal and the speed on the speedometer dial is the actual perception of pain. If the clutch is on while the acceleration pedal is on, then then actual speed is reduced.

The descending pain modulatory pathway (clutch) has Serotonin and Noradrenaline as neurotransmitters at the synaptic junction.

By increasing their concentration at the synapses through reuptake inhibition (SSRI, SNRI), their activity is reinforced, the clutch is stronger, the pain intensity (actual speed) is reduced.

These are some of the analogies used through pictures and dialogues in guiding patient consultations and facilitating understanding of some key principles of pain management.

These may be adopted and used along with other analogies as relevant to the context of your clinical and academic pain practice.

Picture 4 *Coffee mug analogy*

Picture 5 *Coin and bank note analogy*

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THE MANCHESTER FOUNDATION TRUST EXPERIENCE OF INTEGRATED PAIN PATHWAY FOR PELVIC MESH

Dr Bharati Vyawahare
Consultant in Anaesthesia and Pain Medicine

Transvaginal mesh implants have been in use for 20 years in the treatment of stress urinary incontinence and pelvic organ prolapse in women. There has been worldwide awareness of serious complications following mesh implantation.

This growing awareness led to an independent review by the House of Commons on 21 February 2018, which recommended the identification and accreditation of specialist mesh complication centres. NHS England recently published the list of seven regional centres who will be providing service for this cohort. The Warrell Urogynaecology Unit at MFT have managed mesh complications since 2018 and has been selected to be one of seven regional centres for the delivery of this service. Since 2018 the Pelvic Pain Clinic at MFT have provided an additional pathway for the management of mesh pain complications. I would like to share our experience.

Role of our pelvic pain clinic:

We have adopted an integrated patient pathway (Figure 1). Working closely with surgical team since 2018, we have patients referred into Manchester Foundation Trust pelvic pain clinic either for pain (related or unrelated to mesh) or for optimisation for surgery for explantation of mesh.

Patients are assessed in multidisciplinary pelvic pain clinic with pain physician, specialist pelvic physiotherapist and specialist nurse, 80 minutes for each first appointment. We ensure that patients have an understanding of their treatment, including benefits, potential risks it presents and alternative treatment options including doing nothing. We provide an explanation for the cause of pain if related or unrelated to mesh, interventions that can be offered by the pain team and making them aware that current evidence is limited. The holistic approach helps informed shared decision which is fed back to surgical team via monthly MDT.

Type of cases referred to clinic:

- Definite plan for mesh explantation surgery (exposure, erosion and infection): Patients referred for peri-operative optimization of pain to minimise post operative morbidity
- No definite plan for surgery: Patients with chronic pain related or unrelated to mesh.
- Patients with post-mesh explantation pain.

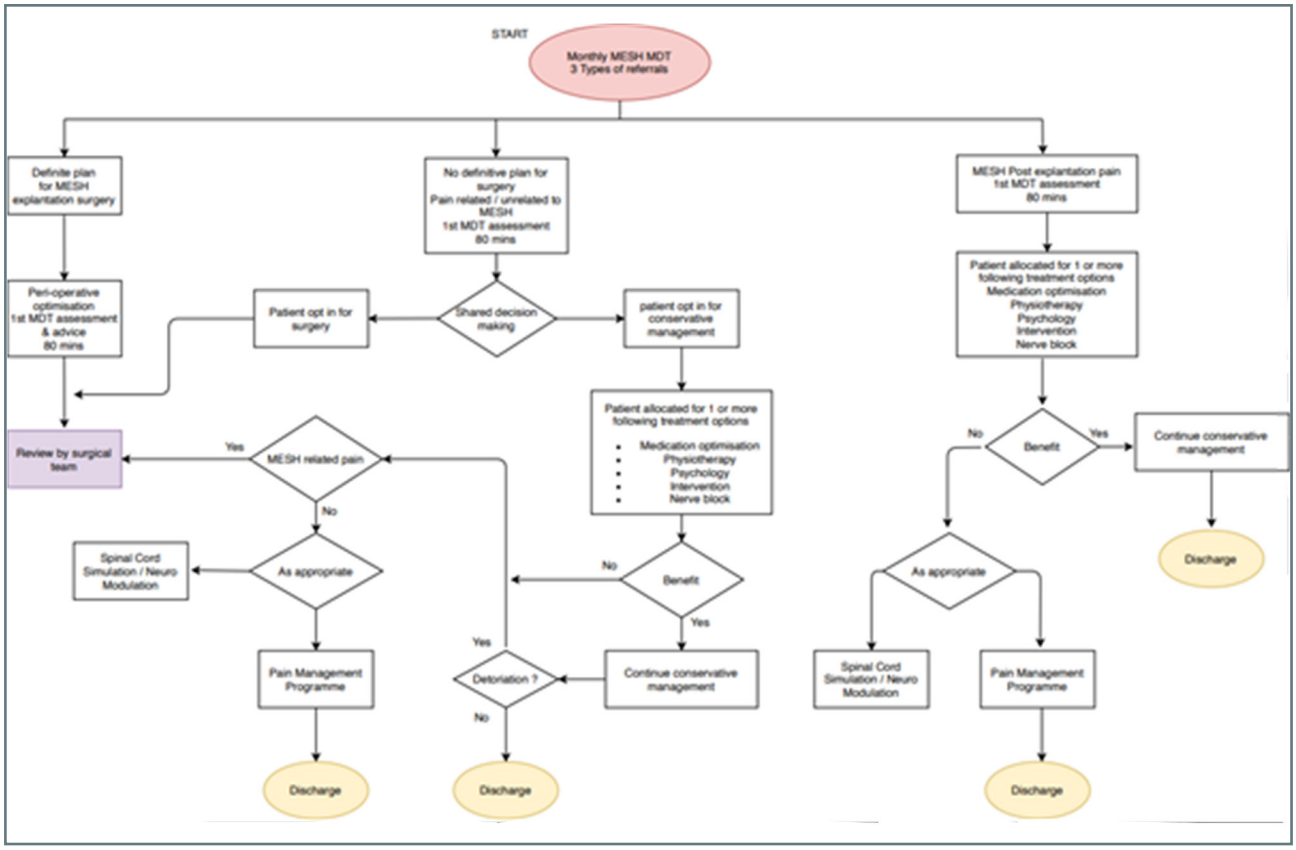
Treatments offered by clinic

For the group of patients moving on to mesh explantation if pain DETECT score is above 19/38, we use pre-operative cover of pregablin for two weeks before and six weeks after surgery. Patients for conservative management are offered combination of specialist pelvic physiotherapy, medication and interventional procedures e.g. pudendal block.

Patients pain pathway

We did retrospective analysis of 51 consecutive patients with mesh pain related complications by a single consultant between 2018-2020. Looking into post consultation outcome for percentage of patients under each arm of pain pathway. The treatment choices for the 51 patients were: 16/51 (31%) opted for explantation surgery. 27/51 (53%) opted for conservative management of which 8 (16%) had decided on a conservative approach prior to the pain consultation; but 19 (37%) changed their

Figure 1 *Pelvic mesh pain pathway*



mind from having surgery and adopted a conservative choice following the pain consultation. 7/51(14%) were with undecided plan as having further pending investigations. 1/51 (2%) with post mesh explantation pain.

Of the 51 patients 40 (78%) were prescribed neuropathic pain medication. 18 (35%) had pelvic pain physiotherapy, 18 (35%) had interventional procedure (e.g. pudendal nerve block) and 8 (16%) had both physiotherapy and a interventional procedure.

Conclusion

These are early days for a mesh explantation surgeries. The pelvic pain consultation reduced the number of patients proceeding to surgery to just 31%. It also increased from 16% to 53% adopting a conservative approach rather than proceeding to mesh explantation whose immediate and long-term outcomes are still to be established. The role of pelvic pain management and specialised physiotherapy is critical in patients with mesh complications irrespective of their triage for surgery. With our structured pain pathway we will learn more about this complex issue.

Acknowledgments

Dr Winston F de Mello (retired Consultant Pain Medicine Wythenshawe Hospital) and Mrs Fiona Hart (Specialist Physiotherapist, Wythenshawe Hospital) for their contribution to the service. My sincere thanks to our surgeons (Warrell Unit) Dr Fiona Reid, Dr Karen Ward for early involvement of pain input and our pain directorate for supporting this.

Dr Paul Wilkinson (Consultant Pain Medicine, Royal Victoria Infirmary, for editorial comments).

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2. 2021 exceptional surveillance of urinary incontinence and pelvic organ prolapse in women: management (NICE guideline NG123) Surveillance report Published: 3 February 2021 www.nice.org.uk

3. Improving the Lives of People with Complex Chronic Pain: How to Commission Effective Pain Management Services in England (FPM) June 2020

Dr Paul Wilkinson
PSC Chair

PROFESSIONAL STANDARDS

With COVID-19 issues now stretching well into 2021, there is understandably continued focus on COVID matters. The COVID-19 domain of the FPM website has a series of resources which continue to be relevant as we move again towards a phase of reopening — hopefully permanently.

The domain also contains resources to enable best practice and up to date advice about steroids and treatment issues[1].

COVID-19 survey and NICE

Results of our second survey have been published2 and contain an extensive thematic analysis creating a published shared experience of the impact of COVID-19 on FPM members' work; what went well and what less so. There has been a lot to learn and very rapidly.

Perhaps going under the radar is the publication of *Improving the Lives of People with Complex Chronic Pain: How to Commission Effective Pain Management*[3]. This is designed to facilitate best commissioning practice and create an opportunity for a positive change. This predated COVID-19, so a supplementary publication has been developed to bring aspects of this document into the context of COVID-19[4].

The Faculty have significant concerns regarding the potential implications of the NICE Chronic Pain guidelines and have released a statement[5]. Work is being undertaken proactively to help to manage this.

Opioids and Core Standards

There have been understandable delays in the joint FPM/RCoA publication of *Surgery and Opioids: Best Practice Guidelines* but this is now published[6]. A publication on specific opioids optimisation advice for members is also near completion. A key priority also has been to complete the update of our *Core Standards for Pain Management Services in the UK* (CPMS UK) 2nd edition document on which much of our wider work relies. This recently went out for open consultation and we thank those of you who have provided comments.

As we move into the year ahead, deferred projects including those related to improving the structure and practice of palliative care and pain and strategies to improve implementation of approved standards will be reactivated enthusiastically.

There is a lot of other essential work that continues in the background of the Professional Standards Committee and I want to specifically mention the running of our successful event programme and the renewal of our publication portfolio which are very important.

As a closing remark of this brief summary, I would like to emphasise that the work of the PSC is very much a team effort. I would like to thank all members of the committee for their untiring hard work in enabling the committee to raise medical standards in pain management.

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5. https://fpm.ac.uk/fpm-concerns-regarding-new-nice-chronic-pain-guidelines
6. https://fpm.ac.uk/sites/fpm/files/documents/2021-03/surgery-and-opioids-2021_4.pdf

RECENT FPM CLINICAL GUIDELINES

Surgery and Opioids: Best Practice Guidelines 2021

www.fpm.ac.uk/surgery-and-opioids-best-practice-guidelines-2021

The FPM and RCoA are delighted to announce the publication of *Surgery and Opioids: Best Practice Guidelines 2021.*

This is a collaborative guidance document with representatives from the Royal College of General Practioners, Royal College of Surgeons of England, Royal College of Nursing, British Pain Society and Royal College of Psychiatry. The guidance is also endorsed by The Centre for Perioperative Care and the Royal Pharmaceutical Society.

This document represents the work of a multi-professional and multidisciplinary collaboration and sets out the guiding principles in opioid management in the perioperative period. This guidance is intended for use by clinicians, nurses and allied healthcare providers, patients, pharmacists and policy makers.

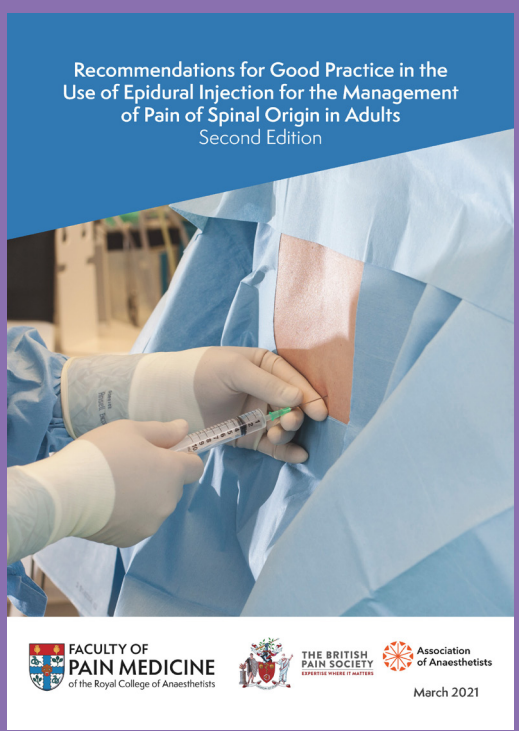
Recommendations for Good Practice in the Use of Epidural Injection for the Management of Pain of Spinal Origin in Adults. Second Edition.

www.fpm.ac.uk/sites/fpm/files/documents/2021-03/Recommendations-for-epidural%20injections-2021_1.pdf

The FPM/BPS guidance document *Recommendations for good practice in the use of epidurals for management of pain of spinal origin in adults* has been updated.

This document describes standards of good practice for clinicians carrying out epidural injection in adults for the management of persistent pain of spinal origin and includes the use of epidural injection for the management of acute episodes of radicular pain.

The recommendations relate to 'single-shot' epidural injection at any level of the neuraxis (cervical, thoracic, lumbar or caudal routes). The document also describes the desirable facilities in which to safely carry out the injection.



CONSENT AND SHARED DECISION MAKING

Dr Robert Searle
PSC Vice-Chair

Dr Suzanne Carty
Consultant in Anaesthesia and Pain Medicine

Dr Paul Wilkinson
PSC Chair

The principle of shared decision making and consent to treatment is fundamental to good medical practice. All doctors are required to practice in line with GMC guidance and legislation passed by the government.

Although legislation does not change frequently, the way in which it is interpreted and clarified by the law courts (case law) sets important precedents which other courts are bound to follow or apply in subsequent cases. Some important court judgements in recent years have influenced new guidance on decision making and consent published by the GMC in 2020[1].

Fellows should be aware of the new guidance and the implications of this for their own practice. The GMC highlight seven important principles. These principles outline a shift away from paternalistic approaches where doctors decide what treatment is best for the patient, and what risks the patient might think are material, toward a patient-centred approach. The new guidelines require meaningful dialogue with patients, sharing information on the benefits and harms of proposed treatments, and the alternatives (including no treatment). This requires understanding of all pain treatment modalities, even if those may not be available locally, and may require referral to other services. Doctors should explain rare complications of treatment, however unlikely, if they are of material relevance to that patient. We can only do this by making time to understand what is important to an individual, listening to them, and in return giving them the time and support they need to make a decision, even though the workload pressures facing many pain teams may make this challenging.

> “Fellows should be aware of the new guidance and the implications for their own practice.

In order to help fellows in their practice, the Faculty plans to release work in the future helping to frame consent and decision making guidance within the context of the practice of Pain Medicine. In the meantime fellows are encouraged to read the full GMC guidance.

Reference

1. https://www.gmc-uk.org/ethical-guidance/

Dr Barry Miller
MAG Chair

OPIOIDS: TIME TO ADDRESS THE DETAIL

"Even without a map, the journey may deliver riches" — Z Dovid.

When I last wrote, we were on the verge of a second wave of COVID, and now we seem to be at the end of a third national lockdown. It seems many changes, such as remote consultations, and waiting times will be with us for a while.

There is strong evidence of late cancer diagnoses, and increased mortality rates from heart attacks and strokes; and these, indirect effects of COVID-19, are reflected in our patients morbidities; options have been reduced, and earlier and greater use of medications is, and will be, an increasing issue. Against this, there are accumulating pressures to reduce medications in long term pain conditions, and the evidence for their positive value is limited.

The management of acute pains, as they morph (pun intended) into chronic, with or without flares remains a challenge in opioid use. Good guidance is lacking; the research base is small, and often a pragmatic approach must be considered; changes, or lack of them, feed a developing tolerance and withdrawal situation.

Optimisation

And this brings us to 'optimisation'. To digress a moment: there is increasing material around 'de-prescribing' and it is an important facet of any medicines management process. But it is not the whole of it. There are patients who benefit from well managed long-term opioid use, and they must not be sacrificed to concerns over overuse.

It is a fundamental feature of opioid/pain dynamics that there is not one; there are many. The Biopsychosocial model, so well applied to musculoskeletal pain, is equally valid for drugs as well as symptoms — beyond a unidimensional pain score, what is the effect of starting/changing an opioid? What are the consequences of an antagonistic reduction process? The recently published *Surgery and Opioids: Best Practice Guidelines 2021* and the *Opioid Guidance for Fellows* are part of an evolving project within the FPM to begin to tackle these 'elephant in the room' issues.

Question time

I want to pose some questions. Not an exhaustive or comprehensive list. Some will be dealing with some, few with all.

- Should opioids be changed before elective procedures? Why are they being taken?
- Should patients be discharged on analgesic regimes different from the ones they were prescribed on the wards?
- If your hospital doesn't provide paracetamol and ibuprofen for the home management of pain after a procedure, how does the patient get enough or prioritise this against the opioids? Have you tried buying two weeks supply of paracetamol and ibuprofen +/- a covering proton pump inhibitor? (Even if you're mobile enough to get to a shop).
- How should opioids be tapered for a given operation? Who is doing the review? What is the issue? Overuse? Normal variant? A surgical query? Recognised poor outcome?
- How should flare ups be managed? What is the place of opioids? What conditions? Who is guiding/helping?
- For a non-surgical pain what is the 'best' acute opioid of choice? If any?
- What guidance is given to the patient? To the GP? What end-points are being assessed? When? By whom?
- How is a reduction managed? By whom? What time period? What are the psychosocial issues? And are they understood?

The answers? Time to get your thinking caps on.

Dr Lorraine de Gray
FPMTAC Chair

TRAINING & ASSESSMENT

The Training & Assessment Committee remains committed to ensuring that our responsibility to train anaesthetic trainees at core, intermediate, higher and advanced pain training continues. The ongoing COVID-19 pandemic continues to have a major impact on our personal and professional lives.

Although delivery of pain services continues, feedback from trainees as well as Pain Regional Advisors (RAPMs) and Faculty Tutors in Pain (FTPs) has made it clear that the second surge of the pandemic has had a considerable impact on training at all levels. A survey of our higher and advanced trainees, conducted by the FPM in the first two weeks of January 2021, found that 65% of services were still running, mainly providing remote consultations with very few pain intervention procedures being provided. 30% of trainees had been redeployed once again.

Trainee meetings

A meeting held remotely with around 16 pain trainees and the Training and Assessment Committee at the end of January confirmed our view that it was not possible to simply issue broad guidelines to support all trainees as the regional variations in delivery of services and training are too disparate. With this in mind, TAC has offered each trainee in pain medicine at the higher or advanced pain level the opportunity to have a remote meeting with Dr Victor Mendis (Deputy Chair of TAC), Dr Hoo Kee Tsang (Chair of the RAPM) and I, as Chair of TAC and Vice Dean. To date we have met with nearly three quarters of these trainees and we have been impressed both by the dedication and commitment of the Trainees and Trainers alike in the face of quite challenging circumstances. This has provided us the opportunity to propose bespoke suggestions and amendments to training programmes to allow trainees to complete their higher and advanced pain training as completely as possible. We have also issued guidance for Intermediate pain trainees to be able to complete some of their mandatory sessions by reading and discussing specific modules in e-PAIN with their Faculty Tutors.

> “Watch out for updated Guidelines for RAPM and Faculty Tutors (Pain) with regards to the implementation of the curriculum.

Credentialing

The process for a Credential in Pain Medicine continues with a further submission of a revised draft curriculum submitted to the GMC in February 2021. The curriculum was discussed by the GMC in March with a potential view to a further submission to the GMC Curriculum Advisory Group in June 2021. The FPM continues to strive to be one of the first credentials to be approved by the GMC.

The 2021 Curriculum in Anaesthesia has now been approved by the GMC with a launch date in August 2021. The sections on Pain Medicine will be different to the old curriculum with mandatory pain modules across all three Stages of training. Watch out for an updated Guidelines for RAPM and Faculty Tutors (Pain) with regards to the implementation of the curriculum.

This is my last Transmitter update as Chair of TAC. I shall be handing over the reins to my Deputy Chair Dr Victor Mendis as of April 2021. I would like to wish him every success in this role and thank all the committee members for all their support and hard work during my time as Chair.

Dr David Gore
Faculty Trainee Representative

SPRING BACK TO TRAINING

As spring approaches and freedom from lockdown looms my only words are "What a winter!" I could even say we are getting used to this — or maybe that should be exhausted by this. What became clear to me, over the past months, is that we are definitely getting better at this.

Despite a large and tragic second pandemic wave many of us (70% according to January's survey) managed to continue pain training and even study for and sit examinations. We have all worked, and continue to work, very hard. As I wrote in the autumn *Transmitter*, the Faculty would like to pass on their sincere thanks for the hard work and dedication shown by the trainee body.

Meeting the Faculty

In January, the trainees seized the chance to remotely meet the Faculty. Both the Faculty and trainees found this a useful and insightful meeting. Our approachable and receptive Faculty have been working diligently for us behind the scenes:

- The Exams team moved our examinations online — feedback shows this is working well.
- FPMLearning is now live - hopefully this will prove to be an interesting and valuable exam resource.
- The FPM team are presently meeting with advanced trainees 1:1 to review and help get training 'back on track'.
- The updated pain curriculum will be released within the new RCOA curriculum this August.

Re-returning to training

The return to training will likely be a different experience for each of us. Practice in pain clinics will also be different. Many clinics are busy planning additional sessions to tackle increased waiting lists and this extra work represents both a challenge and a great learning opportunity. Moreover, some clinics plan to continue video/telephone consultations indefinitely and this may become another normal consultation modality.

Considering support during training I would like to highlight two very relevant items in the Autumn 2020 edition of *Transmitter*. First the excellent exam preparation article written by Drs Eid and Laycock (p.15) and second the list of Faculty statements pertaining to training and on-call commitments (p.18-19). Back issues of every edition of *Transmitter* are all available on the Faculty website.

Taking ownership of training

The well-trodden pain training pathways that existed prior to COVID-19 have been somewhat disturbed to say the least. I have spoken with a number of trainees over the past year and many of us now have unique training gaps and requirements. Therefore we now, more than ever, have to take ownership of our training.

Simply put, we need to use our curriculum, meetings with the Faculty, supervisors and trainee colleagues to identify experiential/clinical gaps then make a plan to address them.

Looking forward

I personally can not wait to see the pandemic over and for face-to-face meetings and teaching to restart. That said, we are going to have to keep our creative hats, or maybe masks, on for the foreseeable future as we navigate the reopening of clinics and get our training back on track.

Finally, and arguably more importantly, we need to make sure we take time to rest and hopefully get our social lives back on track!

Dr HooKee Tsang
RAPM Chair

RAPM UPDATE

In my first update as RAPM Chair, I would like to thank my predecessor Dr Peter Cole for the support and guidance he has provided to the RAPMs. I am thankful that he continues as the RAPM for Oxford for another term.

As we settle into 2021, while the customary optimism that accompanies a new year may have dimmed with the ongoing pandemic, as spring approaches we also see the new shoots of recovery. The pandemic has had a huge impact on Pain Medicine services and training, with a significant proportion of advanced pain trainees redeployed. The last 12 months have demonstrated the resilience and resourcefulness of both trainers and trainees in developing new ways of learning. The RCoA and Faculty have issued statements supporting training during the pandemic. The Faculty has also provided guidance on complementary training modalities to support core and intermediate pain training with acceptance of up to 5 e-PAIN modules or classroom based teaching. This has been well received by trainees.

New challenges

New ways of working have brought challenges to the delivery of training within remote consultations. The GMC provides guidance for conducting remote consultations and prescribing. Trainees have learnt with us as we develop our skills within this modality. There are additional resources and webinars provided by defence unions that are useful for trainers and trainees. Changes in practice have reduced trainee exposure to face-to-face consultations, clinical examinations, and interventions. To support training the Faculty has provided the option for trainees to arrange meetings with myself, Dr Lorraine De Gray (Vice Dean, Chair of TAC) and Dr Victor Mendes (Chair Elect of TAC). These meetings have highlighted variation in impact of the pandemic on training across the country. One trainee we spoke to mitigates the absence of an examination during a remote consultation by discussing the examination and potential findings with his trainer at the end of the consultation, and practising examining on a willing family member.

The shift to online FFPMRCA tutorials has been well received, with 35 delegates in the autumn and 23 delegates this spring. Trainees have reported a preference for this format which is reflected in increased registration compared with in-person tutorials, which attracted up to ten delegates. There continues to be regional virtual teaching and the Faculty has recently launched FPMLearning, an open resource for trainees on our website. Trainees have adapted well to the online format of the FFPMRCA examination. As trainers, we will continue to adapt as services recover, and remain flexible in delivering training opportunities. In order to o address the reduction in interventional procedures, in some regions advanced pain trainees and their trainers have identified pain interventional lists delivered across the region for trainees to attend. Due to the exceptional circumstances in which we currently find ourselves, the interventional lists do not need to occur in an approved hospital for Advanced training.

2021 anaesthetic curriculum

The 2021 curriculum is due to be launched in August. Changes will include the introduction of three 'Stages' in the anaesthetic curriculum. Pain training will be a component in each Stage for all trainees with optional specialist interest areas for inpatient pain and Pain Medicine at Stage 3. This will shift the focus towards formative assessments. The RCoA has created a network of regional leads to assist the implementation of the curriculum. I would encourage RAPMs and Faculty Tutors to contact their regional curriculum lead for their

School of Anaesthesia. The RCoA has also included video resources to support the curriculum (1).

Annual Reports and Appraisals

The Faculty will be asking RAPMs to return annual reports. These are important in mapping the impact of the pandemic on training in each region. We will also be sending out RAPM appraisal forms. The last round of appraisal forms was in 2019, with a gap during the pandemic year. The appraisals are intended for use as a tool to provide evidence of work carried out by the RAPM in order to support their own appraisals, revalidation, and job planning.

Faculty Tutors Study Day

This is provisionally 18 November 2021, watch this space for more.

Everyone is working immensely hard, and your efforts are much appreciated. Stay safe, and hope to see you soon.

Reference

1. www.rcoa.ac.uk/training-careers/training-anaesthesia/2021-anaesthetics-curriculum/2021-curriculum-resources/2021

Dr Sadiq Bhayani
e-PAIN Clinical Lead

E-PAIN UPDATE

It is a pleasure to announce the appointment of Dr Nancy Cox as deputy clinical lead for e-PAIN. Nancy has previously written content for e-PAIN and has been the resource's librarian.

Thank yous

It is time to say a big thank you and farewell to previous e-PAIN leads Dr Douglas Natusch & Dr Rhian Lewis, who have worked very hard with the various e-PAIN module leads and played an important role in taking e-PAIN to the next level. I wish them all the very best.

The COVID-19 pandemic has had significant impact on professional and personal lives. But these challenges also lead to innovations like e-meetings, virtual courses and webinars. To meet the challenges, trainees have been using e-learning platforms like e-PAIN to improve their knowledge base.

Doubling utilisation

Activity reports for e-PAIN for 2019-2021, show that utilsation of e-PAIN has doubled. The huge growth in utilisation since the first COVID-19 wave included a high number of paramedics and students. Currently there are 56,546 active users of e-PAIN and there have been 87,663 launches of the modules.

e-Learning provides an efficient and inexpensive way of publishing to reaching to a large audience. It is a useful resource for both teachers and students alike to complement local teaching and programs such as EPM. Content of e-PAIN is guided by the IASP's Curriculum for Professional Education in Pain and represents multidisciplinary authorship, content and audience.

New pathways

We are working on making e-PAIN more relevant to, and appealing for, nurses, pharmacists, physiotherapist, psychologist and various members of multidisciplinary team. Different learning pathways would increase e-PAIN's use by specific groups in an effective manner.

Our work on various modules was halted by the pandemic with redeployment of staff but we are back on track with updating various modules.

Dr Jonathan Rajan
EPM Deputy
Clinical Lead

ESSENTIAL PAIN MANAGEMENT (EPM)

As with virtually all aspects of our lives, Essential Pain Management has been affected by the pandemic. Nonetheless all colleagues across the country have risen to this challenge.

EPM delivery to undergraduates has been affected by unprecedented demands on the time of all Faculty members involved in running courses, many of whom are pain consultants redeployed in COVID critical care services. This, coupled with the restrictions on face-to-face teaching, has posed added challenges to the delivery of the entire programme.

Online EPM

Across the country EPM has moved to a new online format, ensuring that access to the valuable resources and learning opportunities is still available to students. Exciting developments in terms of embedding EPM within spiral learning formats have also been successful, with EPM now being delivered at various stages of the undergraduate medical school curriculum. While all regions have adapted in increasingly innovative ways, I will set out a few examples.

At Birmingham University, Dr Bill Rea has delivered the whole of EPM over Zoom, facilitated by his University's Information Technology team. The interactive elements, including the Multiple Choice Questions, were compatible with this medium as students were able to vote in real time to answer these questions. Although students made every effort to attend the live presentation (the session was timetabled) the presentation was also recorded so that others could access and watch it back on demand.

Bill has also supported the development of curriculum elements for the new medical school at Aston University. Together with colleagues from the pain service at The Royal Orthopaedic Hospital, he has pre-recorded a voiceover for the EPM slide show, serving as introductory material for pain management, prior to the students moving into face-to-face placements next year.

Deeper dives

In the North West, I have been hugely supported by my team of Base Leads at the major teaching hospital sites, as well as Pharmacy colleagues at the University of Manchester. A pre-recorded session of the standardised EPM teaching along with worked examples has been made available to all students. Following study of this preparatory content, we now schedule a live drop-in Zoom session so that students can clarify subject matter and take a 'deeper dive' into areas such as safety with prescribing as well as further challenging pain cases. Manchester University has now

developed pain teaching within its spiral network for medical students in years 3 to 5. Furthermore, after agreement with Professor Paul Baker, Deputy Postgraduate Dean and Foundation School Director for the Northwest Deanery, we are planning to roll out a pilot scheme to deliver pain teaching solely in the form of EPM to all Foundation Doctors.

In a similar vane, Dr Venkat Hariharan has delivered EPM online in Milton Keynes using pre-recorded lectures followed by live virtual question-and-answer sessions, as well as teaching based on clinical vignettes.

In London, Dr Alan Fayaz and his team have successfully transported their EPM programme (previously a four hour face-to-face session for fourth year students, running three times a year), to an online portal. The new module can now be completed at leisure, but also supplemented by fixed date Q&A sessions, offering students the opportunities to discuss any burning questions or uncertainties.

> We are planning to roll out a pilot scheme to deliver pain teaching in the form of EPM to all Foundation Doctors.

To keep engagement high they have balanced reading material, with voice recording, interactive quizzes and even a home-made cartoon describing how pain can 'feel' different according to context! The reception has been very warm, and the feedback consistently complements the range of educational material and occasional attempts at humour. As Dr Fayaz is keen to point out, "having an online resource allows for flexibility in teaching, as well as scope for immediate expansion; talks are in place to incorporate the platform to Foundation Year training programmes, nurse teaching and even for specialty doctors."

Evolving need

Therefore, it is fair to say that, despite the challenges that COVID has thrown at the beneficiaries, organisers and Faculty of EPM, it is still very much thriving and fit for purpose. Dare I say it, it is evolving to meet the needs of changing environments in these challenging times.

Get in touch

As always, please do get in touch with the team (contact@fpm.ac.uk) if you have any further suggestions, comments or queries.

The Faculty is delighted to announce the launch of FPMLearning, the FPM's open resource for all pain trainees providing a variety of teaching materials including case reports, journal club, recommended reading and podcasts.

www.fpm.ac.uk/fpmlearning

FFPMRCA EXAMINATION UPDATE

Dr Nick Plunkett
Chair FFPMRCA

Dr Ganesan Baranidharan
Vice-Chair FFPMRCA

Starting in 2020, the 'new normal' has been remote working secondary to the pandemic. This update will reflect the challenges and outline how we have managed to continue with exam delivery. The last report was released just before the SOE examination occurred — the first remote SOE in the College's rapidly evolving experience.

The SOE examination was delivered via Zoom on 13 October 2020. There was significant preparation from all colleagues (examiners and the examination department) with training in Zoom technology, and attainment of additional skills in assessing remotely, conducting practice examinations as both examiners and as candidates. This resulted in important feedback on the potential candidate experience, helping us optimise the examination delivery. A series of measures were adopted to mitigate the potential effects of technical failures and glitches. We made provision of a third examiner shadowing each examination rooms, prepared to actively examine at a moment's notice. The process and additional safeguards worked perfectly on the day, with exams department, examiner, and candidate feedback highly positive.

Pass rates

Of 18 candidates attending, 14 were determined to achieve the necessary standard with a pass mark of 31/40, and a pass rate of 78%. The pass rates for both elements of the Autumn sitting (MCQ and SOE) exam were in the upper range of pass rates. This was reassuring for the Examination board given the challenges faced and the remote delivery of the Exam.

The most recent MCQ occurred remotely on 6th January 2021, delivered by TestReach as before. There were 15 candidates- following a remote Anghoff meeting on 20/1/21, the papers were reviewed using the methodology previously described, and a pass mark of 70% was determined, achieved by 13 candidates, giving a pass rate of 87%.

The FPM are well aware of the challenging times that potential candidates may have faced as a result of upheaval in training as well as responding to the pandemic in their varied professional and personal roles. By way of reassuring and encouraging

candidates, the pass marks of all exams delivered remotely thus far are similar to the in person/at College delivery, and pass rates also remained stable.

Taking a slightly longer view of SOE pass rates over a 6-year period prior to COVID, in the first 3-years the average pass rate was approximately 60%, while over the latter 3-years the average pass rate was approximately 75% indicating improved quality of candidate preparation, and demonstrating the exam's standing with trainees.

Candidates can be reassured

The remote exam processes are now 'tried and tested', so candidates will benefit from the FPM's experience, as well bespoke materials to assist the candidate on the remote process. Overall, the impression of all involved appears to be that, once one gets over the fact that the interaction is through a screen, the process is as natural and authentic as it would be face to face.

To further reassure those candidates considering sitting for the next remote SOE on 13 April, we thought it would be useful to feedback the candidates' comments from the remote SOE in October 2020, noting these were provided before the candidates had received their results. The questionnaire was devised to assess remote delivery processes (rather than exam content). There were 13 (out of 18) respondents — percentages are approximate.

Q1 Was this your first time taking the FFPM SOE exam?
Yes 85 %, No 15 %

Q2 How satisfied were you with the online booking confirmation process for the exam?
Either satisfied or extremely satisfied- 85%

Q3 Was the information you received from the examinations department prior to this exam appropriate?
Yes 100%

Q4 Was the candidate brief you received on the day of the exam appropriate?
Yes 100%

Q5 Was the I.D and Environment check appropriate?
Yes 100%

Q6 If you needed assistance during the exam, were the college staff responsive?
Yes 54%, not applicable 46%

Q7 Could you hear and see your examiner throughout your exam?
Yes 100%

Q8 Did you experience any noticeable connection issues?
No 85%, Yes 15% (both candidates affected indicated the problem was minor with no impact on performance).

Sample candidate comments

"It was perfect. Thanks to the exams team and examiners."

"Very well organised."

"The organisation of exam was very well done. No connection issues."

"Wasn't stressful. Clear instructions. I'd be happy to sit this remotely again (fingers crossed I don't have to)."

"The online process made the whole experience better in my opinion, it definitely took away the stress of catching the train to London."

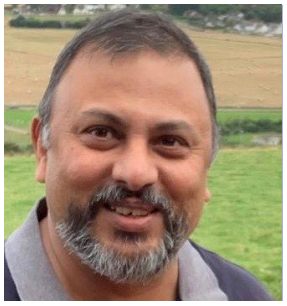
"Very well organised, no issues at all. The college has always set its standard and I am glad they did the same this time in spite of the pandemic."

It is gratifying that the FPM was the first within the RCoA and FICM family to deliver both MCQ and SOE assessments remotely and successfully — all a testament to the additional hard work in preparation for these events from all concerned.

	FFPMRCA MCQ	**FFPMRCA SOE**
Application and fees not accepted before	Tuesday 1 June 2021	Monday 1 February 2021
Closing date for FFPMRCA exam applications	Thursday 8 July 2021	Tuesday 2 March 2021
Examination date	Wednesday 25 August 2021 **Online**	Tuesday 13 April 2021 **Online**
Examination fee	£560	£780

EVENTS UPDATE

Dr Manohar Sharma
Educational Meetings
Advisor



Dr Devjit Srivastava
Deputy Educational
Meetings Advisor

Towards the back end of 2020, chronic pain services started scaling up their operational output. The Faculty set up a webinar at this time specifically to deal with the issues surrounding COVID-19 and pain management.

Discussed first was the risk of steroid injections in view of the importance of immunity in battling COVID-19. Prof Sam Eldabe, who was a member of the ASRA/ESRA guidance on steroids, suggested that evaluation of individual risk factors (age, gender, comorbidity, ethnicity) along with patient preference should guide decision on steroid injections. The local prevalence of infection was also an important factor.

Ms Gail Snowden, Chair of the PMP SIG (Pain Management Programme Special Interest Group) at the British Pain Society, highlighted that we should assign patients to health/remote PMP programmes based on clinical judgement, patient preferences, circumstances and ability to engage.

The role of pain interventions during COVID-19 was discussed by Dr G Baranidharan, who highlighted that the resumption/continuation of pain injections would depend on availability of redeployed workforce, hospital infrastructure, the volume of COVID-19 patients and NHS priorities, which are certain to be redefined going forward. Dr Emma Baird discussed the impact of the pandemic on In-hospital pain services. The scaling down of chronic pain services resulted in an increase in hospitalised patients with chronic pain issues.

For 2021, we have lined up an interesting study webinar on Acute/In-hospital pain. Thefirst session on 8 June will discuss the various issues highlighted in the recently released *Surgery and Opioids* guidance. Topics will include the need for a transitional care model, the importance of prehabilitation for chronic pain patients scheduled for surgery, opioid de-escalation, the preference of immediate release opioids post operatively, diagnosis and management of chronic post surgical pain and the role of post operative stewardship by surgeons.

The second session on 29 June will discuss the rib fracture pathway ,erector spinae and serrated anterior blocks, wound catheters, intrathecal opioids, and more. There will be a round up of recent FPM guidance and the top 5 acute pain research papers. Dr James Cox from UCL will talk about the role of genetics in pain management. We are planning an update on chronic pain issues around November and shall keep you posted.

FACULTY OF
PAIN MEDICINE
of the Royal College of Anaesthetists

Study Webinar: ACUTE/IN-HOSPITAL PAIN

Tuesday 8 June 2021 | 13:00-17:00

- **Summary of recent FPM 'Surgery and Opioid guidance'. Need for a transitional care model?**
  Paul Wilkinson, Newcastle, UK. Chair, working party 'Surgery and Opioid' guidance.
- **Pre-operative chronic pain consult - what are the issues for pain doctors to focus on?**
  Sailesh Mishra, Consultant in Anaesthesia and Pain Medicine, Newcastle upon Tyne.
- **Physiotherapy based prehabilitation for chronic pain patients prior to surgery - is it needed?**
  Prof Paul Cameron, Head of the NHS Fife Pain Service, Scotland.
- **Psychological prehabilitation for effective pain management- is it effective and who should do it?**
  Dr Beth Darnall, Professor of Anesthesiology, Perioperative and Pain Medicine, USA.
- **Chronic post surgical pain - diagnosis and management**
  Dr Joel Katz, Professor of Anaesthesia, Toronto
- **IR vs MR opioids for post operative pain**
  Nicholas Levy, Consultant in Anaesthesia and Pain Medicine, West Suffolk
- **Getting patients off opioids prior to surgery – how to do it?**
  Heath McAnally USA.
- **Postoperative opioid stewardship (surgeons)**
  Susan Hill , Consultant Vascular Surgeon, Cardiff.

BOOKINGS NOW OPEN!

Tuesday 29 June 2021 | 13:00-17:00

- **Rib Fracture pathway**
  Rosel Tallach, Consultant Anaesthetist, NHS Highland, Scotland
- **Case discussion: preoperative optimisation for elective amputaion of forearm - a study.**
  Suchiga Kanagasundaram,
- **Intrathecal opioids - update on effectiveness, dosing and safety.**
  Robert Hart, Consultant - Anaesthesia and Intensive Care Medicine , Scotland
- **Wound catheters - how to do it right and are they effective?**
  Richard Makin, Consultant in Anaesthesia & Pain Management, Newcastle
- **Erector spinal and Serratus anterior blocks - an overview**
  Jayne Halcrow, Consultant in Anaesthesia, Scotland
- **A round up of recent FPM Guidance**
  Manohar Sharma, Consultant in Pain Medicine and Anaesthesia, Liverpool
- **The future is here - gene therapy for acute and chronic pain.**
  James Cox, Senior Lecturer, UCL
- **The top 5 acute pain papers/guidance of 2020/21**
  Dev Srivastava , Consultant Anaesthesia and Pain Medicine, Inverness, Scotland

Book your place: www.fpm.ac.uk/events

Please note that the programme and timings may be subject to change.

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