FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

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TRANSMITTER

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New Core Standards for Pain Management Services

LOCAL ANAESTHETIC WOUND CATHETERS

REFLECTIONS ON EVIDENCE

INTRATHECAL OPIOIDS: ABDOMINAL SURGERY

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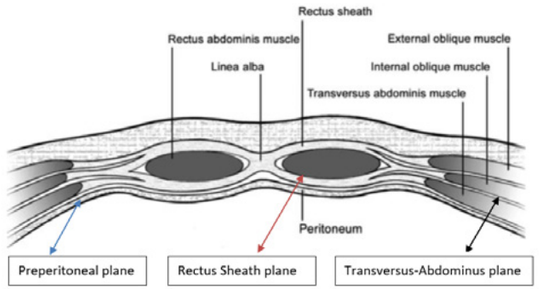

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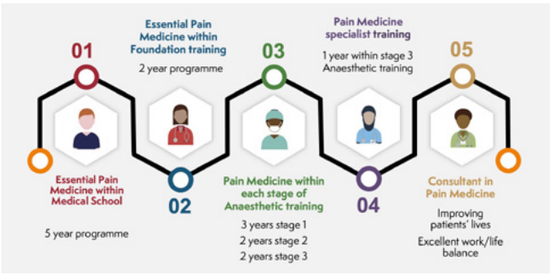

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WELCOME

Dr Manohar Sharma
Clinical Editor

Welcome to *Transmitter* — Autumn 2021 Edition!
With easing COVID restrictions, we are seeing signs of the rapid growth of economy with general strain on supply chains and staffing levels across the board in several organisations.

There is an increase in the number of patients coming into hospital from our cumulated pandemic backlog. With new hope and energy, we all seem to be gradually limping out of the pandemic. I am sure the new normal will be somewhat different from pre-COVID times for the right reasons; to support better work life balance, productivity and our environment.

Core Standards for Pain Management Services in the UK, second edition, has just been launched following highly successful first edition. It has additional chapters on expected standards and recommendations for pain management services. The chapter on commissioning is highly relevant as we encounter the impact of chronic pain guidelines with chronic pain services under commissioning pressure despite evidence supporting delivery of high standards of care and improving the quality of life of chronic pain sufferers. The article by Dr Barry Miller highlights how evidence relates to a particular individual within a population considering published guidelines. Thus, there is a tension in Pain Medicine, between 'the evidence' and 'the individual'. In this context FPM Board and Professional Standards Committee is actively working on a National Pain Strategy and Pragmatic Pain document to counterbalance these issues. Such ongoing workstream is likely to guide appropriate future pain commissioning especially where required high quality evidence is limited.

The FPM examination has continued during the pandemic as a remote written and oral exam, with excellent feedback. FPM has been able to organise several pain webinars and the hope is that in 2022, there will be more face-to-face pain educational events. Work with the GMC on Pain Credentials continues with very significant input from FPM Board led by Dr Lorraine de Gray. This is likely to take some time but I am confident that this will be a positive step for Pain Medicine to be recognised as a specialty.

I am hopeful that by next spring we will be out of the pandemic and fully accustomed to living well with it and a more normal service will resume allowing more face-to-face interaction between the FPM and members.

Manohar Sharma

Dr John Hughes
FPM Dean

MESSAGE FROM THE DEAN

We are moving into the Autumn with all the beauty it brings and the increase in activity after the summer break. There is ongoing monitoring of the COVID situation and what may occur after the winter months alongside a significant desire to address the backlog of patients awaiting care and return service delivery back to normal.

This brings with it an opportunity to review what normal should look like and what lessons we can learn from the pandemic to improve care. There have been changes in how we work across specialties and disciplines, with improved communication across and between organisations. The Faculty has seen, and been involved with, the MSK improvement programme which is developing significant output. It supports integrated services with sufficient flexibility to allow regional and local delivery whilst maintaining a set of national standards.

Pain in the population

With the prevalence of chronic long term pain in the population, the inequalities of current provision, the complexity of where pain may present within the healthcare system and the huge impact on society, there is a strong argument to develop a case for pain to be considered in a similar way. There are a number of workstreams that the Faculty is involved with, or leading on, that support this ambition. These include developing a national pain strategy to provide a framework for patient care, providing opportunities for implementation of the various standards, guidance and pathways already available in a more equitable manner. The GMC credential for pain medicine specialists continues to develop alongside the other early adopters. This is an iterative process on both sides as the mechanisms for credential production develop. Progress is being made within the MSK improvement programme relating to Spinal Services and Fragility fractures which will benefit our patients and easily cross link with the pain strategy. We continue to engage with the various projects looking at prescribing and drugs of dependence and make the points that patient support and review is required during any weaning process, alternative services need to be available for managing their pain, active engagement utilising personalised care principals is required and that those patients that do benefit should not be denied medication.

> “The Faculty is now on the advisory group for the Centre for Perioperative Care and aims to explore avenues where we can better manage patients and ensure standards are maintained.

Core Standards

Closer to our core business I am delighted to see the 2nd edition of the *Core Standards for Pain Management Services in the UK* has been published. This is a significant multidisciplinary piece of work and thanks go to Dr Anna Weiss, Dr James Taylor and Dr Rob Searle for bringing it together, the secretariat for keeping it going and all the authors for their time and contribution. It is an important component to support the development of improved pain services across all healthcare settings.

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Inpatient pain

The importance of inpatient pain management has not been forgotten and the Faculty is now on the advisory group for the Centre for Perioperative Care and aims to explore avenues where we can better manage patients and ensure standards are maintained. This will be important regarding restoration of services following the pandemic.

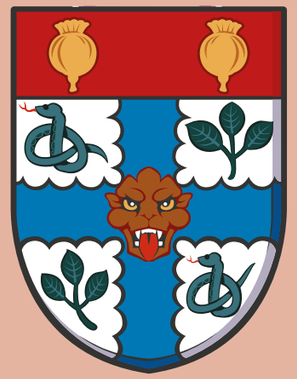
Pain management requires a patient centred approach and much of what we have been doing for many years has involved varying degrees of personalised care. The Personalised Care Institute is now one year old (happy birthday) and producing educational material that will be of benefit to our areas of practice. The Faculty is a stakeholder and will support areas of work which will benefit our patients and trainees.

Congratulations Diplomates

I would like to congratulate this year’s Diplomates that received their certificates in early September. They are thoroughly well deserved and represent a significant amount of work. Welcome, all of you, to the team of pain physicians; you represent the future of our specialty. The exam team continue to do great work ensuring that the sittings can proceed and also to the candidates for their perseverance in difficult times.

This report represents a part of the ongoing work of the Faculty, its committees, fellows and members. Without their engagement we would not be able to deliver on these projects. Going forward there are opportunities which we will pursue and I thank all of you that have been and continue to be involved and am always open to comment, suggestion and feedback.

FACULTY UPDATE



New Fellows by Examination and Assessment

Catherine Cashell
Sarah Curtis
Alia Darweish Medniuk
David Hutchins
Eleanor Hyde
James Jack
Arul Prakash Pandian James
Krisztina Kenesey
Blayne McCann
Hemkumar Pushparaj
Rafik Sedra
Bharti Seth
Leigh-James Spurling
Kunal Targe
Roshan Thawale

New Affiliate Members

Maissara Al-Rakibi
Saweda Cuthbert
Christopher Barringer
Qaisar Khalil
Candice Ramdin

New Affiliate Fellows

Alex Kumar
Gunasheela Kalashetty
Helen Findley
William Rattenberry

New Associate Fellows

Ashok Kumar Puttappa
Rory Maguire

CORE STANDARDS FOR PAIN MANAGEMENT SERVICES IN THE UK SECOND EDITION

"Standards set out a common understanding of how things should be done if they are to be done effectively. They provide a shared expectation that can give confidence to stakeholders, and they hold practitioners to account. Training and knowledge-sharing activity can be focused around familiarisation with them"

— Sally Hayns, Chief Executive at the Chartered Institute of Ecology and Environmental Management

Dr Anna Weiss
CSPMS UK Lead

The setting of standards is a process that many organisations, public and professional bodies and stakeholder groups embark upon when attempting to agree a common ground and understanding, leading to rules of mutual or multilateral engagement. In healthcare, the purpose of setting standards lies in assuring safety and quality to all who require care, without regional or national discrimination, while adapted to individual need and available finance. The Faculty of Pain Medicine is one of many bodies adopting this approach.

Healthcare, notably medicine, has prided itself on setting standards ever since we had records of medical care; the Hippocratic Oath, paraphrased as 'First, do no harm' is an ethical standard familiar to most. Where such essential standards are breached, individual and societal harms follow, often irretrievably.

Standards in practice

Some standards, when applied in practice can feel burdensome to individuals or single organisations. At times, this burden may lie in the perception that a standard is unachievable or unrealistic. The CSPMS team worked consistently on how such barriers to adoption of the document should be minimised; some of the processes are mentioned below.

How does this fit in the preparation of the second edition of the *Core Standards for Pain Management Services in the UK*?

Ahead of the first edition we agreed that there will be a core of standards, derived or mirroring the principles of uniting professional practice — the *Good Medical Practice* GMC Ethical Guidance is a prime ex-ample of this.

We recognised that setting standards that seemed too 'high-brow' or too 'extreme' for the reality of health care delivery in the UK, across all four nations could put off commissioning bodies, clinicians and stakeholders. Achieving positive support and results for people with pain required a process,or combination of processes over time.

This led to the design of chapters carrying both, Standards and Recommendations; the actual layout of the majority of chapters is in keeping with the first edition, including Introduction; Standards; Recommendations; Background and References.

Changes and additions

For the second edition we aspired to hone recommendations from the first, some becoming standards; to add information and chapters previously missed and address topics that have become more urgent since 2016; to allow for healthcare political changes and reforms that have occurred since; and to evaluate which standards offered traction when negotiating, funding, devising, building and maintaining services for people with pain.

It's been a long time coming. Following the publication of the first edition and its fairly publicised introduction into the world of Pain Management in the UK, a second edition seemed an exciting though involved task.

Standards
must be followed. Standards aim to represent current best practice in pain management as published in relevant literature and/or agreed by a body of experts.

Recommendations
are statements that the authors consider should be routine practice in UK pain management. For services where Recommendations are not currently met, there should be a clear strategy to meet them as soon as possible.

The adoption of key core standards from the first edition by the CQC gave clinicians and multidisciplinary teams unprecedented leverage when negotiating their services with commissioners and managers. The Parliamentary Reception in November 2015 hosted by Lord Luce added profile and interest to the inaugural document.

- An editorial team for the second edition recruited from the PSC initially including James Taylor and Anna Weiss. James had to leave the PSC in September 2020, to support his local trust to tackle the immediate and long-term challenges of the COVID pandemic; since, Robert Searle has taken on the job of the co-editor.

The editors agreed to the:

- gaining data on what other aspects of Pain Management ought to be addressed in the second edition
- evaluation of chapter design and clearer guidance to authors
- scrutiny lof editorial processes, including feedback on proposed content and individual chapters as they returned from authors
- process of stakeholder and open consultations.

Gap analysis

A gap analysis tool, devised by James Taylor, was sent to all Fellows and Members of the FPM. This exercise helped us to identify new topics and hone some of the chapters previously included in the first edition. In the interim, we had also contributed to other interlinked RCoA publications through collaborations of *Guidelines for the Provision of Anaesthetic Services* (GPAS) and FPM.

Detailed planning and vetting of the chapters by the PSC and FPM Board contributed to the processes of elimination and streamlining of the document design.

Patience and support

Throughout all the work on the project we were extremely ably supported by Emmy Kato-Clarke, Professional Affairs Manager and, in her absence, Caitlin McAnulty. The patience and support of our colleagues within the FPM and the diligence and generosity of all the authors involved must be commended. This project is a genuine example of multidisciplinary collaboration. A big 'thank you' goes to Paul Wilkinson, PSC Chair, for his knowledge, wisdom and help in supporting this lengthy process.

We are able to present you with this updated, mostly streamlined version of this essential document. This edition holds ten individual chapters, as compared to the nine in the first edition.

To aid your navigation the most significant changes are highlighted below.

Chapter 2: Commissioning of services across the UK

has been appropriately revised and adapted to the current conditions within the individual four nations. The content depends solely on the health political developments nationally, changes to which may be imminent.

Chapter 3: Description of services and level of care

3.3 Pain management services in the community (tier 1)
3.4 Specialist pain management services (tier 2)
3.5 Highly specialist pain management services (tier 3)
3.6 Inpatient pain services

This includes updated nomenclature in keeping with modern practice ('Inpatient pain services') and highlights the new referral pathways. While these are derived from NHS England, implications for commissioning of tier 3 services in Wales and Northern Ireland and, in individual cases, Scotland exist.

There are a number of added sub-chapters, which should aid understanding and continuity of the document. In particular to be mentioned are:

Chapter 5: Pain Management service team

5.9 Multidisciplinary Team Working in Pain Clinics

Added to emphasise the qualities of MDT working and healthy MDT culture, this section is even more urgent in view of the challenges from the COVID-19 pandemic to people with pain and teams supporting them.

Chapter 6: Patient pathways

6.8 Transition of care from children and young people to adult services

This essential addition highlights the principles of the inevitable, but often under resourced and under provided trajectory of care for people with chronic pain conditions, moving from young people to adult services.

Chapter 10: Safeguarding

This essential chapter was included to fully represent the professional commitments to keeping people with pain and their families safe in line with current legislation on safeguarding.

Other changes

We considered that adding a dedicated set of appendices with:

a). Appendix 2: Abbreviations and
b). Appendix 3: Definitions

should support potential users of the document, not fully immersed in the vocabulary of pain management on a daily basis.

Finally: the 'Get in touch' option is a genuine invitation for all of you to contribute. *Core Standards for Pain Management Services in the UK* is a living document. We strive to ensure that it remains an up-to-date and relevant resource. As such, we welcome any feedback on the content and structure of this guidance. If you do have any feedback, please email contact@fpm.ac.uk.

We are also delighted that the guidance has been endorsed by multiple external organisations.

Thank you

Thank you to all who contributed and supported us, including the 70 authors. Without you, none of this would have been accomplished.

Please accept this publication and use it to the best advantage for all the people with pain you support, your teams and services.

For the full guidance, please visit https://fpm.ac.uk/standards-guidelines/core-standards.

Dr Cathy Price
Consultant in Pain Medicine

RADIOFREQUENCY DENERVATION FOR LOW BACK PAIN: RADICAL TRIAL PROTOCOL AND UPDATE

Low back pain (LBP) is the leading global cause of years lived with disability. Some cases of LBP are thought to arise from the facet joints supplied by the medial branches of the primary dorsal rami.

Radiofrequency denervation (RFD) is a minimally invasive procedure utilising heat to ablate these nerves. RFD is endorsed by NICE and over 13,000 RFDs of the lumbar facet joints are performed annually in the NHS. However, there remains uncertainty regarding the effectiveness of RFD due to a lack of high-quality evidence.

What is RADICAL?

The RADICAL trial is a NIHR funded study to investigate the effectiveness and cost effectiveness of RFD for low back pain.

RADICAL is commencing in Autumn 2021, with 18 months recruitment (including a 12-month internal pilot to optimise recruitment strategies), 25 months follow-up, and 8 months data analyses and reporting.

Inclusions

Inclusions are adults with localised, moderate to severe chronic, LBP referred to specialist care, ≥60% pain relief in response to single diagnostic medial nerve branch block and the absence of severe depression. RFD will be performed following standardised protocol as agreed in a consensus meeting with pain clinicians based upon the Nath technique[1]. The placebo arm involves the same protocol as the intervention, but the electrode temperature will not be raised.

Primary and secondary outcomes

The primary outcome is pain severity, measured using a Numeric Rating Scale, at 3 months after randomisation. Secondary outcomes include Functional disability, health-related quality of life, psychological well-being, satisfaction, adverse events, work outcomes and healthcare utilisation. If there is no improvement at three months, participants will be offered the other intervention remaining blinded to both.

Key findings

Key findings to date have been the wide variation in patient selection and technique. To address this standard entry criteria have been agreed amongst participating centres, a video has been produced of the technique and a cadaver workshop is planned for end September 2021. All needle positioning will be checked for accuracy. Patients also have access to a video explaining the trial. The investigating team started to recruit centres in July.

Further information

For further information please visit RADICAL: Bristol Trials Centre. This project is funded by the National Institute for Health Research (NIHR) [Health Technology Assessment programme (project reference NIHR 127457).

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INTRATHECAL OPIOIDS: EFFECTIVENESS, SAFETY AND DOSING IN ABDOMINAL SURGERY

The first publication of the use of intrathecal opioids for analgesia was in 1979[1]. High doses of morphine were predominantly used in the following years, commonly for abdominal and thoracic surgery.

Unfortunately, the high dose led to severe adverse effects such as pruritus and late respiratory depression. The duration of analgesia from lower doses of opioids were insufficient for the postoperative pain after these open procedures. Nowadays, abdominal surgery is predominantly performed laparoscopically, which leads to a shorter duration of postoperative pain[2], making low dose of intrathecal opioids an attractive method of analgesia.

Pharmacological and clinical

Clearly, only hydrophilic intrathecal opioids cause prolonged analgesia, because these opioids diffuse slowly out of the cerebral spinal fluid, thus residing for a prolonged period of time in the cerebral spinal fluid, causing analgesia at the spinal level for a long time.[3] Furthermore, only a small dose is required for a sufficient concentration, because of the low volume of distribution. The most commonly used intrathecal hydrophilic opioids are morphine and diamorphine. While there is a pharmacological difference, it is debatable if it leads to a clinical difference between the two.[4-6] Of note, most of the research was performed with morphine.

Recently, we published a meta-analysis involving randomised trials that compared intrathecal hydrophilic

> The most feared adverse effect is late respiratory depression.

opioids with no intrathecal hydrophilic opioids in all types of abdominal surgery, only excluding caesarean sections.[7] It must be noted that pooling of different types of abdominal surgery is an important source of heterogeneity. Still, it demonstrated that intrathecal hydrophilic opioids lead to a reduction of 18 mg (95% CI: 14-22 mg) of morphine equivalents in the first 24 hours and 25 mg (95% CI: 20-30 mg) of morphine equivalents in the first 48 hours.

Pain scores

On top of that, pain scores are a point lower on a 10-point NRS. Several subgroup analyses did not differ from the main outcomes, including subgroups of laparoscopic and open surgery. No dose dependency was detected. The opioid sparing effects of intrathecal hydrophilic opioids are higher than other strategies, such as intravenous lidocaine (-4.5 mg [95% CI: -6.3 to -2.8]), high dose pregabalin (-13.4 mg [95% CI: -22.8 to -4.0]), and ketamine (-10.3 [95% CI -13.8 to -6.8]).

Fit for discharge

Another interesting outcome is the time to fit for discharge, which is especially of interest since Enhanced Recovery Programs became popular. The meta-analysis demonstrated a minor decrease in time to fit for discharge (-0.3 days (95% CI -0.5 - -0.1)), which can be interpreted as one out of every three patients is discharged a day earlier. Three studies investigated this outcome in laparoscopic colonic resections, of which only one demonstrated a reduction in fit-for-discharge.[8-10] So clearly, this result should be interpreted with caution. It is probably safer to conclude that there are no signs of a delayed recovery after the use of intrathecal hydrophilic opioids.

Adverse effects

Obviously, intrathecal hydrophilic opioids have adverse effects as well. Nausea and pruritus are the most predominant. The incidence of nausea was not increased in the meta-analysis, possibly because the difference in systemic opioids consumption offsets the difference in nausea caused by the use of intrathecal hydrophilic opioids. Pruritus was four times increased and a dose dependent effect was found. It is important to know that the intravenous use of 5-HT_3-antagonists significantly reduces the severity and incidence of pruritus and these medications are recommended to use concomitantly with intrathecal hydrophilic opioids.[11,12]

Urinary retention is caused by all intrathecal opioids for the duration of their action. It causes not only a decreased sensation of urge, but also a decreased detrusor contractility.[13] For this side effect a dose dependent effect is also present. Some studies showed that men may be affected more often than women[14], but I personally do not recognise that finding in clinical practice. So, for safety, an urinary catheter is recommend for the first 24 hours after the use of intrathecal morphine. Alternatively, close observation with ultrasonography reduces the use of urinary catheters, but may increase the nursing workload.

The most feared adverse effect is late respiratory depression. It is believed that the cerebrospinal fluid-flow carries the injected morphine cranially. After some hours, it reaches the respiratory centers, where it exerts a depressive effect. Unfortunately, the severity and incidence are unknown due to a lack of a clear definition of respiratory depression.[15]

> The opioid sparing effects of intrathecal hydrophilic opioids are higher than other strategies.

In fact, some studies include hypoxemia in the definition, which may be caused by postoperative atelectasis, as well. Actually, postoperative hypoxemia may be reduced with the use of intrathecal morphine, because the analgesic effect may facilitate mobilisation and coughing.

Despite the variation in definition, several large observational studies found incidences <3%, which is comparable to PCA-administered opioids.[16-19]

Varying severity

Obviously, with a varying definition, the severity varies, as well. The largest study found a 3% incidence of respiratory depression, but none of the patients required mechanical ventilation or suffered sustained injury.[16] Recently, we have performed a meta-analysis involving all serious adverse events after a single shot of intrathecal morphine for postoperative pain.[20] We found 54 cases of respiratory depression, 25 of which met the criteria of life-threatening respiratory depression. All but four cases received over 900mcg of intrathecal morphine. The other four cases received potentiating medication. High doses and the concomitant use of potentiating medication is therefore best avoided.

An intriguing alternative is to continuously administer intravenous naloxone for the first night.21 It appears that it reduces the risk of respiratory depression, while it hardly reduces analgesic effects. The latter may be caused a concentration difference in morphine between the respiratory centers and the spinal cord. Consequently, lower doses of naloxone are required to antagonize the respiratory depression than the analgesic effects. Still, the reliability of this strategy should be confirmed in larger samples.

When the positive and negative effects of intrathecal morphine are combined, it is found that the positive effects are not clearly dose dependent, but the side-effects are. Consequently, higher doses of intrathecal morphine may not lead to better analgesia, but does lead to more side-effects. The optimal dose for abdominal surgery is therefore between 200 and 300mcg of intrathecal morphine, in my personal opinion. A dose reduction is probably warranted in elderly patients (> 80 years of age).

Summary

Intrathecal hydrophilic opioids reduce postoperative opioid consumption and pain scores, without delaying recovery in abdominal surgery. These effects are not dose dependent. The side effects of pruritus, duration of urinary retention and respiratory depression are dose dependent. It follows that the optimal dose of intrathecal morphine is between 200 and 300 mcg for abdominal surgery. Precautions such as a urinary catheter, 5-HT_3-antagonists and the avoidance of high doses of intrathecal morphine are recommended.

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Dr Barry Miller
MAG Chair

REFLECTIONS ON EVIDENCE

"Your assumptions are your windows on the world. Clean them every once in a while, or the light won't come in." — Issac Avimov.

There is a tension in Pain Medicine, between 'the evidence' and 'the individual'. We aim to bridge this gap pragmatically; but there is a conflict, and we should be aware of where, and why, lines have been drawn; and how we may be on one side or the other, sometimes changing on a case by case basis.

Evidence is not a thing. It is a collection of disparate pieces of information which give a notion of the risk/benefit approach to a problem. It is very rarely comprehensive, it may be very weak, and, is much misunderstood. It is not wholly objective; subject to many biases, and the choice of tools used to analyse may give very different ideas of success or failure for the same data.

In Pain Medicine, outcomes are essentially behavioural in nature (filling in a pain questionnaire etc.), and compounded with expectation: "This will cure you" "It didn't, it's rubbish" versus "this may improve the pain a little" "I definitely feel a bit better, this is great".

Thought experiment

I want to pose a simple thought experiment: Consider a study of a pain treatment given to ten people who rate their pain out of ten. Pre-study: 10, 9, 9, 8, 8, 7, 7, 7, 6, 6. And, after the study, the results are: 6, 10, 5, 7, 9, 3, 4, 7, 6, 7 (same people, same order).

Does this result suggest a potentially effective treatment? I'll look at two approaches to its analysis:

1. Mean: Before 7.7, after 6.4 — an average 1.3 points (13%) improvement. Not sounding like a very impressive therapy.

2. Three patients had a drop of 4 points and one of 3 points. So 40% had a change of 30%-40%. An NNT of 2.5 for 30% relief, and an NNT for 10% worse pain of 3.3.

So, should we offer the treatment? The simple answer is we don't know enough from this information to make a judgement. But one approach emphasised Mean and the other, NNT. This makes the difference between wanting to know additional facts to weigh the risk-benefit, and ending the discussion.

Of course, ten people in a trial is very small. There is no power calculation, no confidence intervals, no significance indicators, and an 'out of ten' assessment is very limited. But the point of the example is to indicate the potential conflict between the 'evidence' and the 'the individual', in the choices made to analyse. This really matters. Statistics are mathematical tools. The wrong tool, and it's a right mess.

Beyond the numbers

There are also many unanswered questions here about the study the study itself: recruitment, exclusions, conditions, length of trial. placebo effects, and side effects. All these are essential in making a clinical decision, but it does demonstrate the importance of how data is presented and interpreted.

Beyond the numbers, consider the risk of mild nausea against developing a rare cancer. This changes the dynamic considerably, but may be different in a chronic or end-of-life situation (may). Statistics can tell you a lot about a group of people, but not about the individual in front of you. Judgement, discussions and informed consent (which is not just for procedures) are essential components of clinical practice; advising on treatments and responsibility for prescribing.

This isn't an excuse to try anything. It is about interrogating the research closely, and recognising that a binary yes/no answer for all usually obscures clinically important options. In dealing with individuals whose pain and suffering is often of years, and with years to come, it is reasonable to question simple answers closely.

Dr Richard Makin
Consultant in Pain Medicine and Anaesthesia

LOCAL ANAESTHETIC WOUND CATHETERS

The landscape of perioperative analgesic techniques for major surgery has evolved over the last decade, with a shift away from traditional central neuraxial techniques associated with a high failure rate, hypotension, logistics of managing and monitoring the technique, and...

...risks of neurological injury related to vertebral canal haematoma or abscess, especially in the presence of antiplatelet and anticoagulant drugs.

Local Anaesthetic (LA) infiltration of the surgical site, single shot nerve and fascial compartment blocks can contribute to analgesia, but effects are limited to the duration of action of the LA. Analgesic effects can be extended into the post-operative period by continuous infusion of LA via multiholed catheters placed in the wound.

PQIP data

Effective post-operative analgesia continues to remain elusive for patients suggested by data collected by the Perioperative Quality improvement Project (PQIP) in the UK. Pooled data from all surgical cases reveals severe pain is reported by 7.5% in Recovery, and 19.8% reported severe pain within 24h of surgery (on the Bauer patient satisfaction questionnaire) particularly within Upper GI and Hepato-Biliary surgery[1].

The data related to individual peri-op interventions raises some interesting questions (**Figure 1**) and the report proposes a need to focus improvements in analgesia for patients within the 1st 24hours to facilitate drinking, eating, mobilising and generally recovering from their major surgery. Whilst an effective local/regional anaesthetic technique is a cornerstone of pain management, realistic expectation setting and management at pre-op, multimodal analgesia, distraction therapy and regular, early post-op review by pain teams are recommended components of an individualised pain management plan.

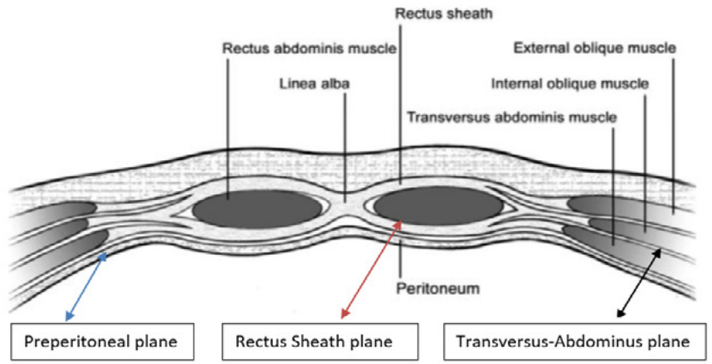
	Severe recovery pain (%)	Severe pain within 24h (%)
GA only	11.3	22.0
Local/regional		
LA infiltration only	4.3	20.4
Regional block	5.7	23.1
Neuraxial		
Epidural	7.5	16.8
CSE	0	17.1
Spinal	5.5	17.9

Figure 1 *PQIP Annual Report 2019/19 Individualised Plan Management Data*

Whilst epidural has been considered the gold standard for open Thoracic/Abdominal and Pelvic surgery data from NBOCA 2019[2] has shown a steady rise in Laparoscopic Surgery (61%) an increase from 48% in the 2013/14 period, with a consistent conversion to open surgery at 8%. Recent evidence suggests using spinal anaesthesia with opiates (diamorphine), or patient-controlled analgesia alone may reduce length of stay compared to epidural after laparoscopic surgery[3].

Newcastle upon Tyne NHS Trust local Acute Pain Service Audit data demonstrated a falling trend in Epidural catheter insertion, and rise in LA catheter use. Despite enthusiasm for perioperative iv Lignocaine a Cochrane review[4] concluded that when compared with placebo, or no treatment the benefit of iv Lignocaine on early post-op pain scores was uncertain and probably has no clinically relevant effect on pain scores beyond 24 hours.

Figure 2 *Myofascial layers to place wound catheters.*



A reasonable approach

As the surgical wound is attributed as a significant generator for somatic pain, intuitively using local anaesthetic at the site of the incision seems a reasonable approach. Multiholed wound infusion catheters have been refined over the 20 years since their introduction, available in different lengths to cover the wound. Pump or Elastomeric balloon devices allow local anaesthetics, levobupivacaine and ropivacaine, to be continuously infused into tissues surrounding an incisional wound via a catheter, which can be placed by the surgeon prior to wound closure. For abdominal surgery, the wound catheter may be positioned within the subcutaneous , musculofascial or preperitoneal layers of the anterior abdominal wall (**Figure 2 & 3**).

Performance of a selection of available wound catheters has been observed in-vitro conditions (**Figure 4**) demonstrating variability in pattern of contrast spread with a steady infusion which may influence outcome and patient satisfaction[5]. .The pattern of contrast distribution also differs if a manual bolus rather than a steady infusion is given, raising questions about the merits of continuous infusions, intermittent bolus or a combination to optimise analgesic effect.

Systematic revew

A systematic review by Liu[6] demonstrated that Continuous Wound infiltration (CWI) of Local Anaesthetic reduced postoperative opioid requirements, nausea and vomiting, facilitated earlier mobilisation, and reduced length of stay across cardiothoracic, general, gynaecology-urology and orthopaedic surgery (44 RCTs enrolling a total of 2,141 patients).

Similar results have been observed after open Nephrectomy[7] with catheters surgically placed between transversus abdominis and internal oblique muscles, open Colorectal surgery[8]. Continuous preperitoneal local anaesthetic infiltration produced similar analgesia vs active control (epidural analgesia or PCA) (13 RCTs, n =887)[9]

Chan[10] demonstrated 33% reduction in opioid requirements following open hepatic surgery with CWI through a standardised Right subcostal incision via two surgically placed catheters. Furthermore, the group receiving Ropivicaine via the wound catheters achieved better spirometry results including Forced vital capacity, compared with the placebo group, although in both groups the reduction in FVC compared with pre-op baseline measures was <50% highlighting the functional impact of a surgical wound.

Tilleu[11] explored the cost-effectiveness of postoperative analgesic technique comparing Epidural analgesia (EDA), Continuous wound infusion (CWI), and Patient controlled analgesia (PCA). EDA required 110 minutes per patient of ward based care to implement and supervise the technique compared with 21 minutes for CWI and 34 minutes for PCA. (**Figure 5**) estimates the calculation of total costs per analgesic technique, including hardware and manpower costs.

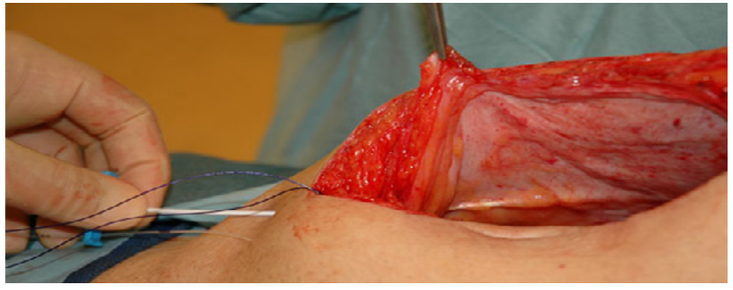


Figure 3 *Preperitoneal wound catheter introduced via a split sheath tunnelled into position with a trocar*

Effective and user friendly

Continuous wound infusion of Local Anaesthesia appears to be emerging as an effective, user friendly technique with low risk of complications which can be used as an alternative to traditional central neuraxial techniques, where these are contraindicated, technically impossible or as part of a 'Plan B', when a planned minimally invasive case has been converted to open.

A recent Cochrane study[12] including 6 RCT enrolling a total of 564 adults undergoing midline laparotomy for colorectal resection demonstrated a high level of certainty that pain at rest, pain on movement, and opioid requirements were reduced in patients on the first day after surgery who received a CWI of LA via a wound catheter compared to people who received an inactive substance.

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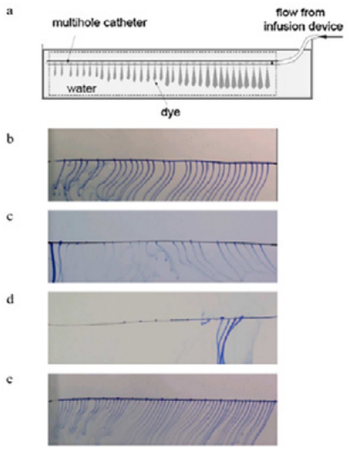


Figure 4 *Distribution of flow of contrast via multiholed catheters (b-e) 20mins after continuous infusion)*

	CWI	EDA	PCA
Cost of devices, drug, staff time	€181	€158	€44
Total costs (mgmt of AE, hospitalisation)	€6,460	€7,500	€7,273
Succcessful pain relief	77.4%	72.9%	53.9%

Figure 5 *Estimate calculation of total costs per analgesic technique, including hardware and manpower costs.*

Dr Emma Baird
Inpatient Pain Medicine Lead

BUDDYING: THE FUTURE IS CONNECTED

Buddying was a concept started in safety critical industries to protect workers in hazardous situations. It is now ubiquitous in many industries and educational establishments.

Buddy schemes, where new recruits are provided with an informal mentor, are an increasingly common feature of the recruitment and induction process. The buddying process is based on mutual and collaborative development and learning. The purpose of an FPM buddy is to develop a relationship between two individuals: one who is looking for help and advice in a particular area and another who has real world experience and knowledge of that area.

Productivity and morale

I think there is always the risk within pain medicine of becoming siloed, especially in small departments. Siloed working reduces productivity and morale. By sharing resources, experience and innovations we break out of our siloes and improve not only our working lives but also patient care. When we relaunch the FPM buddying scheme we are looking to broaden its reach. The new scheme will encompass FPM members, both fellows and affiliate fellows, at all stages in their careers. Traditionally members have soughrt mentorship at the start of their careers; under the new scheme members will be able to seek support at any time in their careers.

For example, this could be when setting up a new spinal cord stimulation service or pain management program. The mentee could be 'buddied' with a mentor that already runs an established service. We see this as a way of improving connectivity and support around the UK and helping our members reach their full potential. Ultimately we are stronger together.

Positive experience

I have had a very positive experience with buddying. When I started as a new consultant I fairly quickly took over as inpatient pain lead. As a trainee I had very little management experience and felt out of my depth. I reached out to Dr Mark Rockett, 300 miles away from myself in Preston. He gave me the benefit of his many years' experience. I bounced tricky clinical guideline questions off him and he offered me valuable sage advice on people management.

Ultimately it was due to Mark's kind words that I applied to be the inpatient pain representative for the FPM and why I am writing this today. In short having a mentor has made me a better pain doctor and gave me the confidence to take my ideas forward at a national level.

Become a Mentor, Mentee or Buddy

Are you interested in helping someone develop their career, find their perfect work/life balance or do you need that extra something to help you achieve your goals?

If so, please find out more at **https://fpm.ac.uk/careers-workforce-wellbeing/mentoring-and-buddying-scheme**

Dr Victor Mendis
FPMTAC Chair

TRAINING & ASSESSMENT

This is my first *Transmitter* update since taking over from Dr Lorraine de Gray as Chair of the Training and Assessment Committee (TAC). I would like to thank Lorraine for all her hard work over the years and wish her all the very best.

I would also like to take this opportunity to welcome Dr Alisdair Dodds and Dr Sonia Pierce to the committee.

Whilst the pandemic is receding and some sort of normality returns, the delivery of pain services and training will continue to be affected for some time and both trainees and trainers will need to adapt to the changing world in order to continue to train and deliver high quality pain services. There is substantial variability in local delivery and TAC encourages local intiative and flexibility and strong leadership from trainers.

New curriculum

In order to familiarise trainees with the new curriculum, which went live in August 2021, the RCoA is organising webinars and workshops. There wil, be a six-month leeway period. The new curriculum is moving from competency- to outcome-based with a shift away from surgical specialties. There are 14 learning outcome domains, seven generic and seven specialty, one of which is pain. The curriculum for pain will be divided into three stages and TAC is producing curriculum guidance. The RAPM, FTP and trainee guidance document is also in the process of being updated in line with the new curriculum.

> Whilst some sort of normality returns, the delivery of pain services and training will continue to be affected for some time.

Careers update

An updated infographic on how to train in Pain Medicine has now been published on the FPM website and is also in this issue of *Transmitter*. The focus is to reach out to anaesthetic trainees to raise the profile of pain medicine. Dr HooKee Tsang is updating our online careers resources and he will be assisted by Dr Alisdair Dodds who will join the Careers Sub-Committee.

SAS Representative

The TAC recognises the pivotal role played by SAS doctors and is keen to encourage all aspects of professional and career development. To this end a decision has been made to have an SAS doctor on this committee and this has been advertised.

The SAS representative will be able to work in liaison with the Faculty, extend opportunities to members for better engagement with Faculty activities and look after the interests of the SAS doctors working in the field of Pain Medicine.

Trainee assessment/logbook

A new assessment form compiled by Dr Sheila Black and Dr David Gore, approved by TAC, is now available on the FPM website. The shortcomings of the current logbook have been identified and Dr Gore has created a wish list which we will discuss with the RCoA Lifelong Learning Platform development team.

Finally, I would like to reassure trainees that the FPM is actively monitoring delivery of pain services across the UK through a series of surveys which will allow us to monitor changing access to training and act accordingly to ensure the best possible training experience.

Dr HooKee Tsang
RAPM Chair

RAPM UPDATE

As our week-long summer draws to a close, I hope you have all managed to get some time to recharge. Feedback from trainees reflects the hard work of all our trainers. They are very appreciative of the flexibility and support towards pain training provided by RAPMs and FTPs.

Pain services have slowly returned around the UK, with variations in pain training opportunities. Access to interventional procedures and pain management programmes have reduced, with some pain management programmes adopting an online platform. Despite the challenges of delivering training during a pandemic, the majority of Advanced pain trainees are reaching their objectives with over 200 interventional procedures during their advanced year.

Guidance and eLearning

The guidance issued by the Faculty has been well received with the acceptance of five classroom, webinar, or self-directed learning modules from e-PAIN towards the Intermediate pain module. Some trainers have asked whether e-learning sessions can count towards sessions for the Higher and Advanced modules.

Whilst e-learning is a valuable resource, the Faculty recognises that Higher and Advanced pain modules require the development of clinical skills, so sessions for these modules must be clinical.

The launch of the 2021 curriculum on the 4 August saw us move away from minimum and maximum numbers of sessions with fixed durations for modules. Holistic Assessment of Learning Outcomes (HALO) sign-offs will be dependent upon evidence gathered by trainees through Structured Learning Events (SLE) supporting achievements of key capabilities and learning outcomes for the stage of training. It is the responsibility of FTPs or RAPMs to sign off the HALOs for each stage of pain training. The two special interest areas in acute inpatient pain and pain medicine following the three stages of pain training, will provide additional clarity on what is required for trainees wishing to pursue a career in inpatient pain work only. The Faculty has published guidance for pain training within the 2021 curriculum.

Transitioning curricula

Trainees transition to the 2021 curriculum over the next two years. Any trainee who is expected to achieve their CCT by 31 January 2024 may remain on the 2010 curriculum. The new curriculum will also require self-directed learning time for trainees, with individual schools adopting their own systems.

The Faculty Tutors' study day on the 18 November 2021 was a virtual meeting with an opportunity to obtain further guidance on the 2021 curriculum. The Faculty has also sent an email to RAPMs and FTPs on what you would like to include for future meetings. This is an opportunity to promote developments in pain training within your region.

Departures and welcomes

There have been a number of changes in RAPMs since the last update. I would like to thank the RAPMs stepping down, namely Dr Nick Hacking (North West) and Jeremey Weinbren (North Thames), for their dedication and hard work. I would like to extend a warm welcome to the new RAPMs, Dr Jonny Rajan for the North West, and Dr Ash Shetty for North Thames. They join us at an exciting time in pain training when the roles of RAPMs and FTPs will be essential in raising the prominence of our speciality within a new curriculum to attract the next generation of pain doctors.

Thank you for your continued support; I look forward to seeing you in person at the RCoA in 2022.

Dr David Gore
Faculty Trainee Representative

TRAINEE UPDATE

I finally feel I can write a *Transmitter* article that is not about a sub-microscopic infectious agent that replicates only inside the cells of a living organism. Therefore, in this article I want to feedback from our recent trainee survey.

As I write, there are 53 trainees registered with the Faculty of Pain Medicine in the UK. Whilst the majority of trainees are Advanced or Higher, we also have 15 colleagues in other posts (see **Figure 1**). I would very much like to thank those 17 of you who completed the pain training survey in August 2021.

Survey Results

Three quarters of respondents were undertaking Advanced pain training, with the remainder in Higher training and post-CCT fellowships. We reported spending most of our training time between chronic pain clinics and procedural lists, followed by acute/post-operative inpatient pain work. A smaller proportion of our training time was spent in 'specialist' clinics, undertaking audit/research or completing administrative duties.

Whilst most trainees reported never having to provide sedation or anaesthetic services during training procedural lists, a few still state that they are asked to do this. Moreover, a quarter of trainees were required to undertake elective weekday anaesthetic cover during pain training. Almost all of us, bar one, reported their training had been impacted by COVID-19 and this is reflected in the previous surveys the Faculty have undertaken. All less than full-time (LTFT) trainees report feeling able to complete APT competencies.

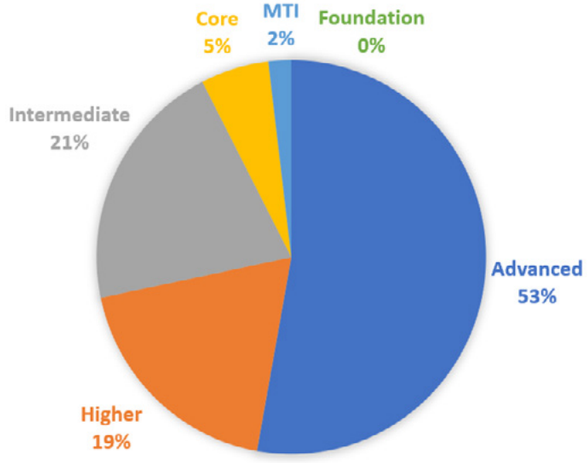


Figure 1 *Registered UK Trainees by Role*

Trainees provided a number of reasons underpinning their interest in Pain Medicine and the positive aspects of training. The main themes are summarised in **Box 1**.

Challenges and concerns

When asked to consider challenging aspects of Pain Medicine, the sparsity of trainees in some regions was a common but understandable theme. Trainees also reported concerns about deskilling in anaesthesia during pain training, this was particularly true for trainees that did not undertake anaesthetic on-call duties. Finally, some trainees were worried about receiving complaints from patients.

BOX 1: TRAINEE POSITIVE ASPECTS OF PAIN MEDICAL THEMES

- **Working within a friendly and welcoming team**
- **Variety of clinical practice such as clinics, interventions and blocks**
- **Interest in the processes underpinning pain and the diversity of pain patients**
- **Working within a wide multidisciplinary team**
- **Working in a specialty with a dynamic and evolving research base**

We all thought highly of the FPM online resources. The vast majority (87%) of trainees access the FPM website at least monthly (40% use the website more than weekly) and we rate it 7/10 on average. Ninety-four percent of trainees were aware of FPMLearning and most trainees report finding it very useful (90%). One hundred percent of respondents were members of the trainee WhatsApp group and for the majority this was the preferred mode of communication with the Faculty.

Career plans

In relation to future career plans, all trainees reported they would like to pursue a consultant job incorporating chronic pain. Most trainees felt positive that they would be able to get a consultant job, although a few reported worries about future funding/commissioning of pain services.

This survey comes after a challenging period for many. Therefore, whilst there are some common themes it is difficult to make comparisons with previous surveys.

Positive experiences

I found it heartwarming reading the different reasons why we enjoy and entered Pain Medicine. A number of trainees reported that a positive experience with a pain team, as a junior doctor, is what drew them to our speciality. I firmly believe pain is a young, growing, enthusiastic and welcoming speciality. Your responses underpin the importance of welcoming trainees with open arms and dispelling old fashioned, negative stereotypes surrounding our speciality. Although colleagues can register with the FPM for free, from Foundation level, we have no Foundation trainees registered and very few junior colleagues. Please do encourage interested junior colleagues to register and join us: https://fpm.ac.uk/training-examinations-training-and-curricula/trainee-registration.

> “I found it heart-warming reading the different reasons why we enjoy and entered Pain Medicine.

Trainees still report undertaking anaesthetic on-call duties during weekdays and providing anaesthetic services during pain training lists. Whilst we need to work flexibly when the NHS is busy, we should not routinely provide anaesthetic/sedation services during interventional lists or undertake weekday (9-5) on calls. The Faculty support us with the following guidance: https://fpm.ac.uk/sites/fpm/files/documents/2020-06/The-Provision-of-Higher-and-Advanced-Pain-Medicine-Training-June-2020.pdf.

Logbooks

In contrast to a survey earlier in the year, the Lifelong Learning Platform (LLP) logbook is now the most commonly used logbook. Just over half of trainees (53%) record pain activities on the LLLP logbook whereas the remainder of trainees are split equally between the Faculty of Pain Medicine Excel spreadsheet and smartphone apps/homemade logbooks. The Faculty are aware the LLP logbook is not perfect and we have recently presented a 'wish list' of adaptations to the LLP development team.

Support and encouragement

Despite the rough two years we have had it is encouraging that we view pain training in such a positive light. Our survey demonstrates the fundamental role we play as pain practitioners in attracting peers to our speciality and helping it grow. We need to encourage junior trainees to join our Faculty and capture interest early. Equally we need to support our peers as pain moves to feature more prominently in the new anaesthetic curriculum.

Finally, keep your eye out for information about the GMC Pain Medicine credential, this has been in development for a while and once in place will afford formal recognition of both our training and speciality.

PERCEPTION OF MEDICAL STUDENTS TOWARDS PAIN MEDICINE

Dr Sara Siew
ST6 Anaesthetic Trainee,
Mersey Deanery

Pain Medicine is not the first specialty that comes to mind when speaking about career aspirations amongst junior doctors, let alone medical students. When I was a medical student, there was very minimal exposure to managing pain and there were no placements in Pain Medicine.

In the most recent 2017 census, it was noted that in the UK, there is one Pain Medicine consultant per 109k of the population comparing to one Pain Medicine consultant per 77k of population across Australia and New Zealand.[1] This workforce shortfall will have significant impact on future services. First impressions of a medical speciality during medical school can influence one's career destination. There are studies that highlight that negative attitudes towards patients with chronic, non-cancer, pain begins early in medical school.[2,3] With that in mind, I wanted to explore how we can influence the future generation of doctors. I set out to conduct a survey amongst fifth year medical students in the University of Liverpool to evaluate their current experiences and perceptions.

Respondents

116 medical students responded. The majority of them were in the 18-25 years old age group with a 4:1 female:male ratio. Encouragingly, 87.5% of the respondents have heard of Pain Medicine as a specialty. However, only 7.5% have considered it as a career. Exploring further into the training aspects of the speciality, 83% responded that they do not know the route of training into the specialty with only 17% having some insight on what we do as Pain Medicine doctors.

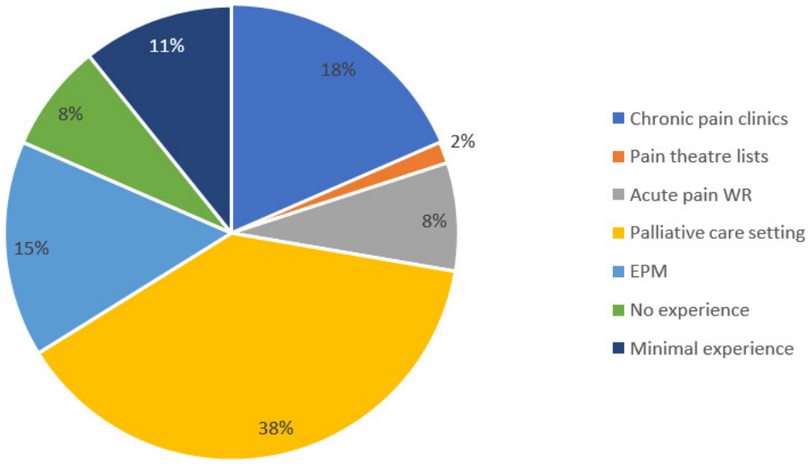
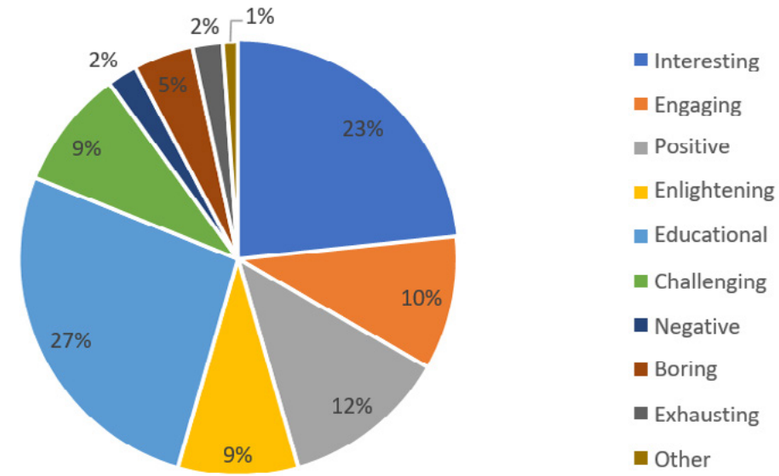


Figure 1 *Clinical experience of fifth year medical students in the University of Liverpool*

Figure 2 *Personal perceptions of these experiences*



The medical students' Pain Medicine experience was undertaken in a number of settings as shown in **Figure 1.** 43% of the medical students gained experience within a Pain Medicine setting. It is very interesting that 38% of the respondents gained their experience of pain management within a palliative care setting. This is not surprising as that is one of the main pillars of palliative care medicine. As a junior doctor, there will be considerable time spent managing pain, such as within a surgical speciality managing postoperative acute pain, acute pain in ED, acute on chronic pain for medical and surgical patients. This raises the question of why there continues to be a low uptake of Pain Medicine training despite The University of Liverpool providing special study modules (Selective in Advanced Medical Practice) on Pain Medicine and Essential Pain Medicine (EPM) for all Year 5 medical students.

Historically, the perception of patients with chronic pain had negative connotations such as an association with drug seeking behaviours or 'patients seeking benefits' described by medical students as the condition most difficult with which to deal.[4] I, therefore, wanted to explore their perceptions on their personal experiences in clinical situations. The results of the survey depicted a very different picture. Majority (90%) of the students reported a positive experience rather than a negative one (see **Figure 2**).

Opportunity and shortfall

This survey has provided further insight into medical students experience of pain training. The Faculty of Pain Medicine has worked to improve undergraduate pain training through EPM–UK. This is evidenced by 90% of the respondents who had pain training reporting a positive experience. Despite the opportunity for pain training at the University of Liverpool, there continues to be a shortfall in uptake. Whilst there was an encouraging 7.5% of the respondents considering a career in Pain Medicine, the lack of interest in the speciality may be related to the lack of exposure during clinical placements and understanding of the career path, with 83% of respondents stating that they did not know the route of training into the specialty.

Pain Medicine remains a key component in the 2021 anaesthetic curriculum and the ongoing work to bridge undergraduate and postgraduate Pain Medicine training provides medical students with a clear blueprint for training, which will be beneficial. However, additional work to locally available training opportunities at an undergraduate level is required.

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Dr HooKee Tsang
RAPM Chair

CAREERS UPDATE

Pain Medicine as a specialty has faced significant challenges over the last 18 months, with an ever changing clinical and commissioning environment. This has an impact on our own perception of the future of our specialty and those we train. I feel there will always be a role for doctors to treat a condition affecting one third of the population.

In recent years we have seen fluctuating interest towards our speciality. Changes in the funding of Advanced pain training posts has impacted on the number of trainees, with the majority of posts restricted to recruiting from within their allocated School of Anaesthesia. The number of Advanced pain trainees in the UK is 28, with significant regional variation. There continues to be more consultant vacancies than available candidates, providing significant choice for candidates. Despite this positive shift in opportunities for consultant posts, this has not filtered down to trainees in anaesthesia. We have also seen an increase in requests from consultant anaesthetists exploring retraining in Pain Medicine.

Lack of awareness

Pain Medicine continues to suffer from bad press amongst anaesthetic trainees, often with trainees reporting poor experiences on placements and a lack of awareness of the opportunities available within the specialty. The ongoing work of the Faculty to embed pain training within undergraduate and postgraduate training will raise the profile of our speciality amongst medical students and junior doctors. Pain training has remained a key domain within the 2021 curriculum at all stages of training. We have a role as trainers in ensuring that trainees gain adequate access to pain training with local programmes. The potential for increased exposure of anaesthetic trainees to Pain Medicine provides an opportunity for us to promote our speciality, and provide an engaging environment to support future doctors.

> “It is well documented that experiences in medical school and early years of postgraduate training influence career choices.

Influential experiences

It is well documented that experiences in medical school and early years of postgraduate training influence career choices. Dr Siew, one of our anaesthetic trainees, conducted a survey of Year 5 medical students on their perceptions of our specialty. The results are published in this issue. Of interest, fewer than 50% of respondents obtained their pain management experience within a Pain Medicine setting, but reassuringly, 90% of all respondents who had any pain training reported a positive experience. This is reflected in 7.5% of the medical students surveyed considering Pain Medicine as a career.

We have created an infographic on pain training (**Figure 1**) to guide trainees on the path to becoming a consultant in pain medicine, which is available on the Faculty website.

Evolving opportunities

We are currently developing additional content on ‘A Career in Pain Medicine’ for the Faculty website. Pain Medicine has long been described as divided into acute, chronic and cancer pain, but this no longer accurately describes the role of consultants in Pain Medicine. Our speciality has evolved, with opportunities for doctors to develop subspecialty interests in a variety of fields. Providing information on subspecialty opportunities will hopefully inspire the next generation of doctors.

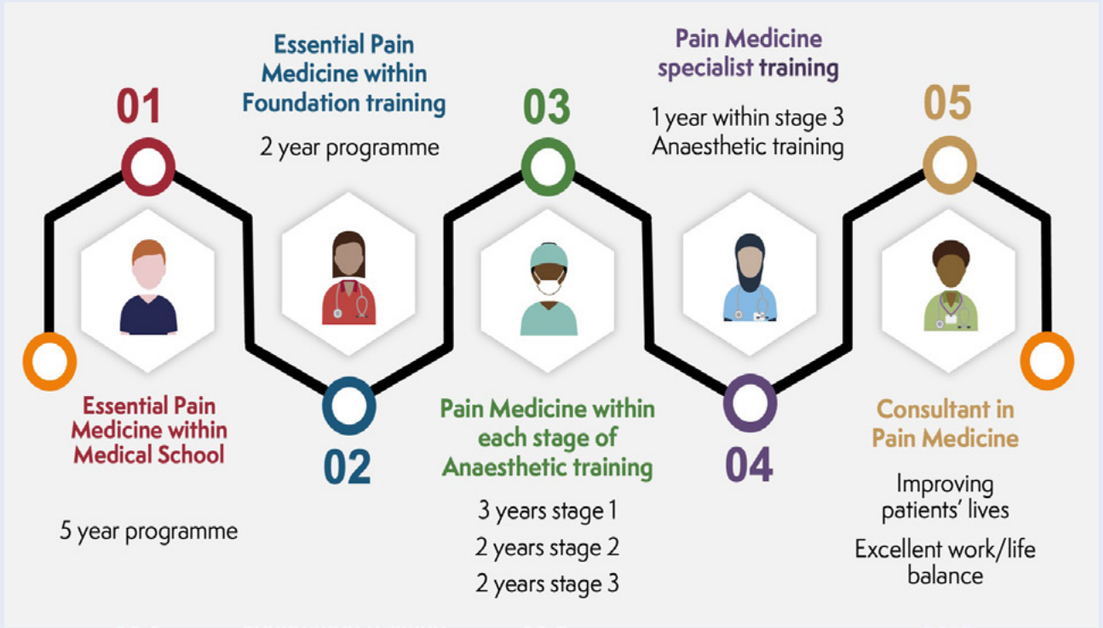
Work/life balance

We particularly need to promote the fact that Pain Medicine can offer an excellent work/life balance, which is so important for those doctors who have caring responsibilities, especially women; the last workforce survey identified that only 25% of pain medicine doctors are women. This imbalance has to change.

Raising awareness

To raise awareness of our specialty, we hope to promote pain training amongst anaesthetic trainees though publications in the RCoA *Bulletin*. Every one of us who works in Pain Medicine has a responsibility to demonstrate the positive aspects of this great specialty. For those of you who are interested in promoting pain training in your region please contact the Faculty via email at contact@fpm.ac.uk.

Figure 1 *Infographic on pain training*



RCoA AAC Pain Assessors Needed

One of the roles of the College is to nominate assessors to sit on **Advisory Appointments Committees (AACs)** this is regarded as an important part of the maintenance and improvement of standards of practice in Anaesthesia and FPM. We have a shortage of AAC Assessors in **Pain Management** we are keen to find assessors suitable to attend these AAC panels.

AAC assessors are asked to volunteer to attend panels throughout the year and there is no limit on the number you can attend. All new assessors must complete our virtual training and update this training every 3 years.

How do I get involved?

The RCoA is currently recruiting AAC Assessors for England Wales and Northern Ireland across all specialties. For more information, visit: Advisory Appointment Committee (AAC) Assessor Information and Application Form or contact: aac@rcoa.ac.uk.

Dr Matthew Brown
Consultant in Pain Management and Anaesthetics

NATIONAL CANCER PAIN NETWORK UPDATE

Pain associated with cancer continues to present a significant challenge to patients and clinicians alike. Cancer associated pain is common at all stages of cancer and arises due to disease, its treatment, or both.

Advances in oncological management are occurring at a rapid pace, resulting in a growing population of cancer survivors, a group in whom pain represents significant unmet need. Additionally, the COVID-19 pandemic has resulted in reductions in cancer diagnosis and later presentations of more advanced disease — a situation which is commonly associated with poor oncological outcomes and subsequently more severe pain.

Timely and effective

Ensuring access to timely and effective pain management for patients living with, and beyond, cancer is of paramount importance. Not only does it have a beneficial impact on the quality of life of patients and their carers and help minimise acute presentations with pain crises reducing demand on finite healthcare resource, it also commonly influences oncological treatment decisions, thereby impacting directly on survival rates.

With an ageing and increasingly multi-morbid population, it is clear that the task of providing adequate pain services to this cohort of patients is only going to become more challenging.

It is recognised that cancer pain remains poorly managed both at a global and national level; with a number of barriers existing to the delivery of optimal care. In 2018 the Faculty of Pain Medicine in collaboration with the Association for Palliative Medicine and The Association of Cancer Physicians published Framework for Provision of Pain Services for Adults Across the UK with Cancer or Life-limiting Disease. This presents a framework and operational guidance for improving pain services for adults across the UK with cancer.

The decision was taken to undertake a pilot of a National Cancer Pain Network (NCPN). I was tasked, along with Professor Michael Bennett, with leading this project.

Collaborative network

Expressions of interest were invited from pain departments across the country with the aim of building a collaborative network of centres. A total of 17 centres reflecting a diverse range of hospital type, existing service and geographical location applied to be involved and the inaugural meeting of the NCPN pilot was held at the end of June 2021.

During this meeting a number of common themes impacting on the provision of cancer pain services were identified. These included opaque referral pathways, the late referral of patients for interventions, the need for an improved evidence-base to guide therapeutic decisions and more well-defined commissioning and funding for services. In order to address these areas, four working groups have been formed: Education and guidelines; Interventions; Project advocacy; and Survivorship. Relevant aspects of audit, data-collection and research will be considered by each group. Additionally, a steering committee for the NCPN pilot will be created to ensure ongoing high-quality governance and will report to the Faculty of Pain Medicine's Professional Standards Committee.

It is hoped that the work of the NCPN pilot will help to define and shape high-quality cancer pain services and that as the project progresses membership will expand. The potential benefits to our patients of a harmonised and coherent structure for cancer pain management is clear and it is exciting that the project has commenced.

Dr Paul Wilkinson
PSC Chair

PROFESSIONAL STANDARDS

The Professional Standards Committee continues to transition from COVID-orientated work back to core work. A key new development is the completion of the update of *Core Standards for Pain Management Services in the UK.*

I would like to thank Dr Anna Weiss, Dr James Taylor, and Dr Rob Searle for their enormous effort to bring this document together. Thanks are also required to all the section authors who have renewed this document. This is a crucial piece of work for Pain Medicine and underpins many other professional documents and the work that we do. I hope this document continues to provide traction for change going forward, as it has done in the past.

Opioid reduction

The guidance for opioid reduction has now been completed and is on the website, and is designed for specialist professionals. It provides a useful companion document to Opioids Aware and to guidance regarding perioperative opioids, which are also available on the website.

Faculty events

Throughout COVID, Dr Sharma and Dr Srivastava have maintained a high quality events programme. This has required changes to remote education. The work done on event programmes can go under the radar. Recent opioid programmes on perioperative opioids were of extremely high quality and feedback was very positive. Using a remote media-based approach enabled us to introduce an international profile to the meeting, raising educational standards further, and may provide a major future opportunity. We enjoyed the virtual Annual Meeting in November and I would specifically like to thank them for their huge effort.

> COVID still causes significant problems and we are also reviewing all our COVID guidance to ensure it remains up to date.

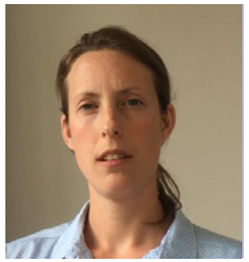
We are continuing to renew our portfolio of documents and the documents we plan to review including implementation policies by Dr Srivatsava. Dr Brown is also beginning an important piece of work creating a National Cancer Pain Network. Now that our bandwidth has increased, our work will hopefully be allowed to change from COVID issues to other important clinical matters. COVID still causes significant problems and we are also reviewing all our COVID guidance to ensure it remains up to date.

Pragmatic Pain

NICE Guidance continues to cause concern and a recent national survey reinforced this view. In conjunction with the Board, the PSC are exploring the provision of advice on individualised care. As NICE have emphasised, their work is to make recommendations across whole populations. This cannot be assumed to help us address clinical questions in individual complex patients, and so we are exploring what advice we can reasonably offer under the heading of 'pragmatic pain' management.

Inpatient Pain

In addition to all other PSC members, I would also specifically like to thank Emma Baird for leading on an opioid survey and contributing significantly to our work regarding in-patient pain and associated issues.



Naomi Scott,
Member of EPM
Advisory Group

ESSENTIAL PAIN MANAGEMENT (EPM)

The Essential Pain Management course has been successful in bringing a standardised, memorable structure to pain teaching for medical undergraduate and postgraduate staff of various grades across the UK.

EPM for Nursing and Allied Health Professionals

Where a principle focus has been on use of the model for education of junior medical staff, EPM has been useful in underpinning the teaching of senior staff dealing with complex pain presentations. The utility of this format can be seen in action during podcasts aimed at more senior anaesthetic staff within the FPM website[1]

The adaptability of the programme however, allows translation across other traditional boundaries. From its origins at the Australia and New Zealand Faculty of Pain Medicine, the initiative has been used to improve management of pain in developing countries, teach nurses, physiotherapists, psychologists and occupational therapists.

Since EPM can be described as the 'ABC' of pain management, in common with the life-support counterpart, this model forms an established basis for standardised pain management training across healthcare groups, and the use of a common language to communicate.

Indeed, EPM has been utilised within multidisciplinary teaching in the UK since 2017. It is well recognised that formal pain education has been historically limited within undergraduate training programmes.[2] Briggs et al (2011) identified that there was a disparity in the delivery of pain education in the UK and that there was little interprofessional learning.[3] Use of the simple EPM-based approach can encourage consistent use of language in cross-disciplinary discussion, and improved understanding of pain mechanisms.

A bio-psycho-social approach

A focus of the EPM model has been to elevate the importance of a bio-psycho-social approach to pain management, rather than a habitual emphasis on pharmacotherapeutic management. In this context non-drug treatments are discussed before drug treatments, and therefore do not marginalise non-prescribers, empowering practitioners to advocate for holistic management, challenge inappropriate prescribing patterns and consider opportunities to de-prescribe.

EPM and Non-Medical Prescribing (NMP)

Non-medical prescribing has evolved over the past 20 years to now include a range of professionals who may train to be independent prescribers including nurses/midwives, pharmacists, physiotherapists, podiatrists, optometrists, therapeutic radiographers and more recently, paramedics. Health Education England describe the NMP role as pivotal in terms of service delivery and in ensuring that patients have safe and timely access to the medicines they need whilst enabling health professionals to maximise their skills.[4]

It is extremely likely that NMPs who are not working in specialist pain roles will be required to prescribe for patients presenting with pain, particularly in areas such as MSK services and the management of long term conditions. The simple, systematic EPM model could be used to support this group of prescribers by providing them with the tools to make a systematic decision in relation to pain management.

Specifically, the EPM model could quickly signpost the NMP and other prescribers to the most appropriate treatment. NMP students are already taught about the importance of evidencing a systematic prescribing decision and the RPS competency framework is at the core of this.[5] The framework has 10 competencies which are illustrated as two domains; the consultation and prescribing governance. The core of the framework is that it is a set of competencies for all prescribers, regardless of their specialism. It could be argued that other models such as EPM should be used in practice alongside the framework to support prescribing in a core area such as pain.

The Aberdeen experience

In Aberdeen, we have been running a chronic pain study day for nursing staff for some years. In 2019 we expanded to include allied health professionals, with particular interest from our local physiotherapists. The EPM model has been easily incorporated within our sessions, with adaptation of case studies to suit the respective trainee field of practice. Pain management courses within our region attract oversubscription, reflecting a widespread desire for training in this area.

While the coronavirus pandemic forced major changes in the way we approach and deliver pain training, it has also generated opportunities to connect more widely with our healthcare teams via the virtual platform. We have experienced a notable increase in requests for pain teaching within other health professional groups' educational sessions, as well as for those in allied medical specialties.

References

1. https://fpm.ac.uk/fpmlearning/podcasts
2. Pain: A content review of undergraduate pre-registration nurse education in the United Kingdom. C. Mackintosh-Franklin. Nurse Education Today. 2017, 48, 84–89
3. Survey of undergraduate pain curricula for healthcare professionals in the United Kingdom. EV Briggs et al. Eur J Pain. 2011, 15(8):789-95
4. Health Education England (n.d.). Training for non-medical prescribers. https://tinyurl.com/y3469on4 [retrieved on 16/09/21]
5. A Competency Framework for all Prescribers. The Royal Pharmaceutical Society (2021). London.

Figure 1 *The RAT EPM Model: Recognise Assess Treat*

Transmitter Autumn 2021

e-PAIN

e-Learning for Pain Management

e-PAIN MODULE WRITERS WANTED!

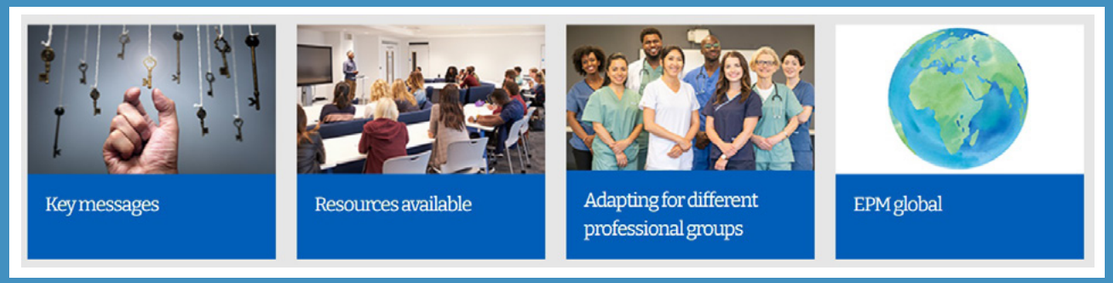
If you would like to be part of developing e-PAIN and help us write and review module content, email contact@fpm.ac.uk.

More information available at: https://fpm.ac.uk/e-pain

NEW EPM e-PAIN MODULE NOW AVAILABLE!

The module contains three sessions:

- **Introduction to EPM:** providing an introduction to the Essential Pain Management (EPM) framework.
- **How to teach EPM:** describes the Essential Pain Management (EPM) resources and how to use or adapt them to teach a variety of different healthcare workers.
- **EPM for medical students:** This session explains how to use the Essential Pain Management (EPM) framework at medical student level, in preparation for work as a foundation doctor.



Dr Ganesan Baranidharan
NSUKI President

NATIONAL NEUROMODULATION REGISTRY (NNR) UPDATE

The National Neuromodulation Registry (NNR) is mandated by Getting It Right First Time (GIRFT) and is an NHS England specialised service outcome indicator (Proportion of patients with neuromodulatory/ITDD devices submitted to NNR).

The NNR has more than 3,500 patients registered. The pandemic has had a significant impact on elective procedures including neuromodulation services. Intrathecal drug delivery is an essential service and every hospital with this service managed to refill and replace intrathecal pumps during the pandemic with no reported untoward incidents. As we are starting to see the services moving to some normality, the numbers enrolled are slowly increasing. The pandemic has had an impact and the NNR rolled out phase 2 and plans to explore further finance models to run the registry.

NNR Phase 2

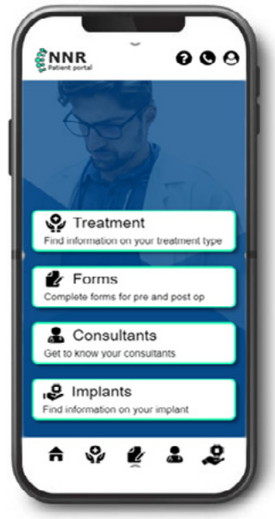
Phase 2 of the NNR was launched in October 2021. This includes the addition of Sacral Nerve Stimulation (SNS) and gastric stimulation for gastroperisis. We also increased the outcome measures by including PROMIS 29 for pain and appropriate questionnaires such as MIDDAS for headache and also male and female specific incontinence outcome measures for SNS.

Increasing outcome measures will add extra burden to the Neuromodulation team. We are planning on a patient application/portal, which could be used either on a computer or a smart phone with browsers such as Chrome or Safari. The patients, when offered this therapy, will be able to register on the NNR. They will confirm the registration via a link sent to their email address. Once registered, the patients can choose the hospital, therapy and also the consultant performing the procedure. There will be a small bio-data of the implanter with picture and the device details along with important features such as MRI conditionality and troubleshooting links. The outcome measures will be on the application enabling the patients to fill them before the implant. The neuromodulation centre will be able to add the device details after the procedure. The follow up data will be collected by automated email or contact to the patient's smart phone app.

Funding and research

The user fee fo the registry is managed by the Neuromodulation Society of UK and Ireland (NSUKI) . This is a recognised funding model for most registries. There were some initial difficulties in identifying the appropriate managers within each trust. We are currently getting this detail through the super users of each hospital. We expect to be independently funded to run the registry by 2022 (delayed due to pandemic).

Research will be an integral part of developing this registry. We are currently looking at inequalities in access and any relation with socioeconomic status to outcome and access as our first project. NNR provides ability for industry to perform post CE mark mandatory data collection studies.



FFPMRCA EXAMINATION UPDATE

Dr Nick Plunkett
Chair FFPMRCA

Dr Ganesan Baranidharan
Vice-Chair FFPMRCA

Since the last Examinations report in the spring edition, the Faculty has delivered two further exams: the SOE on 13 April 2021, and the MCQ for the Autumn sitting on 25 August 2021.

The SOE was again performed remotely. As will now be recognised, both the Faculty of Pain Medicine examiners, and the RCoA Exam Committee are now experienced and skilled at the delivery of remote exams, with very positive feedback obtained following the first remote delivery of the SOE in October 2020 from the examiners, auditors, and candidates. Therefore, there was a high degree of confidence with respect to the delivery of this exam.

The prior specific and bespoke processes, essentially unaltered from our previous remote exam, were employed, and there were no significant technical glitches with respect to the delivery of the examination.

A total of 20 candidates presented for examination, and following the usual and robust quality assurance processes to define the pass mark, a total of 14 candidates were considered to have achieved the required standard, with the pass park set at 32. This represents a 70% pass rate, consistent with recent average pass rates.

Candidate feedback

As before, candidate feedback was sought, with satisfaction expressed with respect to the online booking and delivery process, with a high degree of satisfaction also for audio-visual quality.

There has been a recent sitting of the MCQ remotely on 25 August 2021. There were 10 candidates and there were no reports of significant technical glitches. The FPM Anghoff Group sat on 8 September to consider the examination questions and raw results in detail. Each question was reviewed and some were removed for reasons of ambiguity, for which no candidate was disadvantaged. A total of 16 marks out of 400 marks were thus removed, and following the usual processes a pass mark of 264/386 was agreed, giving a pass mark of 68.39, which 7/10 candidates achieved, giving a pass rate of 70%, consistent within the expected range of previous pass marks.

Due to the now established and reliable delivery of remote MCQ examinations across RCoA and FPM, and candidates very positive feedback on this process, future candidates should be aware that it is planned that the MCQ will continue to be delivered remotely going forward.

The SOE examination 12 October 2021 will also be delivered remotely. It remains the hope and expectation that in the new year (2022) the Faculty will be able to revert to face-to-face SOE examinations.

New examiners

The Faculty is now in a position to advertise for new examinerships. We encourage all eligible colleagues with an interest and some experience in teaching, training, research, and assessment methods/examination to apply for examinerships. Applicants will be assessed according to robust criteria, and are invited from all fields of pain medicine, including acute, chronic, cancer, and paediatric pain medicine, with a special encouragement for female and BAME colleagues to apply. The details will be published on the FPM website, by email to all Fellows, Faculty tweets, and the President's News.

Thank you

The FPM Court of Examiners would like to thank the RCoA exams department especially Fiona Daniels, David Rowand and Beth Doyle, for their dedication and resilience in continuing to deliver the FPM exams within the constraints imposed by COVID, and in effect normalising the candidate experience as much as possible.

	FFPMRCA MCQ	**FFPMRCA SOE**
Application and fees not accepted before	Mon 22 November 2021	Monday 17 January 2022
Closing date for FFPMRCA exam applications	Thursday 6 January 2022	Wednesday 2 March 2022
Examination date	Wednesday 9 February 2022 **Online**	Tuesday 29 March 2022 **Online TBC**
Examination fee	£560	£780

FPMLearning is updated every month. Be sure to have a look at 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

EVENTS UPDATE

Dr Manohar Sharma
Educational Meetings Advisor

Dr Devjit Srivastava
Deputy Educational Meetings Advisor

The FPM held two webinars on Acute pain and related issues on 8 and 29 June 2021. This was an experiment in having short succinct webinars due to COVID restrictions of face to face meetings.

We had 54 delegates which consisted of 7 nurses, 13 trainees/students and 34 doctors. Nearly 80% of the respondents found the content of the webinar good or very good while 100% were satisfied with time keeping.

Webinar 1

Webinar 1 was held on 8 June 2021. Dr Paul Wilkinson spoke about the recent FPM Opioid and Surgery guidance (O&S) that emphasises perioperative stewardship (**Figure1**) and emphasised the need for a transitional care model. The talk was well appreciated with a junior doctor requesting more examples to highlight the good practices in the guidance. One of the key recommendations of the (O&S) guidance is that pain specialists should be involved in complex pain prehabilitation. Dr Sailesh Mishra very ably highlighted the practical implementation of this recommendation and the specific issues that pain doctors should focus on. Prehabilitation of complex pain patients also includes physical rehabilitation and the talk by Prof Paul Cameron (Physiotherapy) reinforced this concept as sound but also highlighted that evidence was scant in this area. One of the reasons patients continue to take opioids long-term after surgery is due to the fact that chronic post surgical persistent pain is frequently overlooked in these patients. Dr Hance Clarke masterfully highlighted the setting up and functioning of the first transitional pain care service in Canada and maybe the world. Dr Beth Darnall from Stanford highlighted the role of single session of psychological pain relief class called 'empowered relief' tailored to the surgical population as 'My surgical success' could help patients experience less pain after surgery. Dr Nicholas Levy made a strong case for using Immediate release opioids in the immediate post-operative period instead of slow or prolonged release opioids.

One of the ways to decrease opioid induced hyperalgesia in chronic pain patients is to decrease opioids prior to surgery improving pain outcomes. This was discussed in detail by Dr Heath McAnally who demonstrated improved outcomes in pain if preoperatively opioids were reduced by 50%. However Dr McNally had a word of caution for performing this de-escalation in a planned and deliberate way after a thorough chronic pain assessment. The speed of de-escalation and the degree to which opioids may be safely de-escalated prior to surgery is yet to be clearly delineated and hence de-escalation should be performed with due care. Dr Susan Hill who is a Consultant Vascular surgeon highlighted the need for surgeons to also come on board with this important guidance.

Webinar 2

Webinar 2 was held on 29 June 2021. Dr Rosel Tallach highlighted the practical steps in setting up a rib fracture pathway. Having such a pathway is vital to providing pain relief to rib fracture patients as well as minimising complications such as chest infections etc. Dr Suchitra Kanagasundaram discussed the management of case of a complex regional pain syndrome patient for surgery. The huge number of unknowns faced by anaesthetists/Pain specialists was ably highlighted along with the CRPS guideline and a charity for patients called Burning Nights. Mark Koning from the Netherlands spoke about the effectiveness, dosing and safety issues surrounding Intrathecal opioids and highlighted a ceiling dose for efficacy over 500 mcg. Dr Jayne Halcrow educated the audience on how to perform serratus anterior blocks as these blocks have become popular recently. Dr Manohar Sharma highlighted recent guidance and from the FPM that are available on the FPM website. Dr Sharma highlighted the surgery and opioid guidance and the epidural guideline in particular to the audience. Dr James Cox is a pain geneticist from University College London and the genetics expert behind two of the most influential publications in congenital insensitivity to pain (Nav1.7 channel and FAAH out gene). James highlighted the key issues in the development of gene therapy for pain conditions. I reviewed the top 5 acute pain papers in 2020/2021. The nociception level (NoL) index is an index of nociception based on nonlinear combination of heart rate, heart rate variability. Meijer's RCT with a small sample size with reported that NoL guided care resulted in less time in post anaesthesia care unit and decreased pain scores post operatively and appears promising as a tool to measure intraoperative nociception.

The other papers highlighted included CYPD6 genetic testing guided opioid therapy to improve post operative pain management, the efficacy of immediate release Tapentadolol in acute pain setting, a met-analysis of 281 trials highlighting that perioperative gabapentinoids did not effect any clinically meaningful decrease in acute, sub-acute and chronic pain.

We do hope to organise face to face edication meetings from 2022. If you have a relevant topic and a speaker, please get in touch and email us: dev.srivastava @nhs.scot or manohar.sharma@thewaltoncentre.

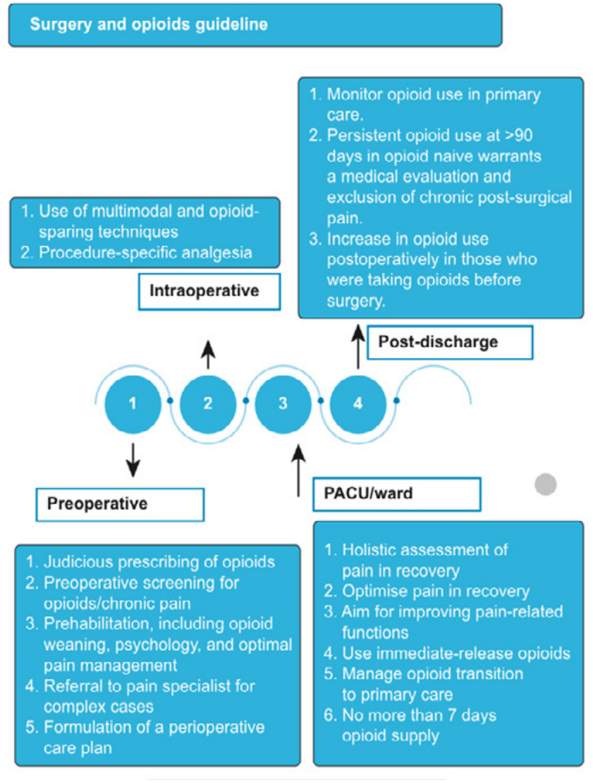


Figure 1 *Key features of the FPM 'Surgery and Opioid Guidance'*

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

DAY 1: Monday 31 January 2022

Faculty of Pain Medicine
Acute/In-hospital Pain Study Days

www.fpm.ac.uk/events **5 CPD points per day anticipated**

09:00	**Welcome and Introduction**	
09:20	Persistent headache and low back pain after accidental dural puncture in the obstetric population	Mr Niraj Gopinath, Leicester
09:50	Methoxyflurane analgesia for acute pain	Dr Stuart Hartshorn, Birmingham
10:20	Managing acute flare up of Trigeminal neuralgia in the hospital setting	Dr Manjit Matharu, London
10:50	**Break**	
11:20	Managing opioid induced constipation. Learning from palliative care.	Dr Jason Boland, Hull and York
11:50	PANDOS study - aims to document perioperative opioid use and its safety in Europe and to describe its association with adverse events and persistent pain.	Prof Patrice Forget, Aberdeen
12:20	*Opioid prescription at postoperative discharge: a retrospective observational cohort study*	Prof Dileep Lobo, Nottingham
12:50	**Lunch break**	
13:50	Epidural safety in the hospital and palliative setting	Dr Richard Gordon-Williams
14:20	The new CCT for Anaesthesia syllabus - focus on pain training	Dr Nigel Penfold, Bury st Edmonds
14:50	Is there any advantage in integrating acute and chronic pain services?	Dr Gordon McGinn ,Glasgow
15:20	Leading with compassion -Staff well being in dire times	TBC
16:00	**Close of meeting**	

Please note that the programme and timings are subject to change.

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

DAY 2: Tuesday 1 February 2022

Faculty of Pain Medicine
Acute/In-hospital Pain Study Days

www.fpm.ac.uk/events **5 CPD points per day anticipated**

09:00	**Welcome and Introduction**	
09:20	Peri-operative Gabapentinoids - Is there enough evidence to continue?	Dr Harriet Kemp, London
09:50	How to conduct/lead an effective Acute Pain round	TBC
10:20	Perioperative anxiety and pain	Dr Mark Rockett, Plymouth
10:50	**Break**	
11:20	Pain signature in the brain	TBC
11:50	Sleep and Pain –what help is out there?	TBC
12:20	*Gap analysis of UK Pain Services*	Dr Devjit Srivastava, Inverness
12:50	**Lunch break**	
13:50	Perineural adjuncts for peripheral nerve block	Dr Neel Desai, London
14:20	**Debate:** on Lidocaine infusion for acute post-surgical pain:	For: Dr Shyam Balasubramanian Against: Dr Sandeep Kapoor
15:00	Medicolegal aspects/implication for peripheral nerve blocks	TBC
15:30	N20/Entonox and climate change/sustainability	Dr Ken Barker, Inverness
16:00	**Close of meeting**	

Please note that the programme and timings are subject to change.

www.fpm.ac.uk | contact@fpm.ac.uk | @FacultyPainMed | 020 7092 1747

IN MEMORY OF WILLIAM CAMPBELL

It was with great sadness that we learned of the death of William Campbell on 16 May 2021. To those of us in the Pain Medicine community William was best known for his dedication to his patients and practice in pain in Northern Ireland, and for his devotion to the British Pain Society.

William graduated from Queen's University in Belfast in 1976 and began his medical life in the Royal Victoria Hospital in Belfast. He became a highly skilled anaesthetist and undertook Pain Medicine training in Northern Ireland and England. William was appointed to his consultant post at the Ulster Hospital, Dundonald in 1984. Unusually, he had subspecialty interests in both Intensive Care Medicine and in Pain Medicine.

Pain Medicine was William's great professional passion. He published 16 papers, wrote numerous educational articles and authored and edited many textbooks. He was a keen teacher and mentor, and held the post of the Royal College of Anaesthetists Regional Advisor in Pain Medicine, contributing and responsible for the pain education of anaesthetists in Northern Ireland.

Many of us recall William in a number of roles in the British Pain Society; it is of note that he held all the BPS offices, all of which he carried out with great ability, skill and dedication. We perhaps know him best for the time he was President from 2013-2016, when he led and guided the society with diplomacy and tact. His contribution to the Faculty of Pain Medicine during this time was invaluable.

We will always remember William for his beloved hobby of photography and indeed how skilled he was. He was ever there at pain meetings with his camera, capturing the mood of the wonderful times shared. When William became President the Society joke became "Who will take the photos now?"

William was a wonderful combination of kindness and strength, wisdom and consideration, leadership and friendship, was profoundly caring and always smiling and cheerful.

The Faculty offers its deepest sympathy to William's loving family.

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.

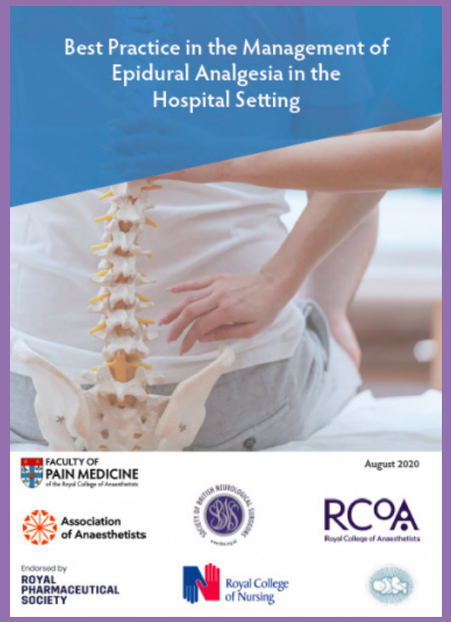
Recommendations for Good Practice in the Use of Epidural Injection for the Management of Pain of Spinal Origin in Adults. Second Edition.

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.



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