FACULTY OF
PAIN MEDICINE
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TRANSMITTER

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Do we need a new Chronic Pain definition?

OPIOID-INDUCED HYPERALGESIA

N_2O/ENTONOX & CLIMATE CHANGE

SOE EXAMINATION PERFORMANCE

CONTENTS

Specialist in Pain Medicine: My Journey
HemKumar Pushparaj's path to becoming Britain's first full-time specialist in Pain Medicine.
page 6

Nitrous Oxide: It's been around
Nitrous oxide is a potent greenhouse gas with an atmospheric lifetime of 110 years.
page 16

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WELCOME

Welcome to the new edition of *Transmitter*!

We are living through a very rapid change politically and economically, and significant international events impact us all in our daily lives.

Since the publication of the last *Transmitter* in spring, the Faculty of Pain Medicine has published the *Four Nation Strategy for Pain Management*. FPM is hopeful that this document provides direction and support for our members in shaping and further developing pain services, and their interaction with service managers and commissioners.

I am grateful to our current Dean Dr Loraine de Gray for her efforts on GMC credential for Pain Medicine. This work has been ongoing since 2018, with the Pain Medicine curriculum being endorsed by the GMC curriculum oversight group and subsequently by the GMC curriculum advisory group in August 2022. FPM is currently working with the GMC on the framework of implementation of credentials. Credentialing for the Pain Medicine Specialist is another milestone for the Faculty. This will open the road to training in Pain Medicine to non-anaesthetic specialties, thus providing depth and stability to the workforce of doctors who work as Pain Medicine Specialists, allowing them to support services and to raise standards in practice of Pain Medicine.

The FPM Court of Examiners have decided that it would be a learning point for all concerned, if there was a specific report covering qualitative aspects of SOE examination question performance. This will assist future candidates and their trainers, and we have highlighted some questions in this edition of *Transmitter*.

ICD-11 pain classification was presented to the World Health Assembly in May 2019 and came into effect on 1 January 2022. This is an effort to improve understanding and recognition of chronic pain as a disease. However, we still grapple with various chronic pain definitions and terms, and some of you may find the article in this edition on 'Whither with CPP, ICD-11 and CRPS?' interesting.

The Annual Meeting of the Faculty of Pain Medicine, which took place in London on 25 November 2022, provided ample opportunity for education and updates on some of the exciting, relevant and topical issues in Pain Medicine, especially as routine clinical work picks up.

Also, please contact FPM if you have any queries/comments on professional standards or training and assessment issues where you would wish FPM to provide further direction, guidance or support.

Manohar Sharma

Dr Lorraine de Gray
FPM Dean

MESSAGE FROM THE DEAN

It is with great pleasure that I write my first Dean's update. I am honoured to have the support of the Board of the Faculty to take on this role as the sixth Dean — this year being the fifteenth anniversary of the Faculty of Pain Medicine.

I would like to start by thanking my immediate predecessor, Dr John Hughes who over the past three years as Dean has worked tirelessly throughout his tenure.

Dr Hughes led the Faculty through the turbulence of the ongoing pandemic, ensuring that Fellows, Members, trainees and trainers continued to be supported with guidance published on a regular basis. Dr Hughes has also been instrumental in the development of Credentialing, as well as supporting the production of the second edition of the *Core Standards for Pain Management Services in the UK*. He has also worked to promote co-operative working with the British Pain Society and other national groups which influence health care in relation to pain management. These include amongst others the Personalised Care Institute, the Pain Parliamentary Campaign Group and Best MSK Health Collaborative.

Legacy

His legacy will be the production and publication of the *Four Nation Pain Strategy*, a document which provides a framework where pain management integrates across other stakeholder sectors of health and social care. It will be used to coordinate, deliver and further develop care using the resources and pathways already available while supporting future quality service developments. The Strategy has been endorsed by multiple regulatory bodies and royal colleges. As Dr Hughes' Vice-Dean during the past three years, I have learnt a lot from him — I know I have very large shoes to fill and take great comfort in knowing that Dr Hughes will remain a board member for one more year.

It is with great pleasure that I introduce Dr Ganesan Baranidharan as the new Vice Dean. Barani brings a wealth of experience with him, currently also holding the posts of Chair of the Professional Standards Committee as well as Vice Chair of the Court of Examiners.

I must mention at this point the Faculty Secretariat who work extremely hard. During the pandemic they have risen to the challenge of virtual and hybrid working, allowing us to meet very tight deadlines with publishing guidelines. The Faculty Team is contactable via contact@fpm.ac.uk and are always very happy to help with any queries or concerns.

Board election

Thank you to all who stood and for all who voted in the recent board elections. I would like to extend a very warm welcome to Dr Sarah Love-Jones, who has been elected and will take up her post in March 2023. I would also like to thank Dr Sanjeeva Gupta who will be demitting as Board Member at that point in time. Dr Gupta has made very significant contributions during his tenure and will be missed.

I would also like to thank Dr Helen Makin who is leaving her role as Lead for Essential Pain Management. In the past years, Dr Makin has worked incredibly hard to advance teaching of pain medicine to undergraduate and foundation year doctors and EPM has now been incorporated into the curriculum of many universities across the country.

Milestones

I am also delighted to report that the GMC Credential for the Pain Medicine Specialist has reached another milestone. In 2015 the GMC introduced the concept of Credentialing defined as "a new process to formally recognise a doctor's expertise in a specific area of practice". The Faculty of Pain Medicine applied to the General Medical Council to be one of the five pilot Credentials in 2018 and was accepted in 2019. Over the past four years, there has been significant progress with the curriculum first being endorsed by the GMC Curriculum Oversight Group (COG) in 2020 and subsequently reviewed and endorsed by the GMC Curriculum Advisory Group (CAG) in August 2022. The FPM is currently working with the GMC on the framework of implementation of Credentials, with the next step being grandfathering into the Credential, which we anticipate will occur early next year.

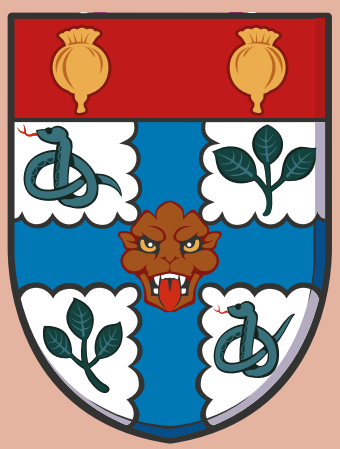
Credentialing for the Pain Medicine Specialist is another milestone for the Faculty. For the first time it will open the road to training in Pain Medicine to non-anaesthetic specialties. The Credential will be open to pre- and post-CCT doctors as well as Specialty Grade doctors. It will provide depth and stability to the workforce of doctors who work as Pain Medicine Specialists within the UK, whilst raising standards in the practice of pain medicine. Credential Holders will be listed as Pain Medicine Specialists in the GMC List of Registered Practitioners. This importantly improves patient safety as it allows recognition of specialist training in Pain Medicine by patients and employers.

A second credentialing stream that we continue to work with in conjunction with the British Pain Society, Health Education England and NHS Education for Scotland, is a Credential for Advanced Health Care Practitioners in Pain Management. This is still in the early stages of development and is intended to provide a workforce of primary care doctors and allied health professions in the community, that can manage patients with less complex pain presentations and also provide a step-down service for patients discharged from pain services in secondary and tertiary care.

Workforce

Lastly, I must mention the Workforce Census, which the Faculty undertakes every five years. The 2022 survey has been sent out to our membership. With grandfathering for the Credential anticipated to be occurring in the (hopefully) not-too-distant future, this census will provide us with extremely valuable data. Please do ask any medical colleagues working in pain services but who currently have no affiliation with the Faculty to contact us so they can also complete the survey. The deadline for completion is 16 January 2023.

FACULTY UPDATE



New Fellows by Examination and Assessment

Dina Abdel-Gadir
Hareth Bader
Christopher Bull
Barry Campbell
Stephanie Hii
Natasha Kale
Jawaad Saleem Malik
Molola Oyewole
Richard Wassall
Steven Young

New Affiliate Members

Vasiliki Archontaki
Nilay Chatterjee
Samaresh Das
Rajashree Madabushi

SPECIALIST IN PAIN MEDICINE: MY JOURNEY

Dr Hemkumar Pushparaj
Specialist in Pain Medicine,
The Walton Centre

I have been appointed as a specialist in Pain Medicine and neuromodulation at the Walton Centre NHS Foundation Trust in July 2022. I am the first full-time specialist in Pain Medicine in the UK.

This editorial is to briefly share my journey into this current post. I was trained in anaesthetics at the All India Institute of Medical Sciences, New Delhi, India, which is one of the leading institutes in the country.

India to Aberdeen

After my MD in anaesthetics, I was looking to explore anaesthesia practise in the western world. I had the chance to work as a MTI (Medical Training Initiative) doctor for two years at the Aberdeen Royal Infirmary. During my tenure, I had the chance to observe and work with the chronic pain management team, which opened my eyes to the vast field of pain management options available in the western world. Furthermore, I wanted to explore the options in interventional pain management and after searching online and on various pain society websites (which provide fantastic resources for fellowships available to international applicants), I found a few suitable options.

Toronto to Liverpool

I had a couple of interviews and was selected for an interventional fellowship post at Toronto Western Hospital, Ontario, Canada. The training there was intense but provided a fantastic learning experience. My interest for neuromodulation was sparked during my time in Aberdeen, and I managed to further my skills to some level at Toronto. After 18 months in Toronto, I started to search for a dedicated neuromodulation fellowship, which was not available in Canada at that time.

However, I had an overwhelmingly positive response from the interview panel from the Walton Centre in Liverpool, and eventually I moved to the UK in late 2020. With the obvious shortage of training during pandemic, the department agreed to extend my fellowship for another year. During these two years I managed to get through FFPMRCA. My department and RAPM were very helpful and encouraging and I managed to get through both MCQs and SOE in one go. I also had a number of academic publications during this time.

With this background and an unexpected sudden shortage in pain clinicians doing neuromodulation, my department was keen to retain me long-term. After my clinical and technical skills were peer reviewed, they made sure that I was ready for the job as specialist in Pain Medicine. I applied for the specialist job with interest in neuromodulation at the Walton Centre NHS Foundation Trust and was appointed in July 2022.

Scope of work

My scope of work currently includes general pain, neuromodulation, female pelvic pain, and pain management programme. I still work with my senior colleague, assisting him in theatres during difficult and complex cases. I am involved in various academic events, and I am organising an in-person practical pain management course next year. Additionally, I am the audit lead and involved in several local and national research activities.

Influences

I think my progress to become a specialist in Pain Medicine was greatly influenced by my varied experience. I tried to keep my skills as up to date as possible in different aspects of Pain Medicine. I also cannot deny a factor of chance in being in the right place at the right time. I was also the first anaesthesia MTI trainee in Aberdeen and the first neuromodulation trainee at the Walton Centre, Liverpool.

For fellows and non-APT pain trainees, I would suggest choosing a particular field in Pain Medicine to focus on and develop a unique set of skills which makes you an exciting option wherever you apply for a job.

WHITHER WITH CPP, ICD-11 AND CRPS? ICD-10 AND THE NEED FOR A NEW CHRONIC PAIN DEFINITION

Dr Rajesh Munglani
Consultant in Pain Medicine
Cambridge

Dr Manohar Sharma
Consultant in Pain Medicine
The Walton Centre

The ICD-10 classification had many shortcomings. It is important to understand these limitations which led to the imperative to develop a better classification system. Pain classification in ICD-10 refers to pain attributable exclusively to an underlying pathophysiological mechanism. In the absence of a clear (pathophysiological) aetiology, and when psychological and social factors seem to be contributing to a chronic pain presentation, ICD-10 offers only the option of "somatoform pain disorder". However, this term or diagnosis cannot be used when pathophysiological factors are also considered to be contributing to the pain problem. A way forward was proposed to designate chronic pain its own category in ICD-11 and hence the term Chronic Primary Pain (CPP). But what did it mean?

"The concept of chronic primary pain (CPP) overcomes these limitations by providing a clear definition unencumbered by inappropriate classification within psychiatric disorders, and it allows for subtypes. The challenge to conceptualize chronic pain as a long-term condition has been accentuated by advances in the understanding of psychological, social, and central nervous system mechanisms that may account for many hitherto inexplicable pain phenomena. These developments have meant that attempts to classify chronic pain presentations need to acknowledge the likelihood of multiple interacting contributors to a chronic pain presentation." (Nicholas et al. 2019)[1]

A study looking at the practical differences in pain classification between ICD-10 and ICD-11 when applied to chronic pain patients found some interesting results:

- That 30% of the population would be assessed to have chronic pain. The assessment found that the incidence of self-reported chronic pain was lower (n= 337) than on clinical examination (n=399)

- That 63% had chronic primary pain, 81% musculoskeletal pain, and 77% more than one chronic pain condition where CPP patients were defined as having symptoms that could not be accounted for by the underlying biomedical disease process
- The incidence of psychopathology was said to be similar in the two groups and was reported as 10%.[2]

The thrust here seems to be that a diagnosis of CPP (or centralised pain or pain as a disease) is independent of any concurrent psychological or psychiatric diagnosis. In Nicholas et al. (2019), it also states:

"the diagnosis of CPP is considered to be appropriate independently of identified biological or psychological contributors, unless another diagnosis would better account for the presenting symptoms".

However, a slightly different emphasis is given later in Nicholas et al. (2019) where the CPP seems to implicitly encompass psychosocial aspects.

"...The challenge to conceptualise chronic pain as a long-term condition has been accentuated by advances in the understanding of psychological, social, and central nervous system mechanisms that may account for many hitherto inexplicable pain phenomena. These developments have meant that attempts to classify chronic pain presentations need to acknowledge the likelihood of multiple interacting contributors to a chronic pain presentation. The alternative of pain being either 'somatic' or 'psychogenic' has become obsolete in several ways. Psychological factors such as learning and coping play a role in chronic pain that was previously considered 'somatic', e.g. chronic osteoarthritis (now classified as one of the 'chronic secondary pain syndromes'). Vice versa, biological changes are closely linked to psychological processes; this is most obvious in neurophysiological brain reactions contributing to changes in pain perception. As will become apparent, these developments are acknowledged by the new diagnostic entity of CPP."

> The general results of lumping together of such diverse categories of pain conditions into the CPP categories seem to have led to clinical nihilism.

Indeed, other research has shown that CPP is associated with a higher incidence of health-related guilt and anger[3,4] and the same risk factors for chronic pain (and CPP) also apply to depression[5]. Thus, it may be very difficult in an individual to tease out chronic primary pain from all the other psychosocial contributions and our current view is to accept the ambiguity that CPP will usually encompass the psychosocial aspects, but CPP can also be diagnosed in the absence of any apparent psychosocial contributors.

Are some pains primarily a CPP?

The next leap in the development of the concept of CPP was to assign certain pain conditions primarily to the CPP category. From Nicholas et al. (2019) again:

"Many chronic pain conditions have an obscure aetiology and pathophysiology, but they are characterized by a complex interplay of biological, psychological, and social factors.Currently, these conditions are covered by labels such as chronic widespread pain (CWP), fibromyalgia, complex regional pain syndrome, type I (CRPS1), temporomandibular disorder (TMD), irritable bowel syndrome (IBS), and most back pain and neck pain conditions, which invariably include vague and ambiguous terms such as 'nonspecific', 'somatoform', or 'functional'."

While not disputing the psychosocial contributions to these conditions, the conditions mentioned above are themselves diverse and to lump them together probably is disadvantageous to an individual, in whom the relative contributions of biomedical causes (or chronic secondary pains CSP) and psychosocial / chronic primary pain aspects is unknown. For example, if we accept that 70% of individuals with lower back pain is nonspecific, it means that in 30% of cases it is not. We also must consider the likelihood that we may have both a CPP and a CSP concurrently in the same patient.

Part of the role of a Pain Medicine consultant is to consider a pain diagnosis[6]; we have to understand clinical symptoms, examine and investigate in an individual and ascertain the relative contributions of the bio (CSP) and psycho

and social aspects (CPP). It is a challenge in clinical practice to disentangle these components due to still evolving understanding of neurobiological pain mechanisms.

Furthermore, the general results of lumping together of such diverse categories of pain conditions into the CPP categories seem to have led to clinical nihilism. Such conditions should only be treated with those therapies that have shown to work in CPP – which according to NICE are exercise and psychotherapy and an antidepressant. This has led to many patients having their medications withdrawn and limited the opportunities to try biomedical therapies which may also be relevant to their condition.

Aforementioned has occurred in the case of CRPS. Rajesh Munglani was asked why he was still going to recommend spinal cord stimulation and analgesia for an intensely painful

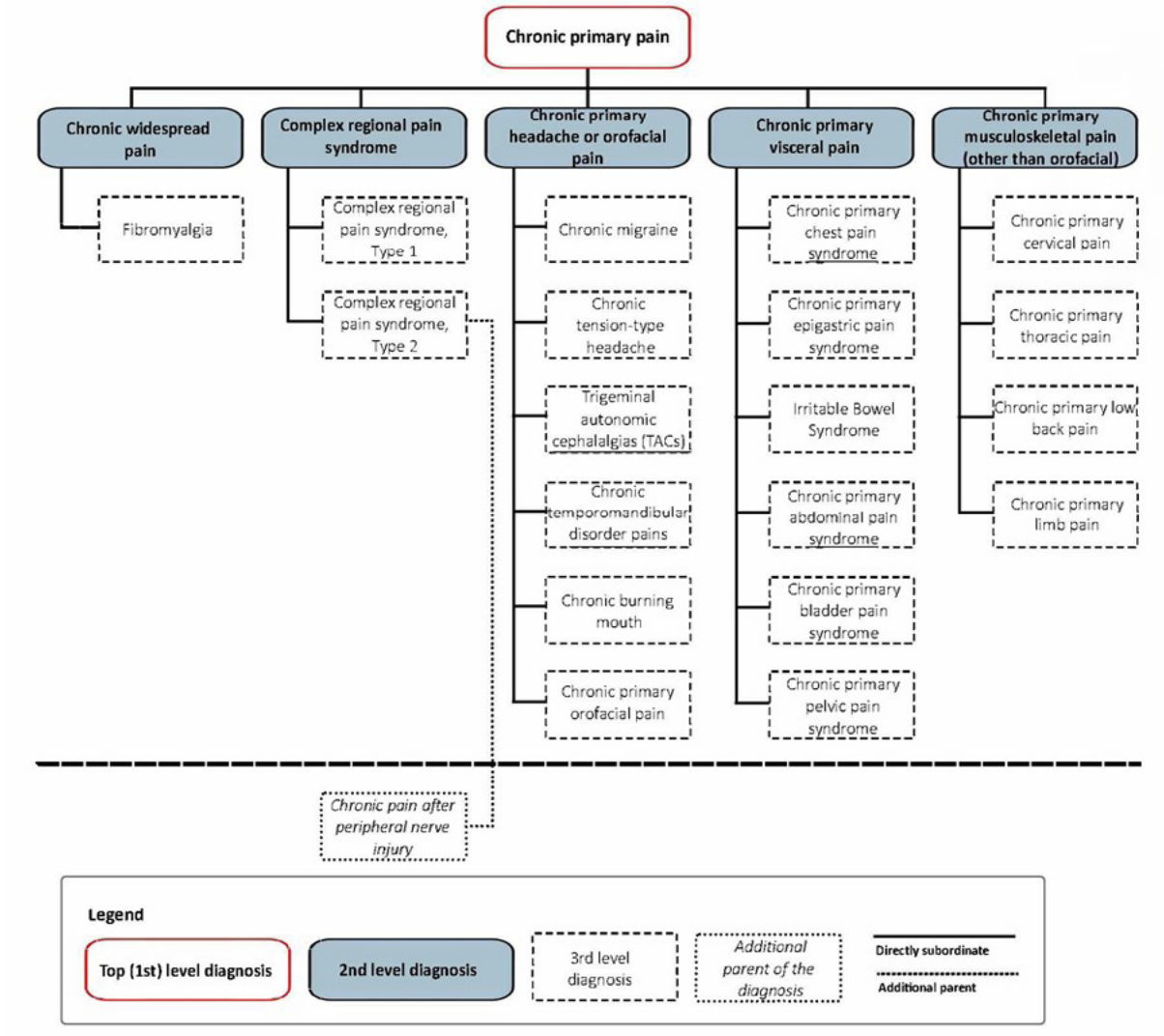


Figure 1: Multiple parenting that is the pain process or entity –'the child' in a patient can simultaneously belong to multiple parent categories. From Treede (2019). (Redrawn) "The general structure of the classification of chronic primary pain. Level 1 and 2 are part of the 2018 frozen version of ICD-11: level 3 has been entered into the foundation layer. According to the new concept of multiple parenting in ICD-11, an entity may belong to more than one group of diagnoses ." (original Treede caption).

case of CRPS when CRPS was now considered a CPP? The question is addressed near the end of the article and illustrates the unintended consequences of not understanding the guidelines or how ICD-11 pain classification works and its implications for diagnosis and treatment.

Origins of ICD-11 and the concept of multiple parenting

As part of its mandate to advance global health, the WHO took on the task of updating what was then known as the International List of Causes of Death, a taxonomy used to track mortality across the globe. The WHO then updated the list to include morbidity, which is defined as the amount of disease in a population and renamed its effort as the ICD. ICD-11 was presented to the World Health Assembly in May 2019 and came into effect on 1 January 2022.

In preparation for this, six years of work was required from a joint IASP-WHO

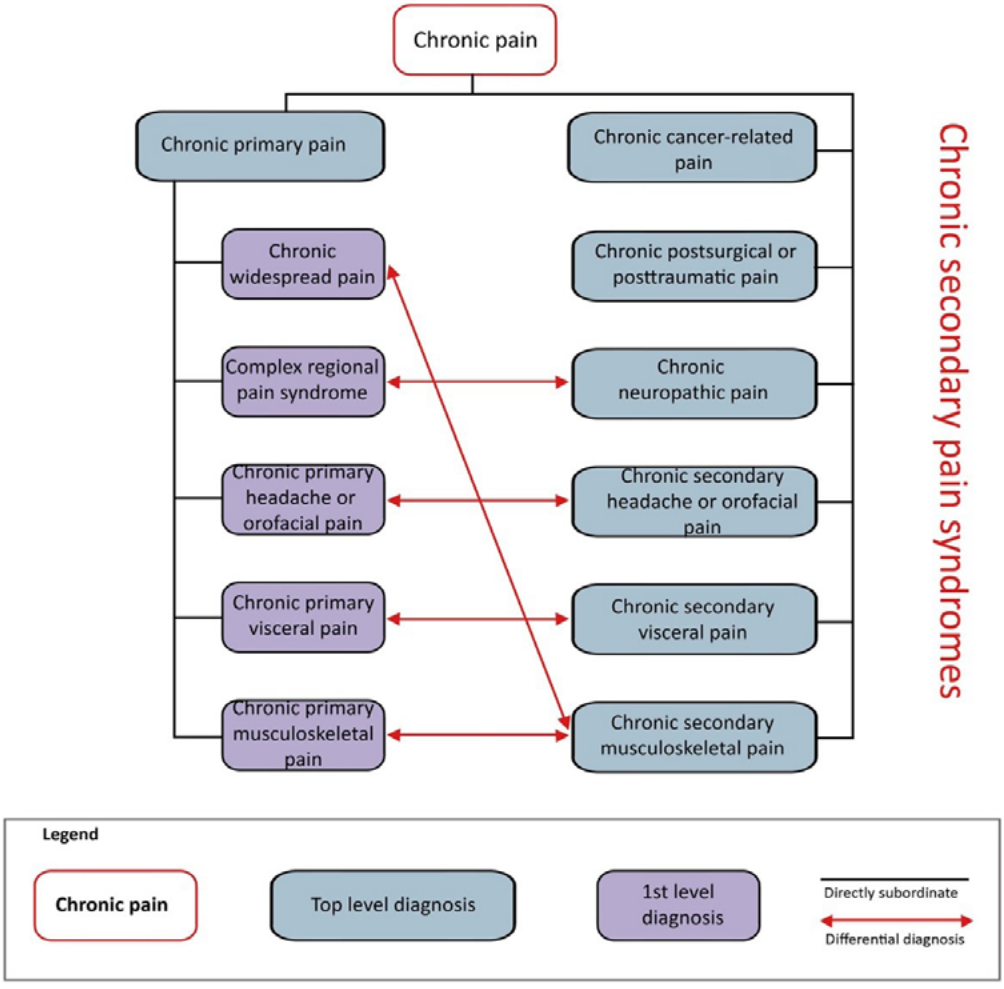


Figure 2: Structure of the IASP Classification of Chronic Pain. In chronic primary pain syndromes (left), pain can be conceived as a disease, whereas in chronic secondary pain syndromes (right), pain initially manifests itself as a symptom of another disease, such as breast cancer, a work accident, diabetic neuropathy, chronic caries, inflammatory bowel disease, or rheumatoid arthritis. Differential diagnosis between primary and secondary pain conditions may sometimes be challenging (arrows), but in either case, the patient's pain needs special care when it is moderate or severe. **After spontaneous healing or successful management of the underlying disease, chronic pain may sometimes continue and hence the chronic secondary pain diagnoses may remain and continue to guide treatment as well as health care statistics.** From Nicholas (2019). (Redrawn)

Working Group, led by Rolf-Detlef Treede (who became President-elect of IASP in 2012) and the co-chair Winfried Rief, which gave rise to the new classification system for chronic pain to be adopted in ICD-11. The new system introduced a single code for the diagnosis of chronic pain alongside other codes for other chronic pain conditions. Critically, this new system of classification viewed chronic pain as both a standalone health condition, as well as a symptom that is secondary to an underlying disease. This allowed a further refinement of classification since it allowed multiple overarching disease states, and one of these disease states could be CPP, but importantly you could have another contributory disease state.

If we imagine chronic pain as a 'child', then it could have two (or even more) parent diagnoses. Furthermore ICD-11 was also nuanced and adaptable and takes into account not only the intensity of pain but also pain-related disability and distress, along with psychosocial factors that contribute to the experience of pain[7]. In summary, the (profoundly important) concept was that in ICD-11 a chronic pain condition in an individual could have multiple parent diagnoses.

In ICD-11, where now chronic pain itself is considered a disease process or condition in its own right, as a diagnosis, it is given a name, Chronic Primary Pain (CPP). The biomedical components would be loosely termed Chronic Secondary Pain (CSP) and the two could co-exist. Thus, the ICD-11 classification recognised the complexity and the makeup of chronic pain.

This concept of multiple parenting is discussed at length in the explanatory papers produced at the time. Treede (2019)[8] states:

"...multiple parenting concept of WHO for ICD-11 [...] in contrast to the strictly linear structure of all previous versions of ICD, ICD-11 allows for any given disease ('child') to belong to more than one section ('parent'). This is called 'multiple parenting'."

This new system of classification viewed chronic pain as both a standalone health condition, as well as a symptom that is secondary to an underlying disease.

Focusing on the intention of the authors as regards chronic primary pain, Nicholas et al. (2019) wrote the following:

The definition of the new diagnosis of CPP is intended to be agnostic with regard to aetiology; "…it aims to avoid the obsolete dichotomy of 'physical' vs 'psychological'. 'Nonspecific' and 'functional' is also ambiguous. Some take it to mean 'all in the mind' and others as a 'disorder of function'. The introduction of 'chronic primary pain' [is meant to] eliminates this ambiguity".

Chronic primary pain is defined as pain in one or more anatomical regions that

- persists or recurs for longer than 3 months
- is associated with significant emotional distress (e.g. anxiety, anger, frustration, or depressed mood) and/or
- significant functional disability (interference in activities of daily life and participation in social roles)
- and the symptoms are not better accounted for by another diagnosis.

The experience of chronic pain should be sufficiently concerning for the person to seek help for it. Importantly, it goes on to say:

"As in all conditions, before a diagnosis is made, it has to be ascertained whether another diagnosis better accounts for the chronic pain presentation, in which case, the diagnoses are the chronic 'secondary' pain syndromes, e.g. chronic cancer pain, chronic postsurgical or posttraumatic pain, chronic neuropathic pain, secondary headache or orofacial pain, chronic secondary visceral pain, and chronic secondary musculoskeletal pain (this list is not exhaustive — our addition)."

The schematics from both Nicholas (2019) and Treede (2019) below emphasise this fact of dual or more parent diagnoses for any pain. See Figures 1 and 2 and the accompanying legends.

It was recently explicitly recognised by NICE that multiple parenting may be present in any pain condition and, accepted by NICE itself, that chronic secondary pain and chronic primary pain can coexist. See Figure 3.

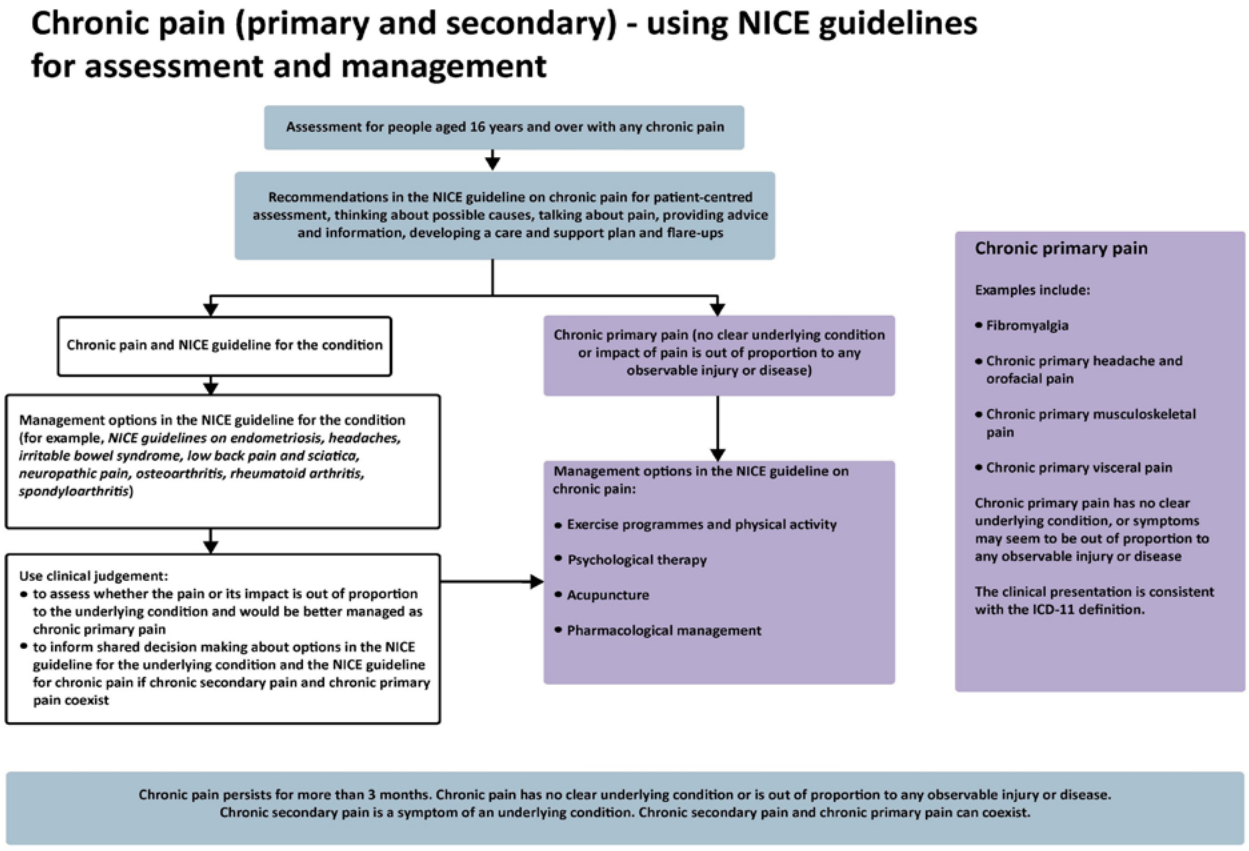


Figure 3: From NICE Guidance NG-193 Chronic Primary Pain Guidelines. (Redrawn)

From the Figure 3 legend: "Chronic pain persists for more than 3 months. Chronic primary pain has no clear underlying condition or is out of proportion to any observable injury or disease. Chronic secondary pain is a symptom of an underlying condition. Chronic secondary pain and chronic primary pain can coexist." This last statement probably has been largely ignored or not received the desired attention.

Caveats and cautions

These caveats and cautions from the NICE guidance committee, and also the original principals fundamental to pain diagnosis in ICD-11, seem to have been lost in understanding and are a barrier to what constitutes a high-quality pain management service for complex pain cases. This has further negatively impacted clinical pain services commissioning processes by not appreciating the comprehensive approach required to assess, treat and manage chronic pain.

The chronic primary pain guidelines (NICE NG-193)[9] concluded that looking at the (admittedly poor) evidence base examined, very few treatments have been demonstrated to work therapeutically at a group level in CPP patients, apart from physiotherapy and antidepressants. It is important to remember, however, that a CPP may co-exist alongside a CSP in an individual patient. So, more than one treatment guideline will be relevant and appropriate in our view.

Put simply, this NICE guideline only covers the treatment of chronic pain conditions where the CPP and, by implication, the 'psychological' and 'social' dimensions of chronic pain is considered likely to be a major part of the disease process. It does not cover the 'biological' aspect. This explains why there is

such a strong emphasis on multiple parent categories in ICD-11 to allow for more than one parent diagnosis, and treatment for that CSP diagnosis should follow in parallel.

Furthermore, in an individual patient the influence of the two (or more) parent diagnoses can be very different from another individual and moreover the influence of the parent diagnoses can vary over time and with disease progression.

As has been said since 1977 by George Engel[10] and Loeser (1982)[11] , pain has to be considered in its biopsychosocial context. ICD-11 simply restates that in a new language for a modern time, as we come to understand more of both the biomedical basis and the pathophysiological processes of chronification of pain. The concept of multiple parenting applies to assessment, diagnosis and treatment within an individual with chronic pain.

It continues to be the explicit prerogative of the clinician assessing an individual patient to apply clinically as many parent diagnoses as they see are clinically appropriate. Taking less than full consideration of the guidelines along with less than full assessment of the patient, and the complexity of their condition, is therapeutically harmful and nihilistic and, in our view, falls below a reasonable standard of chronic pain assessment and management.

NICE itself states elsewhere:

"When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility

It continues to be the explicit prerogative of the clinician assessing an individual patient to apply clinically as many parent diagnoses as they see are clinically appropriate.

to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian."

Application to CRPS of multiple parenting

Complex regional pain syndrome (CRPS) is a debilitating, painful condition mostly in a limb, associated with sensory, motor, autonomic, skin and bone abnormalities. CRPS commonly arises after injury to that limb[12]. However, there is no relationship to the severity of trauma, and in some cases, there is no precipitating trauma at all (9%). CRPS usually affects one limb, but in 7% of cases later spreads to involve additional limbs. The cause of CRPS is unknown but there is an interplay between peripheral and central pathophysiology. The earlier concepts, arguing that the predominant problem is sympathetic dysfunction and that CRPS evolves in stages, are now obsolete. It is also clear that CRPS is not associated with a history of pain-preceding psychological problems, or with somatisation or malingering. Pain is typically the leading symptom of CRPS and is often associated with limb dysfunction and psychological distress.

While the aetiology of CRPS remains obscure, landmark studies have shown the transfer of CRPS symptomology when blood from a CRPS patient (but not blood from another chronic pain patient) is performed in an animal model[13].

Thus, in an individual case of CRPS we can diagnose a neuropathic pain parent and use neuropathic pain guidelines and the guidelines referring to spinal cord stimulation (which are CSPs). We can in addition diagnose a secondary musculoskeletal with a central pain component, which will likely include psychosocial factors that is a CPP and apply guidelines relevant to the latter diagnosis (NICE NG 193). Put simply, one must consider including multiple diagnostic parents of a CRPS diagnosis based on thorough biopsychosocial evaluation.

An integrated interdisciplinary treatment approach is recommended, tailored to the individual patient. The primary aims are to reduce pain, preserve or restore function, and enable patients to manage their condition and improve their quality of life. The four 'pillars' of care (education, pain relief, physical rehabilitation and psychological intervention) addressing these aims have equal importance.

If one was to apply only one parent for CRPS and treat it as a CPP

as per NICE NG-193, there is a potential to miss treatments for neuropathic pain component (NICE CG 173[14]), spinal cord stimulation (NICE TAG 159[15]) and intrathecal baclofen, to help deal with a specific clinical problem impacting CRPS presentation, and likely to compromise engagement with rehabilitation to impact prognosis and outcome.

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NITROUS OXIDE: IT'S BEEN AROUND, AND WILL BE AROUND, FOR HUNDREDS OF YEARS

Nitrous oxide is a potent greenhouse gas, each molecule contributing the same global warming effect as 300 carbon dioxide molecules.

Dr Kenneth Barker
Consultant Anaesthetist
NHS Highlands

The atmospheric lifetime of nitrous oxide is 110 years and it occupies the same atmospheric window as the fluoride gases, amongst them our volatile anaesthetic agents. It blocks one of the routes by which the earth can reflect radiation back into space, and therefore contributes to the process of radiative forcing, the root cause of climate change.

We as clinicians have been able to make major changes in our carbon footprint due to volatile agents, mainly by abandoning the use of Desflurane; in Scotland dropping from 7423 tonnes of CO_2 in 2018/19 to 1088 in 2021/22. But the contribution of Nitrous Oxide is far greater, and not showing the same percentage reduction; 28,274 to 25,009 tonnes in the same period.

Nitrous Oxide Mitigation plan

1. Education
2. Address waste
3. Rationalise sites and indications
4. Seek alternative analgesics
5. Nitrous oxide cracking

Pure nitrous oxide has traditionally been utilised in anaesthesia and dental practice but its use as a carrier gas in routine general anaesthesia has fallen to almost zero, a combination of its undesirable side-effects and recognition of its climate effects. About half of paediatric anaesthetists still find it useful in inhalational inductions, and there remains some use in general anaesthesia for Caesarean sections. This step change, however, has not been reflected in dental practice. In fact, the offer of sedation with nitrous oxide is often seen as a quality marker. A recent audit of practice in Highland showed wide variation in flow rates and percentages of nitrous oxide administered, from 5 to 12 l/min of nitrous delivering 30 -70% mixtures, so education remains one of the first steps in addressing this part of the climate emergency and is rightly **Step 1** of any mitigation plan.

Step 2 is to address waste. In 2020, Alifia Chakera, a pharmacist with NHS Lothian noted significant disparities in purchased nitrous oxide compared to that actually utilised by patients. In some hospitals up to 95% of gas was wasted, through pipeline and manifold leakage, poor stock control and out-of-date returns. Unfortunately, manufacturers are legally obliged to vent any remaining gas in returned cylinders to atmosphere. This gave rise to the Nitrous Oxide Mitigation Plan, now in use worldwide, and concerned with decommissioning manifolds and leaning the procurement process. A detailed aid for implementation can be found on the Association of Anaesthetists website[1].

Step 3 involves addressing the ubiquitous use of Entonox in

particular. It is a familiar and effective treatment for acute pain, so many areas have adopted its use, sometimes in small rooms without assessment of the site of administration — is there scavenging or adequate ventilation in place and is there an occupational health schedule in place for monitoring nitrous oxide levels and staff exposure, as per COSHH regulations?[2] There are many new treatments or procedures where Entonox use has been adopted without making a formal assessment of all analgesic strategies.

Step 4. Many areas need to simply formalise the agreed analgesic pyramid, particularly areas where there can be a rapid turnover of staff such as emergency departments. Newer pain relief options such as intranasal fentanyl or sublingual sufentanil should be considered and discussed with the Acute Pain Team.

For acute traumatic pain methoxyflurane vapes are used by paramedics and in many Emergency Departments[3]. The drug is an excellent analgesic, has been used in Australia for 10-15 years with a good safety profile, and environmentally its global warming potential (GWP) is 4 compared to 300 for nitrous oxide. Methoxyflurane is not currently licensed for procedural analgesia in the UK, but evidence of its use in Australia has prompted work to identify areas where methoxyflurane could be a suitable replacement for Entonox[4].

Procedures such as colonoscopy, colposcopy, Transrectal Ultrasound Scan (TRUS) biopsies, or bone marrow sampling may be appropriate, and local practice has found it to be an excellent agent for pleural procedures, previously an area unable to use Entonox and reliant on intravenous opioids for pain relief. On a direct cost comparison, methoxyflurane represents a significant cost pressure compared to Entonox.

However, when including the hidden costs of installation and maintenance of ventilation/ scavenging, monitoring, and transport of cylinders, the difference is less marked. In addition, many health systems are increasingly recognising the triple bottom line of social and environmental cost as well as financial in their decision-making processes. Rough costings of dental use in Highland have suggested a spend of less than £1 per kg of CO_2 saved.

Finally, **Step 5** is for those areas where there is no alternative to Entonox use — primarily in Obstetrics for labour pain — about 68% of Nitrous use. Although a number of options exist for expectant mothers such as TENS, epidural analgesia, and opioids; both intramuscular and patient controlled intravenous with remifentanil, no-one could deny the essential role that nitrous oxide plays in labour analgesia.

Technology to 'crack' nitrous oxide back to nitrogen and oxygen and release these harmless gases back into the atmosphere has been around in industry for many years. Units to deal with medical nitrous oxide are now available, either at the bedside or a central destruction unit. The costs of these systems are significant and rely on coaching expectant mothers to exhale gases through a mask cuff and coaxial expiratory tube. This can mean the efficiency of capture as low as 50%. To minimise this user dependence, alternative models where the whole labour room ventilation system allows capture of higher percentages of expired Entonox are being investigated.

So, every nitrous oxide molecule we produce can have a deleterious effect on our climate for over one hundred years. There are many actions we can take to reduce our demand and mitigate the harmful effects of nitrous oxide use in our healthcare facilities. The first is to recognise the existence of the problem and take that initial step to deal with it.

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Photo by Engin Akyurt

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www.fpm.ac.uk
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@FacultyPainMed

Faculty of Pain Medicine Study Days

Tuesday 21 February 2023 | 09:00—16:30

- Anatomy and physiology of the pain system
- Diagnosing Neuropathic pain in the hospital/acute setting - a primer
- A non-injected opioid analgesia protocol for acute pain crisis in adolescents and adults with sickle cell disease
- Managing acute pain in children
- Designing an In-hospital complex pain service
- PEC Blocks vs LIA for Breast surgery – RCT results
- Implications of nocebo in anaesthesia care
- Mentoring for trainees

Wednesday 22 February 2023 | 09:00—16:30

- Neuroimmune interactions in pain
- Pain biomarkers
- Efficacy and safety of intrathecal morphine for analgesia after lower joint arthroplasty
- Interventions for the prevention or treatment of epidural-related maternal fever
- Prevention and management of intra-operative pain during caesarean section under neuraxial anaesthesia
- Results from the FPM National Opioid audit
- Development and external validation of multivariable models to predict patient-reported outcomes after lumbar spine surgery
- Pre- emptive analgesia - current status

Booking info
www.fpm.ac.uk/events/fpm-study-days-february-2023

BOOKINGS NOW OPEN!

Please note that the programme may be subject to change.

Dr Barry Miller
MAG Chair

OPIOID-INDUCED HYPERALGESIA

"Does morphia tend to encourage the very pain it pretends to relieve?"

— Dr Clifford Allbutt, *The Practitioner*, 1870

Opioids are probably the oldest medication and, paradoxically, one of the least understood in terms of its place in therapeutics. Studies on its use are legion, and yet it remains a difficult medicine to use well, and increasing medico-political-legal issues do not always focus on prescribing for the individual patient.

Consider the phenomena of 'Opioid-Induced Hyperalgesia' as an example. Not a research review, but to highlight a clinical conundrum. There must always be a coda to such missives; the intention is to add to the considerations of ongoing pain when opioids are a part of the management, and not to encourage knee-jerk assumptions of its presence, and inappropriate de-prescribing — which I hope to consider in a later piece.

Opioid-induced Hyperalgesia is the phenomena of an increased sensitivity, and increased pain sensation, to nociceptive stimuli. It may be associated with the development of tolerance, but appears to be a distinct entity, and there is recent work even in the perioperative period, with opioid exposure. This puzzle, that our most potent analgesics might actually be worsening the pain problems for which they are prescribed is well documented, but poorly researched. Its incidence and severity are unclear, but as clinicians tasked with managing symptoms, it is into that pool of uncertainty we need to look.

Opioid prescribing has begun to decrease after its rapid rise in the 2000s; total individual doses are coming down, and we are getting a greater sense of the health risks of higher doses. But there remains uncertainty about the long-term benefits. Most clinicians will see individual patients on moderate doses who claim benefit, and conversely similar doses that appear to do little.

Is the issue clear? A patient on long-term opioids continues to be in pain. They may have tolerance (being on a dose that would flatten a naive patient), withdrawal (worse pain when they forgot their dose), no change in pain scores from when first seen, and little change in other assessments (function, activities, etc.). Everything seems to hurt, all the time. But their faith and attachment to the status quo, to the 'strong' analgesics they are on remains firm. Few guidelines truly acknowledge these challenges. Helping an individual in such a situation is more than a one-sided reduction, or reluctant acquiescence, especially if the overall condition seems stable. Far from ideal, but stable.

The approach must include understanding. Education has increasingly been at the forefront of Pain Management. From the formal Pain Management Programme, to a calm out-patient conversation; a recognition that the suffering from pain is as much a function of fear and misinterpretation. Those beliefs can be countered, and that fear of change needs to be responded to in a professional manner. The slow road to recognition that not only is the medication not working, but it might also be worsening the primary pain, and any other painful event (stubbed toe etc.) is a potent trigger for acceptance.

And this requires time. Double or triple slots in the out-patient schedule. Time to listen, to explain; for the patient to recognise that time is being spent in their service. As always, the science and understanding of the issue advances much more quickly than the solutions!

Dr Ganesan Baranidharan
PSC Chair & Vice Dean

PROFESSIONAL STANDARDS

I am honoured to take on the position of Chair of the Professional Standards Committee (FPMPSC) from Dr Paul Wilkinson. He has had six years as Chair, contributing considerably to professional standards in Pain Medicine.

I will continue with the work already initiated and look for new work streams to improve the quality and standards of Pain Medicine in the UK and Northern Ireland. We also welcome Dr Manohar Sharma as the Deputy Chair of the PSC.

COVID-19

The pandemic has had a significant impact on our lives in the last three years. FPM has responded quickly and appropriately to the membership in Pain Medicine therapies. We have successfully updated the guidance, and there is nothing new on COVID-19 to focus on. Hence COVID-19 will continue to be part of the professional standards standing items, but we will not update any further guidelines in this area. We thank all our PSC members for contributing to the timely release of guidelines and helping the Faculty during the COVID-19 pandemic.

Wellbeing

Wellbeing is an essential aspect of professional life. FPMPSC has looked into and has provided information and useful websites managed by Dr Carty to help Fellows access appropriate content for wellbeing. It is a handy online resource that you may find helpful. Visit www.fpm.ac.uk/careers-workforce/wellbeing for more.

National Cancer Pain Network

Both Dr Brown and Dr Sharma are currently leading this project and there has been some steady progress on the amalgamation of the network. We will keep you informed of further advances.

Core Standards

You will all be aware that the second edition has been published, and we have an excellent timeline to try and introduce the initiation of the next edition. We have agreed that *Core Standards* will be reviewed after two and a half years as a soft review to see if any significant changes need to be addressed. The next edition will be published five years from now, and we endeavour to start the work eighteen months in advance for a timely publication. PSC thanks Dr Anna Weiss and Dr Robert Searle for their excellent contribution and insight on the timeline and plan towards the next edition.

Gap Analysis

Dr Srivastava has started work on the Gap Analysis. Gap Analysis is an essential work for professional standards, and we hope to identify the gaps between core standards and what is currently available in the country. This is timely and will ensure pain services

have what they need to run a successful multidisciplinary service. We kindly request that all fellows participate in the survey, to help us move forward.

Medicines Advisory Group

This committee is available to deal with any medicine-related questions and update as appropriate. Dr Miller will continue to lead the Medicines Advisory Group for any advice or medicine-related queries to the Faculty.

Transitional Pain

The Transitional Pain Working Group is a work stream that looks at the pre and postoperative optimisation of patients at risk of severe postoperative pain and gives guidelines on prolonged opioid use and the development of chronic pain. It will be a multi-national body project. We will update you as the project evolves. We feel this project will also help to address a recent audit looking into peri-operative opioid prescriptions led by Dr Cathy Price. Multiple recommendations have been made through this audit and this group's guidance will hopefully address many of the gaps present in our current work.

Publications

PSC is currently reviewing more than 25 publications. We will update the publications, some of which need other societies' approval, such as BPS, NSUKI, etc.

Various work streams have come through to improve governance, and *International Guidelines for the Management of General Surgical Emergencies in Pregnant or Breastfeeding Women* is one of them. We are currently part of this work stream initiated by the Royal College of Surgeons. It is an evidence-synthesis guideline on various aspects of surgery during pregnancy or breastfeeding. We are currently involved in the pain management section of these guidelines.

As mentioned, Professional Standards are there to improve the quality and governance of Pain Medicine. We usually get projects via the Board and also via Committee members. We are always happy to receive suggestions from Fellows and members on essential areas to focus on and improve.

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

Dr Victor Mendis
TAC Chair

TRAINING & ASSESSMENT

On behalf of TAC, I wish to congratulate Dr Lorraine de Gray on her appointment as our Dean and Dr Ganesan Baranidharan as the Vice Dean. Lorraine has taken on the role of leading the Faculty at an important phase when credentialing of our speciality with the GMC is being considered.

Paediatric pain

The difficulties for pain trainees in obtaining appropriate clinical experience in paediatric pain medicine has been the subject of discussion for many years, and a document was produced by the Paediatric Pain Working Party previously. With the implementation of the new curriculum it was decided to revisit this issue and my wholehearted thanks to Dr Paul Rolfe and Dr Helen Laycock, for producing a draft proposal for learning outcomes for a paediatric pain training module in SIA pain medicine. This will be discussed at FPM Board and cascaded widely in due course.

Curriculum

There are seven generic professional and seven speciality-specific domains of learning outcomes for each stage of training within the anaesthetic curriculum. Completion of the three stages of pain training is required before undertaking a Specialist Interest Area (SIA) in Acute Inpatient or Pain Medicine. The new updated guidance states that SIA's will have a time range which will be 12 months for chronic pain and six months for acute pain.

EPM

I would like to extend my sincere thanks to Dr Helen Makins for leading and developing EPM. Helen now hands over this role to Dr Sibtain Anwar who will be taking the lead position with Dr Sailesh Mishra in the deputy role. EPM UK are finalising e-PAIN sessions for foundation doctors and there has been a recommencement of international work, and adverts having gone out for volunteers to assist with upcoming opportunities both on e-PAIN and on Mercy ships.

Workforce

The 2022 workforce census has now been launched. The survey will collect a broad range of data that can be used to guide some of the future work of the Faculty and potentially contribute to submissions to various UK-wide national stakeholders. I must thank Dr Sonia Pierce and Claire Driver-Edwards who have worked very hard to get this off the ground. I am reassured by the appointment of two Bernard Johnson advisors by the RCoA, who will look at trainee welfare. I do hope that our trainees continue to enjoy working in multidisciplinary teams and have access to the various modalities to help their patients, and are able to receive the training required to become good pain doctors.

Dr Nick Plunkett
Chair FFPMRCA

FFPMRCA EXAMINATION

Since the spring report, the Faculty has delivered the MCQ for the autumn sitting on 24 August 2022 and the SOE on 11 October 2022.

There were 15 candidates in the recent sitting of the MCQ. The FPM Angoff Group met on 9th September to consider the examination questions and raw results in detail. The group reviewed each question and removed four MTF questions and one EMQ answer on ambiguity — a total of 396 out of 400 marks were possible. Adhering to the usual processes, an Angoff raw pass mark of 290, following application of 1.64 SEM, set the pass mark at 274/396 = 69%. 12 out of 15 candidates achieved a pass, resulting in a pass rate of 80%, similar to current trending pass rates.

Face-to-face

In the most recent SOE exam (October 2022), we were delighted to return to face-to-face examinations for the first time in three years! Although we reflected that the exam was eminently deliverable to the expected high standard remotely, we all agreed that the exam process was much more enjoyable and sustainable in person.

14 candidates attended, of which 11 passed (78%) with a pass mark of 31. This was determined as usual by using multiple standard setting techniques for pass mark determination, including a review of candidate performance in the borderline area by the Exam Board. The Exam Board was particularly pleased to learn that of the group that passed, two candidates took the SOE for the second time, and two for the third time — special congratulation to those candidates!

New examiners

At the October exam, we were especially pleased to meet the three new FPM examiners — Dr Jonathan Rajan, Dr Senthil Jayaseelan, Dr Arasu Rayen — and a new question writer Dr Arumugam Pitchiah. The new examiners had structured training over the three days, with a view to participate in examining duties at the next exam. The FPM Exam Board is fortunate to have attracted such new talent, which will help invigorate the exam content, process and delivery. We wish them well in their future examination career.

Farewells

The Exam Board also fare-welled Drs John Goddard and Mark Rockett, both foundation examiners since the exam's inception in 2009, and thanked them both for their expert work and efforts in question writing, significant group contribution and examining for many years.

The SOE exam was attended by three external observers — Dr Saurabh Nagpaul (Bucks Healthcare), Dr Sonia Pierce (advisory Board for Wales), and Dr Roshan Thawale (East Midlands Health). Initial verbal feedback was positive on all aspects, including the content and delivery of the exam.

Exams review

Readers may have been aware that an external RCoA exams review was invited in 2021, with a remit to consider all its exams, and led by Professor John McLachlan through 2022. The FPM was pleased to participate in this alongside all other RCoA-deliveerd exams, and we anticipate that the final recommendations will be published in the New Year.

The FPM Court of Examiners would like to thank the RCoA Exams department for all their expert assistance in delivering the exam and look forward to ever-increasing ties in the future.

SOE EXAMINATION QUESTION PERFORMANCE REPORT

Dr Nick Plunkett
Chair FFPMRCA

Dr Ganesan Baranidharan
Vice Dean

Following deliberation within the FPM Court of Examiners, it was decided that it would be a learning point for all concerned, if there was a specific report covering qualitative aspects of SOE examination question performance in March 2022.

This is a reflection on how the Court of Examiners felt the questions were answered, with comment from the SOE section chairs in some detail, gathered from in-depth conversations within the FPM Court of Examiners on the questions the day before, and the day after the SOE examination itself.

It should be noted that the information given herein cannot and should not be construed as comment on individual candidate performance.

We believe this FPM examination question report — the first such report, with aims to make such reporting a regular feature — will help future candidates (especially those who unfortunately may have failed), and their trainers to better understand the scope, focus, and depth of questioning, and to assist with future exam preparation.

Long Clinical question: Paediatric CRPS

Dr Richard Sawyer, Chair Clinical SOE Group

Q1: This question is the usual ice breaker and candidates generally all came to the same diagnosis (CRPS). Candidates were able to discuss the differential diagnoses, further management and investigations of this condition with a high degree of competency. This is to be expected as candidates should be very familiar with CRPS.

Q2: The second part of the long question dealt with the biopsychosocial aspects of pain management, and feedback indicated that candidates were able to consider the multiple factors and nuances that can influence chronic pain perception in a paediatric patient.

A particular nuance of this question was exploring family and parental factors that can impact a paediatric patient with a chronic pain condition. Candidates were also (in the main) familiar with child safeguarding factors.

Q3: The third part of the long question was focussed on transitional care between paediatric and adult chronic pain services. This question

was considered by the FPM Board of Examiners as the most difficult part, and the observations post examination were that candidates had less experience of this and/or of paediatric pain services. The detail around service organisation and provision proved to be more challenging for some candidates, and this in part was probably a reflection of clinical experience as well.

Short clinical questions

Dr Richard Sawyer, Chair Clinical SOE Group

Q4: Shoulder pain

Post-examination discussions revealed that several candidates found great difficulty in classifying shoulder pathology and thus causes of chronic shoulder pain. There was some significant weakness in some candidates in relation to explaining rotator cuff tears, which was considered reflective of limited clinical experience, as shoulder pathology is frequently seen in pain clinics and it is reasonable to expect candidates to be able to discuss examination findings etc.

Q5: Occipital Neuralgia

In general, all candidates were able to explain what occipital neuralgia is, and the anatomy of the occipital nerves. Few candidates knew all of the areas of occipital nerve entrapment. All the candidates were aware of, and were competent in describing, the process of doing an occipital nerve injection. Few examiners got onto the filler which was about the classification of headaches. The consensus view was that this was a good question and relevant to the scope of chronic headache conditions presenting to a busy pain clinician.

Q6: Long COVID and chronic pain

This question was considered to be very topical! The FPM Board of Examiners' view in post examination discussion was that most candidates were familiar with long COVID symptoms, and the risk factors for developing long COVID. These parts of the question were well answered. The area of weakness within the question was the pathological causes of the development of long COVID. Few candidates were able to competently discuss this.

Science question

Dr Vivek Mehta, Chair Science SOE Group

Q1: Stellate Ganglion

This question seeks to explore basic anatomical knowledge of the stellate ganglion and its clinical application. This also forms a core aspect of anaesthetic training and FRCA examination and the question was thought to have been a reasonable subject area pre-examination. The majority of candidates scored highly as expected, and for those who scored poorly, it reflected a significant gap in their knowledge.

Q2: Inflammation

This question covered the cellular mechanism of inflammation. Pre-examination this was considered to be a relative tough question. However, many candidates passed this question, and a few were reflecting the nature of the question, in particular the cellular aspects that candidates were not aware of. The consensus view was that this question explored essential science knowledge that underpins clinical practice, a key principle of the FFPMRCA examination.

Q3: Tramadol versus Tapentadol

This question was thought to have been a very reasonable subject area pre-examination, as it covered two very commonly prescribed drugs in pain medicine. However, to the surprise of the examination body, there were quite a few candidates who had poor knowledge of the topic. This was considered reflective not only of a lack of core knowledge, but also the brevity of understanding of a key topic in pharmacology in those candidates. The question was considered a good discriminator between a good candidate and poorer candidates. The examination body agreed that this question may also be used in future, as it explored a very important aspect of routine prescriptive medicine in pain.

Q4: Radiation

This physics question was intended to explore basic measurements of radiation, and identify satisfactory knowledge, as radiation and its exposure is a routine part of clinical practice, and the safe and appropriate use is essential to pain medicine practice. As expected, the majority of candidates had a good knowledge about the clinical guidelines relevant to day-to-day practice. However, candidates found the basic science, especially units of radiation challenging, which reflects the spread of scores for an essential, although relatively difficult topic.

Dr Richard Berwick
Faculty Trainee Representative

TRAINEE UPDATE

Welcome to all those who have joined pain training this year! As services are approaching something closer resembling the pre-pandemic situation, I hope that you all have a great time as part of our community!

For those familiarising themselves with how to do pain training, or for those preparing for exams, I cannot recommend the FPM Learning website highly enough. It is a fantastic resource detailing current research development, to opioid conversions tables and everything in between. It is continually being updated, so if you feel there is something you would like to see added let me know.

Trainee Survey

The trainee survey has just finished and thank you to all those who have commented on this. It is a crucial part of the FPM's quality of training assurance process, and the Training and Assessment Committee (FPMTAC) will analyse the results to see how we are able to improve the shape of pain training across the UK. Previously training disparities in teaching and experience, especially around obtaining paediatric pain exposure, were raised. A plan for delivery of paediatric training, given the difficulties, is currently being worked on by Dr Laycock and Dr Rolfe.

Teaching and Training

Teaching and training opportunities have been often cited as an issue due to regional disparities. This year we have had a few developments to start to address this. The London School has agreed to continue to offer their sessions virtually where possible. Earlier this year the Walton Centre provided a few months of teaching sessions, and now the North of England Pain School has also contributed to a teaching programme which comprises of clinical talks and a journal club.

We have been developing a repository of all recorded resources which can be accessed through a shared drive, disseminated through the trainee WhatsApp Group. This is a hugely promising resource and should go some way towards improving the situation. Training disparities have also been raised with the RCoA through the Anaesthetists in Training Committee, with a commitment from the College to resource improvements.

Pain Trainee Day

Just recently we organised the Annual Pain Trainee Day, which has suffered a hiatus for the last few years due to COVID-19. This was a hybrid event and focussed on the future of Pain Medicine and of training. It was a great opportunity to meet trainees from all around the country and, also, for trainees to meet the new Dean, Dr De Gray and FPMTAC.

At the beginning of September, the Pain Trainee Research Community restarted (Pain Train) Carla Hakim and Nicola Johnson headed this with support from Harriet Kemp, Prof Tripathi (the research lead on the FPM) and me. The inaugural event was based on collaborative research with some research-based CPD. It was a very successful day and well received. Please send your details to paintrainresearch@gmail.com if you are interested in being part of the mailing list.

Get in touch

If you know anyone interested in joining the pain community, please ask them to sign up on the FPM website so we can add them to the WhatsApp Group, which is our primary means of communication. Finally, if anyone has any training concerns or issues, please do contact me.

Dr HooKee Tsang
RAPM Chair

RAPM UPDATE

As I come to the end of my term as Chair of the RAPMs, this will be my last RAPM update. I will pass on the baton to Dr Jonny Rajan, RAPM Chair-Elect, who will take up the post of Chair in January 2023. Dr Rajan is currently RAPM for the North West. I am sure he will have your support.

Hospital review forms

The Faculty has initiated its quality assurance programme with the roll-out of Hospital Review Forms to be completed by FTs and RAPMs, which will provide the Faculty with up to date information on the pain training delivered and the local infrastructure for training. The programme will capture changes to pain training following the introduction of the new anaesthetic curriculum and the reconfiguration of clinical services within integrated care systems. This updated information will provide prospective pain trainees with information on pain training opportunities regionally.

Curriculum update

It has now been over 12 months since the implementation of the 2021 anaesthetic curriculum, and the GMC has formally provided full approval. We are still within the transition phase and we all have trainees still on the 2010 anaesthetic curriculum and completing advanced pain training (APT). Over the next 12 months, we will start seeing the emergence of trainees who will need to complete the special interest area (SIA) in Pain Medicine rather than an APT. Trainees will still be required to complete Stage 3 pain, which can be completed before starting the SIA if the local training programme allows. Parts of Stage 3 pain can also cross over to the SIA in Pain Medicine with overlapping competencies. The Faculty and RCoA have mapped the common competencies that can be recognised. For Stage 3, **Capability F** & **Capability G** will only be partially covered by the SIA for pain medicine, and these capabilities will need to be gained during anaesthesia placements at stage 3.

- **Capability F:** Prescribes appropriately in the perioperative period and recognises the long-term implications of not reviewing patient analgesia in the post-operative period following discharge
- **Capability G:** Plans the perioperative management of patients for surgery who are taking high dose opioids and other drugs of potential addiction

The SIA in Pain Medicine will also require trainees to gain patient feedback as part of their multisource feedback. The Faculty recommends the use of the Care measure form or equivalent validated tool for patient feedback. It is expected that trainees obtain an indicative number of at least 10 patient feedbacks in the second quarter, and 20 patient feedbacks in the fourth quarter of the SIA, covering outpatient and procedural work.

Additional development

There will be additional work to develop the SIA in acute inpatient pain within anaesthetic programmes, which did not exist in the 2010 curriculum. The RCoA has updated information about SIAs on their websites with SIAs divided into Group 1, with an indicative time period of 6-12 months, and Group 2, with an indicative time period of 3-6 months. The SIA in Pain Medicine is in Group 1, with the SIA in the acute inpatient pain within Group 2.

It is not possible to deliver the SIA in Pain Medicine in just six months. The RCoA has agreed to provide additional guidance, stating that the SIA in Pain Medicine has an indicative time period of 12 months, and the SIA in acute inpatient pain has an indicative time period of six months.

FFPMRCA EXAMINATION CALENDAR

	FFPMRCA MCQ	FFPMRCA SOE
Application and fees not accepted before	Monday 7 November 2022	Monday 23 January 2023
Closing date for FFPMRCA exam applications	Thursday 22 December 2022	Wednesday 8 March 2023
Examination date	Wednesday 8 February 2023	Tuesday 18 April 2023
Examination fee	£585	£815

Visit www.fpm.ac.uk/training-examinations/ffpmrca-examinations for the latest updates on the FFPMRCA exam.

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EXPERTISE WHERE IT MATTERS

BRITISH PAIN SOCIETY

56TH ANNUAL SCIENTIFIC MEETING

8 - 11 May 2023
Glasgow, UK

www.bpsasm.org

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