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Timely topics in pain research and treatment have been selected for publication, but the information provided and opinions expressed in this SIG on Acute Pain newsletter have not involved any verification by the International Association for the Study of Pain (IASP®) or the SIG on Acute Pain of the findings, conclusions and opinions stated in this publication. Thus, opinions expressed in this publication are solely those of its author(s) and do not necessarily reflect those of IASP® or the SIG on Acute Pain, or of the Officers or Councillors of IASP® or of the Officers of the SIG on Acute Pain. No responsibility is assumed by IASP® or the SIG on Acute Pain for any injury, and/or damage to persons or property resulting, whether as a matter of product liability, negligence or otherwise, from any use of or reliance on any methods, products, instruction or ideas contained in this publication. Because of the rapid advances in the medical sciences, the publisher recommends that there should be independent verification of...
The first official meeting of the AP SIG took place at the 2005 Sydney World Congress on Pain under the leadership of a core group of clinicians and scientists whose support and activity have continued to this day. Professors Neugebauer, Schug, Chapman, Meissner, Rawal, Pogatzki-Zahn and Zaslansky (among others) had begun planning this new SIG a couple of years earlier. During the planning, Rolf-Detlef Treede presented a draft for the new AP SIG’s bylaws modelled after those of the NeuPSIG, the IASP SIG on Neuropathic Pain, and served as the first liaison between the AP SIG and IASP Council (a role now filled by Irene Tracey). Of note, at the end of first AP SIG formation meeting Winfried Meissner suggested "a worldwide benchmarking project on acute pain comparable to an…existing and well functioning project in Germany built up on an internet-based databank...to compare the efficacy and the outcome of acute pain treatment in different institutions of different countries....This project would allow close relationship to the IASP Task Force of Richard Chapman (Utah) and Ruth Zaslansky (Israel) (International Pain Registry)." [quote from first AP SIG Newsletter, archived on IASP website].

The original aims of the AP SIG were articulated in a far-sighted fashion; few changes have been needed to keep them timely and relevant to clinical practice and research. As now stated on the IASP website, the AP SIG "seeks to advance and promote the understanding of mechanisms, assessment, prevention, and management of acute pain through the following activities:"

- Collaboration between basic and clinical research.
- Study of the underlying mechanisms of acute pain, including the transition from acute to chronic pain, and the implications of acute pain therapy for clinical outcome and quality of life.
- Exchange of guideline developments, its methodology and implementation strategies.
- Exchange of information and experience about the assessment and treatment of acute pain, both within IASP and in exchanges with other national and international NGOs such as the World Federation of Societies of Anaesthesiologists.
- Identification and implementation of programs to minimize the development of acute pain and related suffering.
- Furthering the educational objectives of the SIG via international meetings, an annual symposium, workshops at IASP World Congresses, Congress satellite meetings, a newsletter, and the IASP website.

Few could have anticipated the degree to which, as the AP SIG nears age 10, the topic of acute pain would remain at the forefront not only of patient-centered, evidence-based, outcomes-driven care, but also innovative research on individual risk stratification with respect to chronicization of acute pain, and corresponding
personalization of clinical practice guidelines. Basic research on how, and in whom, acute pain becomes chronic is leading to novel therapeutics such as DNA “decoys” to inhibit the acute, post-injury expression of nerve growth factors, or agents to prevent activation of microglia. Translational science continues to specialty pharmaceuticals to apply in daily clinical practice, such as extended-release local anesthetics or tamper-resistant opioids. Clinical outcomes are now collected worldwide in registries such as PAIN OUT and analyzed through sophisticated techniques to mine “big data”. Educational efforts to improve acute pain assessment and treatment are taking place worldwide, among which must be noted the AP SIG’s recent coordination of, and preparation of fact sheets for IASP’s Global Year Against Acute Pain. Other highlights include the dynamic, biannual Acute Pain Congresses organized by Eddy Neugebauer in Cologne (see related article in this Newsletter including photos of 2013 Cologne Acute Pain Congress).

It is a privilege to follow Professors Neugebauer and Schug as Chair of this collegial SIG. Together with other SIG members, I am committed to better understanding and controlling – ideally, preventing – acute pain. This commitment reflects the universal view among AP SIG members that failure to do so produces poor long-term outcomes and unnecessary burdens on patients and society. As one of several IASP-based contributors (including Richard Chapman and John Loeser) to the 1999 Lancet series on pain, in my review of acute pain I wrote “The traditional dichotomy between acute pain with its recent onset and short duration, and chronic pain that persists after an injury has healed, is increasingly untenable…[Numerous] observations indicate that the biological and psychological foundation for long-term persistent pain is in place within hours of injury”. To that understanding must be added the compelling insight during the past decade (as IASP Past President Professor Michael Cousins has pointed out in leading the IASP Declaration of Montreal) that failure to control pain when we have the ability to do so violates a fundamental human right.

I look forward to an ongoing, hopefully increasing series of interactions at the national and cross-national level that benefit from the AP SIG as a mini social network. To date, the PAIN OUT project is the most significant offshoot of such interactions. Further opportunities exist for projects in a host of dimensions both preclinical and clinical, and participation in national and cross-national meetings and initiatives, recent examples of which are described elsewhere in this Newsletter. An initial preview of the upcoming AP SIG Satellite Meeting at the World Congress is provided briefly elsewhere in this Newsletter. AP SIG members and those who may wish to be, please let me hear from you as to how we may best meet your needs!

Daniel B. Carr, MD, DABPM, FFPMANZCA (Hon)
Tufts University, Boston, USA

News Flash: AP SIG Satellite Symposium Accepted for Upcoming World Congress on Pain

We were delighted to receive word from IASP that the AP SIG’s proposal for a Satellite Symposium was approved. Scheduled to take place in Buenos Aires at the NH Crillon Hotel on Sunday 5 October 2014, it is titled: “Faces in the Crowd: Variability and Diversity in Acute Pain Control”. The topic reflects our assembling a range of experts who will explore a crucial, clinically relevant topic in acute pain: the tension between policies and systems of care based upon aggregate, group mean evidence and those based upon the primacy of individual patient-reported outcomes. It will provide a timely "umbrella" beneath which a number of clinically relevant developments in research and practice will be presented. Presenters and discussants – AP SIG members plus persons outside this SIG, including some from other SIGs -- will present their viewpoints in a fashion that would foster new collaborations and strengthen existing ones within and between SIGs, and outside SIGs.

The sessions for this all-day program are:

• Person-centeredness in 21st century acute pain care
• The evidence base for acute pain control: how solid is it?
• Individualized care in a mean-minded world
• Population-based care
• How effectively do acute pain control teams and systems accommodate variability?

We are now confirming the initial commitments of a range of outstanding speakers to participate, and finalizing
logistics (including meals and a post-meeting cocktail reception). The next issue of this Newsletter will provide further details – but for now, please hold the date for a stimulating program to lead into the upcoming World Congress.

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**Message from the Newsletter Editor**

I am very happy to present this AP SIG e-newsletter. It was a challenge for me to include everything important for those affiliated with acute pain and IASP into one newsletter because there have been so many international meetings, activities and great projects recently. It is exciting to see the growing interest in acute pain – both at general pain meetings with more and more lectures about acute pain and at meetings specifically targeting acute pain.

Dr. Schug, a past Chair of the AP SIG, published an extensive account of the Satellite meeting at the IASP World Congress of Pain in Milan, in Harvard’s team research newsletter last year that can be accessed at the following link: [http://painresearchforum.org/comment/252#comment-252](http://painresearchforum.org/comment/252#comment-252)

The meeting on Acute Pain, held November 2013 in Cologne, Germany was organized by the first Chairman of the AP SIG, Eddy Neugebauer and included a strong panel of national and international speakers. During the meeting, the AP SIG officers and board members laid out plans for future meetings such as the October 5, 2014 IASP satellite meeting in Buenos Aires. The description of this congress follows below.

A very intense and outstanding meeting was the 11th IASP research symposium: "Brain and Pain: Researching pain persistence after surgery." It was held in Papendal, The Netherlands, from the 7th to the 9th November 2013. Organized by Oliver Wilder-Smith, Kris Vissers, David Yarnitsky and Lars Arendt-Nielsen, this meeting addressed a topic that is included within the AP SIG bylaws/aims: "...the transition from acute to chronic pain...". Persistent, chronic pain after surgery or trauma is a very common problem but knowledge about its cause, patients’ risk factors and prevention is sparse. However interest in this topic is increasing and the meeting in Papendal focused on better understanding the transition from acute postoperative pain to chronic pain is reviewed in detail by Jane Quinlan, AP SIG Secretary

Because of the high impact produced by the "PRACTICE GUIDELINES FOR ACUTE PAIN MANAGEMENT IN THE PERIOPERATIVE SETTING" published by the American Society of Anesthesiologists Task Force on Acute Pain Management in Anesthesiology in 2012, Brendan O'Donnell, AP SIG Treasurer, lists eight findings of their most recent update published too late to include in 2012 Milan Congress.

In this issue, we recognize the work of Mary Korula for advancing Acute Pain Medicine in India. A long-term member and supporter of the AP SIG, Mary was among the core group that developed Fact Sheets on its behalf for IASP's Global Year Against Acute Pain.

The final section briefly describes a most remarkable project, PAIN OUT. This international project within the European Commission's 7th Framework Program, with nearly 3 million EUR in funding through 2013, aims to improve management of postoperative pain. Winfried Meissner led the team of researchers from Jena University Hospital in Germany and from seventeen collaborating institutions from nine countries. Now, more than 50 hospitals from all over the world have announced their intention to participate in data collection and feedback of results. One of the next hospitals could be yours! The objective is to build a worldwide network for clinical and healthcare research.

I thank all the people who made this newsletter possible and hope to have provided you with a nice overview of recent activities related to acute pain.

Please see the "News Flash" immediately above, announcing IASP’s approval of the next AP SIG satellite meeting in Buenos Aires and providing some details on the venue and the program.

*Esther Pogatzki-Zahn, MD, PhD*
Biennial Cologne Acute Pain Congress

For many years the flagship meeting for the AP SIG – other than the Satellite Symposia at the time of the World Congress – has been the biennial Acute Pain Congress in Cologne, founded in 2003 and chaired by Eddy Neugebauer. This well-established interdisciplinary congress allows attendees to hear what key “thought leaders” in the field are thinking now, and where it is likely to advance. The rationale for selecting “Quality Management in Acute Pain Therapy” as the theme of this year’s Acute Pain Congress, held from 29-20 November 2013, was presented by Eddy in his Congress Chairman’s Greeting: “To this day, we have achieved some success through certification procedures via Quality Management in Acute Pain in German Clinics. However, the breakthrough is still outstanding. Discussions with the AQUQ Institute on introducing pain as an interdisciplinary quality indicator for all hospitals in Germany have begun. We must keep on rolling and mutually develop our expertise in consensus.”

Towards this end, an international group of speakers and attendees heard presentations by Richard Chapman and Winfried Meissner in a session on “E-QUIPS goes Europe – PAIN OUT goes Worldwide”, during which they were joined by Dr Ezihe-Ejiofor from London presented on her work in managing post-caesarian section pain in low-resource settings (Uganda). On the second day of the meeting, during a symposium honoring Dr Chapman’s contribution to pain research generally and PAIN OUT specifically, Drs Meissner, Zaslansky, Pogatzki-Zahn and other PAIN OUT leaders presented Dr Chapman with an award and hiking gear, recognizing his love of the outdoors and recent retirement and relocation to the American West. Drs Neugebauer, Rawal and Carr also spoke at the symposium honoring Richard.

Other Congress presentations covered clinical topics in a session featuring the current status of the PROSPECT project (Narinder Rawal, Stephan Schug, and Christian Simanski). Current translational research on acute pain was the subject of two sessions. The first, moderated by Michel Schafer and Esther Pogatzki-Zahn, surveyed preclinical and clinical aspects of the possibly detrimental effects of NSAIDs on postsurgical wound healing in the gastrointestinal tract, e.g., anastomoses. Joining Professor Schafer as presenters were Danish and German gastroenterological surgeons, Mats Klein and Misha Luyer. The theme of new developments in pain research was extended in a later session in which Achim Schmidtko surveyed animal models of inflammatory and neuropathic pain and Tim Hucho described his lab’s recent work on intracellular signaling molecules and sensitization.

This reporter’s account of the Congress was limited to those sessions conducted in the English language, but an equal number of exciting sessions such as the chronification of acute pain (chaired by Esther Pogatzki-Zahn and Wolfgang Schwenk), the increasing importance of wound infiltration, and organizational aspects such as teamwork were conducted in German. As in prior years, the Congress was officially supported by pain-related and other, e.g., surgical, organizations, and provided a convenient venue to conduct an official IASP AP SIG business meeting.

Shown left-to-right in the photo after this meeting are the core group of the AP SIG leadership and supporters: Dick Chapman, Jane Quinlan (SIG Secretary), Stephan Schug (past SIG Chair), Dan Carr (current SIG Chair), Winfried Meissner (Liaison, PAIN OUT), Ruth Zaslansky (Liaison, Intl Pain Registry), Narinder Rawal (SIG membership advisor), and Esther Pogatzki-Zahn (SIG Newsletter editor). [Editor’s note: Eddy Neugebauer is not in the picture because in typical behind-the-scenes fashion he was holding the camera!]

University of Muenster, Germany
11th IASP Research Symposium: Brain and Pain: Researching Pain Persistence After Surgery

The National Sports Centre in Papendal is the national sports development centre for the Netherlands, where top Dutch sporting talent develop their expertise. It was a fitting venue for the 11th IASP research symposium on chronic postsurgical pain, where top-flight pain researchers and clinicians came together to share their expertise and develop the understanding and management of persistent pain after surgery, albeit in an atmosphere of international collaboration rather than competition.

The meeting's four organisers: Oliver Wilder-Smith and Kris Vissers from Radboud University Nijmegen Medical Centre, the Netherlands, David Yarnitsky of the Rambam Health Care Campus, Israel, and Lars Arendt-Nielsen from the Center for Sensory-Motor Interaction in Aalborg, Denmark, had compiled a clever programme of internationally renowned speakers to lead us through pain pathways from skin nociception to the spinal cord, then to the brain and back down again in descending modulation; from cells and neurotransmitters to genetics and psychology; to measurements of pain activity from QST to PET; and finally to how we might combine this knowledge for improved patient outcome using drugs or adapted surgical or anaesthetic techniques.

Henrik Kehlet (Copenhagen, Denmark) opened the meeting with a summary of the current issues in persistent postsurgical pain (PPSP). He called for more procedure-specific data for PPSP, just as has been developed for acute postoperative pain, as psychological factors such as catastrophizing appear to be very strong determinants of pain persistence after some operations but not after others. Similarly, measures of postoperative function to reflect the impact of pain on quality of life are of little value if a patient's preoperative fitness has not been recorded.

Professor Kehlet was followed by Tim Brennan (Iowa, USA) who discussed the role of the skin incision in PPSP; then Thomas Graven-Nielsen (Copenhagen, Denmark) explored the role of muscle, bone and joint in persistent pain; while Jørgen Sandkøl (Vienna, Austria) spoke about peripheral nerves and neurogenic inflammation; and Asbjørn Drewes (Aalborg, Denmark) talked about visceral pain.

Stephen McMahon (London, UK) gave a talk on the peripheral nervous system and described the cascade of changes in ion channels after nociception. The idea that chronic pain is driven purely by central changes has been challenged recently by the finding that inhibition of nerve growth factor, which is expressed in inflammation and increases pain sensitivity, reduces chronic pain. Vania Apkarian (Chicago, USA) escorted us up to the central nervous system. He described chronic pain as having four elements: 1) predisposition, 2) injury, 3) transition (to a chronic pain state), and 4) maintenance. Descending pathways were then addressed by Mary Heinricher (Oregon, USA). She discussed the pivotal role of the rostroventral medial medulla (RVM), which forms the intersection of bottom-up pain pathways and top-down control.
Tony Dickenson’s (London, UK) talk on neurotransmitters, neuromodulators and ionophores began with a car analogy: that, for pain, sodium channels were the accelerator, potassium channels the brake, and calcium channels the transmission. In theory this should provide a rational and positive basis for drug development, although the clinical application hasn’t been as encouraging. Min Zhou (Toronto, Canada) spoke on central sensitisation and microglia, and focussed on long-term potentiation produced across all areas of the brain after injury.

On Friday, various forms of nerve testing and imaging were put to the test. Lars Arendt-Nielsen (Aalborg, Denmark) opened proceedings with quantitative sensory testing (QST), cautioning that, owing to spreading sensitisation where pain thresholds are altered in areas distant to the point of pain, studies using QST on the contralateral side (as opposed to the painful side) as a control area will not be seeing a true difference: it would be better to use a pain-free control group to determine “normal” values. Ole Andersen (Aalborg, Denmark) argued the case for electrophysiological techniques, whereby reflex receptive fields provide an insight into spinal nociceptive neurone activity, by monitoring the electromyography (EMG) in a muscle and measuring the nociceptive withdrawal reflex (NWR). The benefits of electroencephalography (EEG) were presented by André Mouraux (Louvain, Belgium). Laser stimulation produces an evoked response which is specifically nociceptor-related with no mechanosensor involvement, is reproducible, controllable and phasic, producing an early fast component from Aδ fibres, followed by a slower prolonged component from the C fibres. Interpretation of the laser evoked response may allow a functional examination of nociceptive afferents.

Unfortunately, Irene Tracey (Oxford, UK), was unable to attend the meeting so, at short notice, Vania Apkarian (Chicago, USA) nobly stepped in and gave a comparison of the different techniques used in functional magnetic resonance imaging, including BOLD (blood oxygen level dependent), DTI (diffusion tensor imaging), ASL (arterial spin labelling) and MR spectroscopy.

The use of positron emission tomography (PET) in pain was described by Thomas Tolle (Munich, Germany). By using a variety of specific radioligands, brain activity, metabolism and receptor density can be assessed.

Bill Maixner (North Carolina, USA) started the Friday afternoon session with a summary of genetics and genomics in altered pain processing.

Oliver Wilder-Smith (Nijmegen, Netherlands) then addressed the issue of altered perioperative pain processing and persistent pain with the question: is altered central processing dependent on continuing peripheral nociceptive drive? He presented the key premise as chronic pain consisting of altered pain processing which is manifest as spreading hyperalgesia. The mechanism of this is central sensitisation with pronociceptive endogenous pain modulation and loss of inhibitory descending controls, ie increased sensitised bottom-up signalling with decreased inhibitory top-down modulation. The protocol known as NASQ (Nijmegen-Aalborg standardised QST) addresses both these facets of the pain system, with central sensitisation assessed by QST, and descending inhibition measured by conditioned pain modulation (CPM). Emanuel van den Broeke (Louvain, Belgium) discussed altered cortical processing and persistent pain where EEG can be used to measure central neuroplasticity in acute and persistent post-operative pain.

The psychological predictors of persistent postsurgical pain were then considered by Stefan Lautenbacher (Bamberg, Germany). Many psychological variables have been investigated in the context of PPSP prediction but the results are not consistent. It may be that many measures are too broad - depression and anxiety are not pain-specific – although catastrophizing appears to be one of the strongest predictors in reviews.

David Yarnitsky (Rambam, Israel) compared altered pain processing in terms of the pain state measured with conditioned pain modulation (CPM) – facilitatory, normal or inhibitory – against the clinical pain state – pronociceptive, eunociceptive, antinociceptive - and asked the chicken and egg question: do patients start in a facilitatory state and are therefore more sensitive to pain, or does pain make the system more excitable? CPM may help us decide which drugs are appropriate for our patients. If a patient has efficient CPM there will be little benefit from augmenting descending pathways, while if they have inefficient CPM, drugs such as duloxetine will be beneficial. Similarly, temporal summation measured as part of a QST protocol can predict the efficacy of pregabalin. A steep temporal summation curve indicates excitability of ascending pathways so pregabalin would be expected to reduce this central sensitization. The concept of tailoring drug treatment to the individual patient is an attractive one but is likely to be oversimplified and not all studies have been consistent, possibly related to the multiple actions of single drugs.
Andrew Moore (Oxford, UK) had to cancel his talk due to sickness, so Kris Vissers (Nijmegen, Netherlands) kindly took his place. Professor Vissers reminded the audience of the work of George Engel who was the first to describe the biopsychosocial model of disease, and of the progression from nociception to pain to suffering to pain behaviour. It is with quality indicators such as those developed by the PainOut project that we can improve acute postoperative pain management and reduce the risk of this progression. Next, Guy Simonnet (Bordeaux, France) spoke about hyperalgesia modulation and chronic pain after surgery.

Eske Aasvang (Copenhagen, Denmark) addressed the surgical aspects of PPSP. Deliberate nerve transection does not usually lead to persistent pain, but accidental damage such as when a nerve becomes enmeshed during hernia repair leads to severe pain, relieved only when the nerve is transected. Pre-operative testing of patients (eg to a 47oC stimulus) may reveal a tendency to severe acute pain and it is these patients who should have the least invasive surgery, eg laparoscopic rather than open hernia repair. Those with low pain at 47oC will do well with either an open or laparoscopic repair, and these patients may dilute results for PPSP if included in analyses as their risk of long-term pain is extremely low.

Patricia Lavand'homme ((Brussels, Belgium) was the last speaker of the meeting and talked about the anaesthesiological aspects of PPSP. If there is a neuropathic element to PPSP, patients have higher pain intensity and a poorer quality of life. The concept of pre-emptive analgesia is obsolete, instead we now consider preventive analgesia where we aim to prevent central sensitisation, and protective analgesia where we aim to reduce peripheral and central processes. A recent Cochrane review found that only ketamine reduced PPSP, although the studies were small. The review found no benefit with pregabalin which was surprising, although the heterogeneity of study design precluded direct comparisons. Regional analgesia appears to prevent the progression of acute to chronic pain. There was initial hope that minocycline would reduce the reactivity of glia and thus reduce PPSP and the development of neuropathic pain but, in a study following lumbar discectomy, there was no benefit. In some cases, postoperative pain may decrease initially but then worsen after a few days or weeks following surgery, so there is a need to follow patients up and identify this group of patients who may then benefit from early pregabalin or gabapentin.

Professor Lavand'homme felt we need to:

- Individualise treatments
- Use thorough pre- and postoperative pain assessment
- Address the pharmacological and psychological aspects of treatment
- Provide a transitional clinic for patients whose pain is not improving postoperatively

Oliver Wilder-Smith brought the meeting to a close with a suggestion to develop a standard protocol for studies into PPSP to address the current heterogeneity, and thus lack of comparability, of the studies so far. Researchers should collect pre-operative data with QST and CPM, with procedure-specific quality of life, pain and psychological information; robust intraoperative details on surgical and anaesthetic technique; and prolonged postoperative follow up with pain and quality of life markers. Only when we are able to pool large numbers of procedure-specific, comprehensive and detailed studies will we be able to reliably identify vulnerable patients and trial manipulations to the pain system to reduce the incidence of PPSP.

Dr. Jane Quinlan FRCA FFPMRCA
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Chair, Acute Pain Special Interest Group, British Pain Society
Secretary, Acute Pain Special Interest Group, IASP

Acute Pain and AP SIG Efforts in India: Spotlight on Mary Korula
Professor Mary Korula, the Head of the Department of Anesthesia and Acute Pain Services at Christian Medical College in Vellore, India, introduced the Acute Pain Service in her institution in 2007. During the past year she has outdone herself with many contributions to advance pain research and practice. She was featured in a September 2013 in-depth profile in the national newspaper, the Indian Express, in which she emphasized that postoperative pain services should be mandatory in any institution performing surgery. This interview was cited in the IASP Newsletter for October 2013.

Mary – shown fourth from left in the photo – organized the Vellore Anesthesia Society, and last fall gave an update on acute pain management at Madurai under the auspices of the Tamil Nadu chapter of IASP, that she helped inaugurate. She also conducted two workshops on acute pain for nurses and other health professionals at her own institution, and co-directed a number of “Traveling Pain Schools” with Dr Vijayanand, Honorary Secretary of the Indian Society for the Study of Pain. She has been off to a brisk start in 2014, hosting the ISSP Tamil Nadu chapter meeting at her home institution, CMC Vellore, and participating in the February ISSP meeting in Mumbai, where she lectured again on the topic of acute pain.

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Practice Guidelines for Acute Pain Management in the Perioperative Setting
In a document of 25 pages and 242 references the American Society of Anesthesiologists Task Force on Acute Pain management published Practice Guidelines in 2012. The evidence was reviewed and findings rated. Eight with Class A evidence include:

Techniques to decrease pain:
- pre-incisional infiltration of bupivacaine/ropivacaine (A1)
- pre-incisional plexus/other blocks (A1)
- multimodal techniques with central regional analgesics (A1)
- intercostal/interpleural bupivacaine (A2)
- IV PCA > IM morphine, (A1)
- IV morphine + ketorolac or gabapentinoids > morphine alone (A1)

Techniques to decreased analgesic use:
- post-incisional intrathecal fentanyl (A3)
- IV morphine + ketorolac or gabapentinoids > morphine alone (A1)


Brendan O'Donnell, MD  
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Improvement of Postoperative PAIN OUTcome: An International Project Goes Worldwide

For more than 10 years, quality of postoperative pain treatment has been measured and fed back by the German QUIPS project and – since 2009 – its international counterpart PAIN OUT. The large number of participating hospitals in these benchmarking projects shows that for most clinicians an almost painless recovery of their patients is of utmost priority.

Every year, about 40 million surgeries are performed in Europe and, quite rightly, most patients expect less pain after their operation. Unfortunately, at least half of all patients suffer from moderate to severe postoperative pain. The price of poorly managed pain is high: Pain impedes recovery, it causes suffering and it overloads healthcare resources. But there is hope: An optimized pain therapy can significantly reduce intensity and duration of pain. This is where QUIPS (Quality improvement of postsurgical pain therapy) and PAIN OUT (Improvement of postoperative PAIN OUTcome) come into play.

Both projects aim at improving clinical care of patients with postoperative pain and use the same simple methodology: On the first postoperative day, in a random sample patient-reported pain outcomes like minimum and maximum pain, side effects of the medication, interference of pain with activities, satisfaction, etc. as well as clinical data on age, gender, type of surgery and medication are collected according to a highly standardized procedure, using a validated questionnaire that is available in 18 different languages. After that, all data are anonymized and transferred to an external database. Subsequently, hospitals and clinicians receive an immediate online feedback about the patient reported outcomes of patients in their ward. They can also compare these outcomes with those of patients undergoing similar procedures in other wards. User-friendly filter functions allow clinicians to analyze outcomes by specific surgery. By this approach, potential for improvement can be detected, hospitals can learn from one another and a follow-up of new treatments over time is possible.

Offline analysis allows inquiry into the numerous variables in the database. This provides opportunities to plan,
design, and conduct epidemiological and clinical studies regarding prevention and management of postoperative pain. Hospital administrators can use the data to estimate costs of services, thereby facilitating efficient allocation of resources for pain management.

In addition, an “Electronic Knowledge Library” provides succinct summaries of recommendations for treating postoperative pain. The summaries derive from evidence-based international guidelines and are presented in electronic format with hyperlinks to the original citations.

QUIPS and PAIN OUT are non-commercial projects. Between 2009 and 2012, PAIN OUT was funded by the European Commission’s 7th Framework Programme and run by a group of 17 academic and clinical sites throughout Europe. QUIPS is supported by the societies of German and Austrian anesthesiologists and surgeons.

More than 300 hospitals participate in QUIPS and PAIN OUT, having collected more than 300,000 datasets altogether. Even Helios and Asklepios, two of Germany’s largest private hospital operators, chose QUIPS as their tool for improving pain management. For all of them, the benefits from joining QUIPS or PAIN OUT are obvious: immediate, continuous feedback and analyses of their treatment outcomes help to assure quality of care, benchmarking their own results allows comparison with other hospitals around the world, change management concepts can be implemented and monitored by evaluating own results, research opportunities offered by one of the world’s larges databases on postoperative pain and use of the Electronic Knowledge Library. Last but not least, joining QUIPS or PAIN OUT means becoming part of the world’s largest network of clinicians involved in acute pain. All these benefits result in one overall goal: better patient care.

Participation is open to all hospitals, worldwide. A small participation fee covers the further development and the administration of both projects. Further information can be found on www.quips-projekt.de and www.pain-out.eu.

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