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Message from the Chair

Acute Pain SIG Satellite Symposium on October 5 in Buenos Aires – Rapidly Approaching!

IASP’s Acute Pain Special Interest Group is happy to announce a world-renowned group of speakers covering many aspects of dynamic, resurgent interest in acute pain worldwide. Its timely theme – the challenge of providing evidence-based care based upon group data, when patients and policymakers expect personalized, individualized care – is expressed in the symposium's title: "Faces in the Crowd: Variability and Diversity in Acute Pain Control."

The Satellite Symposium will take place from 9 a.m. to 5 p.m., followed by a cocktail reception in the same venue, the NH Hotel Crillon (telephone +54.11.43102000). Centrally located at 796 Santa Fe Ave., at the intersection of Esmeralda St., and with excellent reviews on multiple websites, the hotel "is located in one of the most exclusive areas of Buenos Aires, just steps from downtown, San Martin Square, Florida Street, and Puerto Madero."

Registration for the Acute Pain SIG Satellite Symposium is free of charge to all participants, though first priority for admission and seating will of course be to the speakers and moderators, followed by the officers and other current loyal members of the SIG, and then to any other IASP member. Our meeting room in Buenos Aires was selected to offer ample accommodations for attendees, comparable to our last Satellite Symposium at the IASP World Congress in Milan. Still, to avoid a possible overflow, we request that all attendees reserve their place by emailing Lindsay.StLouis@tufts.edu to confirm your intent to attend. Please enter your name and the word "attend" in the subject line.

AP SIG Officers and other members are also invited to the SIG Business Meeting during the World Congress. Details regarding time and location will be available in the World Congress program.

Please note that visitors to Argentina from some countries (e.g., India) require a visa. Entrants into Argentina from most EU countries require neither a visa nor a "reciprocity fee." The reciprocity fee is not the same as a visa. Visitors from some countries – notably the U.S., Canada, and Australia – do not require a visa to enter but may need to pay the reciprocity fee online and must present a hard copy of the receipt before boarding a plane to Argentina and upon entry. It is not possible to pay the reciprocity fee upon landing in Argentina. For visitors from the U.S., here is where to learn more and pay the fee. Australian visitors can read the
We look forward to seeing you in Buenos Aires!

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**Agenda - Faces in the Crowd: Variability and Diversity in Acute Pain Control**

9:00-9:10am Welcome and Opening Remarks

Daniel Carr (organizer)

9:10-10:40am Evidence Base for Acute Pain Control: Knowns and Unknowns

Chair: Eddy Neugebauer

Co-Chair: Brendan O'Donnell

A. Moore - Single-dose analgesic trials: 60 years in 20 minutes

P. Desjardins - The actions of ACTTION and the impact of IMMPACT

N. Singla - Decreasing placebo response and false negative outcomes in analgesic clinical trials

10:40-11:00am Coffee Break

11:00-12:30am Individualizing Care in a Mean-minded World

Chair: Stephan Schug

Co-Chair: Jane Quinlan

P. Gulur - Postoperative pain control algorithms: one size does not fit all

L. Collocca - Modulation of acute pain by negative expectation (nocebo)

M. Korula - Modulation of acute pain by positive expectation (placebo)

12:30-1:30pm Lunch Break

13:30-15:00pm Big Data and other Systems Approaches to Population-based Care

Chair: Marcus Komann

Co-Chair: Robert I. Cohen

M. Komann - Comparing treatments worldwide with the PAIN OUT acute pain registry

S. Mackey - Big data meets acute pain: where are the opportunities?
D. Gordon - Training institutions to improve quality and safety of acute pain control

15:00-15:30pm Coffee Break

15:30-17:00pm Personalized Acute Pain Control: National Initiatives

Chair: Daniel Carr

Co-Chair: Gillian Chumbley

R. Gallagher - Trauma, pain, PTSD and other sequelae in warfighters and civilians

E. Neugebauer - Update on pain control as a national priority in Germany

S. Schug - Personalized care in the new ANZCA

Acute Pain/ Scientific Evidence monograph

S. Mackey - The new US National Pain Strategy

17:00-18:00pm Cocktail Reception

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**Acute Pain and other Consequences of the Boston Marathon Bombings: Reflections**

Beth Israel Deaconess Medical Center (BIDMC) is a 631 bed urban level 1 trauma center and a teaching hospital of Harvard Medical School. It is located in Massachusetts, 1.8 miles from the finish line of the Boston Marathon. The Department of Anesthesia, Critical Care and Pain Medicine supports an internationally recognized research and fellowship training program in pain medicine at the William Arnold-Carol A. Warfield, MD Pain Management Center. The Division of Regional Anesthesia and Acute Pain Medicine provides acute pain treatment for surgical and trauma patients in a team-based model directed by Marc Shnider, MD and coordinated day to day by Meghan Connolly, a nurse practitioner with advanced training in pain management. She offers the following reflections from her unique perspective during a time of great challenge.

On Monday April 15, 2013, two brothers walked to the finish line of the Boston Marathon and are alleged to have planted rudimentary explosive devices and then remotely detonated them. 264 people sustained injuries and 3 people were killed including an eight-year-old boy.

In total 24 victims of the bombings were treated at BIDMC. Their injuries were varied and included ocular globe rupture, ruptured tympanic membranes, concussion injury, upper extremity fracture, lower extremity blast injury, and in the worst cases, traumatic lower extremity amputation.

As a whole, the BIDMC community responded swiftly. April 15th was a hospital holiday, thus the vast majority of the hospital's 41 operating rooms were empty. The bombing occurred at nursing shift change, doubling the usual number of nurses on duty. Surgeons and anesthesiology staff watching the race just showed up and within 40 minutes of the first bomb detonation there were 7 ORs fully operational for these patients. The hospital never had to activate its emergency/disaster staff contingency plan.
The BIDMC Department of Anesthesiology, Critical Care, and Pain Medicine played a pivotal role in the care of these patients, both on that first day, and over the course of the subsequent months. The most critically injured patients were taken to the Trauma-Surgical ICU where critical care-credentialed anesthesiologists resuscitated and stabilized patients. The majority of the patients treated at BIDMC had sustained blast injuries to their lower extremities, which are not typical of the trauma generally seen at our urban medical center. Because most of the victims were young and healthy, they were able to tolerate the multiple complicated limb salvage procedures. Many of the patients returned to the OR 10-12 times for debridement, washouts, and revision surgeries. The anesthesia staff absorbed the additional volume in stride and provided exceptionally compassionate and sensitive care — often allowing family members in the recovery room (not our routine,) and making a point to provide continuity of care with the same providers when possible.

The “marathon patients” as they came to be known at BIDMC, required a multidisciplinary approach to their care. A Mass Casualty Incident (MCI) team* was activated, and included representation from Acute Care Surgery/Trauma, Plastic Surgery, Orthopedic Surgery, Psychiatry, Acute Pain and Regional Anesthesia Service, Infectious Disease, Social Work, and Physical Therapy/Occupational Therapy. The team would meet each morning for table rounds to discuss the unique needs of each patient. Each team would then subsequently round individually. The daily MCI meeting allowed for across the board communication with the many teams involved.

The Acute Pain and Regional Anesthesia Service remained involved in the care of a smaller group of patients who remained hospitalized up to 52 days beyond the bombing. This group of patients all sustained catastrophic injury to their lower extremities. All had at least one limb amputated and in some instances had significant injury to both lower extremities. We employed pain management strategies adapted from recent literature on battlefield analgesia championed by Chester 'Trip' Buckenmaier, MD.* For example, femoral and sciatic indwelling nerve catheters were placed, and replaced, over the course of 4-5 weeks with continuous infusion of local anesthetic. Multimodal medication management was also employed. Neuraxial techniques including IT morphine and continuous epidural analgesia were also employed.

Because of the sensitive nature of the incident, and because the marathon patients required such extensive, multidisciplinary care, it was decided to keep the team small and most of the 15 anesthesiologists who usually shared this duty were reassigned. In order to optimize continuity of care, the APS NP and attending/resident rounded twice daily on weekends, and offered a 24/7 response. Detailed hand-offs and sign-outs were routine among the small number of providers sharing this duty. Patients were provided with direct call access to the APS NP should an issue arise during the day or after hours. Although this immediate access was not used frequently, it provided an increased sense of control to those who had lost so much control in their lives. In retrospect, this care model, while highly effective in achieving continuity of care, took an unanticipated physical and emotional toll on the providers involved.

I personally had difficulty sleeping some nights, and would often dream of bomb blasts and amputated limbs. I founds as the months passed, I would sometimes dread going into a patient’s room because the ongoing battle to preserve limbs sometimes felt overwhelming considering the damage sustained from the bombs. In one instance, I was with a young patient and I found myself crying when they received the news from their surgeon that the second attempt at saving a limb with a muscle flap had failed. On a happier note, I remember the day, when a young patient, after their 14th surgery, received the news that we had successfully salvaged sufficient tissue below the knee to provide a better fit for a prosthetic that would permit improved balance in the long run. I was literally crying out of sheer joy with this patient and their family.

It was probably the most difficult time I have experienced in my professional life, but also the most significant. Ultimately I forged such close relationships with these patients that we’re still in touch through and beyond the rehabilitation phase of their recovery.

Meghan A. Connolly, NP
Acute Care Nurse Practitioner, Pre-Operative and Post-Anesthesia Care Unit
Beth Israel Deaconess Medical Center, Boston, Massachusetts, USA
 Commentary on Boston Marathon Reflections

Similar to the posttraumatic stress spectrum symptoms experienced by many following long term care of patients who were severely injured in the Boston Marathon bombing, military healthcare multidisciplinary team members caring for polytrauma patients may experience prolonged psychological stress whether in the operational or military health care facility setting. (1) Although annual education regarding risk factors, symptoms and treatment of PTSD as well as screening questionnaires and exams are in place to assess the physical and mental health status of military healthcare providers, sophisticated healthcare providers may avoid screening positive on PTSD screening tools due to concerns regarding career, stigma and family responsibilities over personal wellbeing. A strong sense of meaning and purpose, unit cohesion and social support may protect against the development of adverse psychological effects such as posttraumatic stress symptoms, depression, anxiety and detrimental psychosocial impact following secondary or primary exposure to trauma. (2-4). Due to robust VA and DoD funding of over 2,300 projects, the innovative use of promising holistic and biologic therapies, (5-8) added to existing evidence based therapies have the potential to decrease the stigma associated with seeking early treatment and prevent the development of more intractable PTSD in those at risk.

Anita H. Hickey M.D., Captain/Medical Corps/United States Navy


Navy Pain Management Consultant, Area Pacific.


Editor's Comment: Caring for the Boston Marathon Bombing Caretakers

By the very nature of their jobs, sometimes in caring for patients with horrific trauma, health care workers are at risk of becoming "secondary victims" of trauma. Dr. Hickey reports (above) that in the United States, there has been a robust response to identify and treat medical personnel at risk within the Department of Defense and the Department of Veteran's Affairs. Similar programs are being developed in US civilian hospitals. The Joint Commission, a private organization tasked with accreditation of US hospitals, published the results of University of Missouri Health Care second victim rapid response teams, recommending early diagnosis and intervention should be available to providers at all health facilities. (Scott, Hirschinger et al. 2010)

Such a program, the Mass Casualty Incident (MCI) team, was in place at Beth Israel Deaconess Medical Center (BIDMC) and activated when two devices exploded near the finish line of the Boston Marathon in 2013. The MCI Mental Health Unit Leader, Barbara Sarnoff Lee, LICSW, organized the hospital's social workers to proactively meet with hospital staff in order to identify what was needed for them to sustain themselves while working in conditions of unusually high stress and to lessen the risk of caretaker PTSD. If staff members experience symptoms of PTSD, they were offered early treatment. They collaborated with the Israeli Trauma Coalition, which specializes in trauma recovery and promotes community resiliency. They continued outreach even after the last patient was discharged. Programs were offered to staff and the public to address feelings and possible anxieties as the 2014 Boston Marathon approached.

For their work, the Massachusetts Chapter of the National Association of Social Workers presented the Hospital Social Work Award for Extraordinary Service to the Social Work Department at BIDMC and to six other Boston Hospitals. Barbara Sarnoff Lee attributes much of their success to having plans in place for a mass casualty incident well before the 2013 Boston Marathon bombing.

Making tools and resources available to enable caretakers to remain as effective as possible during times of especially high stress should be a routine component of every hospital's disaster planning.

Robert I. Cohen MD, Co-editor, AP SIG Newsletter
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Department of Anesthesia, Critical Care and Pain Medicine
Beth Israel Deaconess Medical Center, Boston, Massachusetts, USA
A Breakthrough in Pain Management in Germany: Successful initiative on pain management as an interdisciplinary quality indicator in German hospitals.

After years of discussion at IASP AP SIG-sponsored conferences – including the most recent one in Cologne in Nov 2013 – German physicians have resolved to make the management of acute and chronic pain a national medical priority. The 117th German Physician’s Congress, held in May 2014 in Düsseldorf, recognized the patient's right to up-to-date acute and chronic pain care. The declaration cites the significant human and economic burden of pain in both adults and children as a driver of the need for reform.

This resolution – available in full at [http://www.dgss.org/fileadmin/pdf/Antrag-Deutscher_Aerzetetag-TOP_IV_Schmerz.pdf](http://www.dgss.org/fileadmin/pdf/Antrag-Deutscher_Aerzetetag-TOP_IV_Schmerz.pdf) -- lays out broad goals and objectives for improving pain care in Germany. At the primary care level, German family physicians and internists will gain access to further general training in pain medicine. This will be coupled with increased clarity about specialist referral options and the creation of specialty pain clinics. The hope is to reduce the barriers to pain care experienced by many German patients.

In the inpatient setting, the Congress recognizes the risk and potential burden associated with acute pain, including longer hospital stays, increased treatment costs, and progression to chronic pain. In an attempt to combat this, the Congress recommends making pain management a quality benchmark for all inpatient settings. Comparing pain prevention and treatment to hospital hygiene standards, the report recommends the use of pain as a quality marker of the same importance as nosocomial infections and pressure ulcers.

The declaration does not discuss specific agents or treatment modalities. It encourages financial support for pain research with a focus on both evidence-based optimization of current approaches and the development of new multi-modal strategies for pain treatment. It is gratifying to see this milestone achieved as the result of the efforts of so many in the IASP AP SIG, Wolfgang Koppert and Winfried Meissner in particular.

Eddy Neugebauer, PhD
Witten-Herdecke University, Cologne, Germany

[English translation by Johann Nikolas Patlak MD]
Harvard University, Boston]

Transition from acute to chronic pain
Acute pain is often the precursor to chronic pain and the transition is a continuum. Patients with chronic pain describe surgery or trauma as the initiating incident in a large number of cases. Similarly, persistent postsurgical pain is a common complication after many operations.

It is assumed that in particular, nerve injury or persisting changes in neural pathways leads to the development of chronic pain. Peripheral and central sensitization processes are the presumed pathophysiological mechanisms. Other risk factors identified for the development of chronic pain are severe unrelieved postoperative/posttraumatic pain, female gender, younger age, genetic predisposition and a number of psychosocial factors: depression, psychological vulnerability, stress, catastrophizing and hypervigilance. However, the exact role of each of these factors has not yet been determined.

Current research projects focusing on identifying patients at risk by assessing response to experimental pain or strength of inhibitory controls have shown variable rates of success. Attempts to identify preventive strategies are also finding their way into publication. Early interpretations of the data suggest risk of persistent post-surgical pain can be reduced by minimizing peripheral and central sensitization. The risk of a persistent sensitized state is reduced with surgical approaches that minimize nerve injury, regional anesthetics that block the afferent barrage resulting from tissue injury and inflammation, and effective early and consistent use of multiple enteral, parenteral and/or neuraxial analgesics which benefit from synergy when multiple receptor systems are targeted.

For clinicians there are new opportunities to contribute to the research answering questions about appropriate drug selection, combination and dose regimen, as well as treatment duration. An impact can be made in developing procedure-specific strategies as well as strategies based on identifying and modifying individual patient risk factors prior to surgery. We hope this work will lead to public health based stratified preventive treatment plans.

The frequency with which inadequately treated acute pain transitions to persistent pain is widely underestimated. Persistent pain frequently transitions to chronic pain. Thus the incidence of chronic pain can be reduced when persistent pain is prevented by the rapid and effective treatment of acute pain.

Stephan A. Schug MD(Cgn), FANZCA, FFPMANZCA
Professor and Chair of Anaesthesiology, Pharmacology and Anaesthesiology Unit, University of Western Australia & Director of Pain Medicine, Royal Perth Hospital

Esther Pogatzki-Zahn MD, Co-editor, AP SIG Newsletter
Professor of Anesthesiology, Department of Anesthesiology, Intensive Care Medicine and Pain Management, University Hospital Muenster, Muenster

For further reading:
New Efforts in Acute Pain from the American Academy of Pain Medicine: AAPM’s Acute Pain Medicine Special Interest Group (APMSIG)

Following the launch of the Acute and Perioperative Pain section within the journal of Pain Medicine in 2009, a number of leaders in the field of acute pain in the United States (US) worked with the American Academy of Pain Medicine leadership to establish the Acute Pain Medicine Special Interest Group (APMSIG; see http://www.painmed.org/acute). The organization was established to provide a forum for acute pain medicine physicians to discuss new developments in the field and future directions for this emerging subspecialty of anesthesiology. From my perspective this is an ideal time for the formation of the APMSIG with the significant increase in the establishment of acute pain services throughout the US. Since the group’s establishment, the organization has been very active. The APMSIG vision, goals, and objectives were recently published in Pain Medicine. The organization has also attracted corporate investment administered through the AAPM to study the state of acute pain medicine in the US and develop a taxonomy of practice for this emerging subspecialty. This new organization is also coordinating its activities with the established IASP AP SIG and the Acute Pain Fellowship Directors Group sponsored by the American Society of Regional Anesthesia and Pain Medicine.

We are actively seeking providers with an interest in acute pain medicine to join this group which can be accomplished through the web link provided. As the practice and importance of acute pain medicine continues to develop within the US and the world, the APMSIG will provide a forum for thought leaders in this field to shape the practice for the future. With the variety of ongoing activities, it certainly is an exciting time to be a part of the acute pain medicine community.

Chester ‘Trip’ Buckenmaier III, MD, COL, MC, USA

Uniformed Services University of the Health Sciences, Bethesda, Maryland, USA

US Accreditation Sought for Fellowship Training in Acute Pain Medicine and Regional Anesthesiology

In May of 2013 during a meeting of the Regional Anesthesiology and Acute Pain Medicine Fellowship Directors, this group voted unanimously to explore the process of accrediting a new fellowship through the Accreditation Council for Graduate Medical Education (ACGME).

At this meeting, I was selected to head the subcommittee tasked with pursuing fellowship accreditation. Our subcommittee, helped by Directors of the recently-accredited Obstetric Anesthesiology fellowship, prepared a letter that with attachments totaled 161 pages requesting that our new fellowship be considered for accreditation. With the support of ASRA and AAPM leadership, we submitted this letter to the ACGME on December 5, 2013.

Up until that meeting in May of 2013, there had been ongoing discussion on this topic of accreditation for many years, often with heated debate. What had changed? In my opinion, it was the overall landscape of pain medicine and the growing need for specialists focused on acute pain. Here is an excerpt from our letter:
"In summary, increased understanding of the pathophysiology of pain, advances in surgical treatments, and the demands of health care reform in terms of maximizing patient-centered value compel us to pursue accreditation of fellowship training in acute pain medicine and regional anesthesiology at this time. Accreditation of fellowship training programs in acute pain medicine and regional anesthesiology is not expected to have an adverse effect on anesthesiology or other disciplines. In fact, further development of this subspecialty will only complement the cohort of pain specialists with pain medicine fellowship training because the existing pain medicine fellowship programs focus on chronic pain. Acute pain medicine and regional anesthesiology is a subspecialty focused on the in-hospital patient experience related to acute injury or surgery and the potential long-term implications of inadequately-treated pain. Uniform fellowship training programs in acute pain medicine and regional anesthesiology will enhance the training in core anesthesiology residency by promoting standards in clinical care and education and innovation in research."

Since the letter's submission, our request has been assigned with nearly unprecedented speed to a special ACGME subcommittee for evaluation. Although we eagerly await the subcommittee's response, submitting this proposal letter is simply the first of many steps, with many more to go.

Edward R. Mariano, MD, MAS (Clinical Research)
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