American Pain Society

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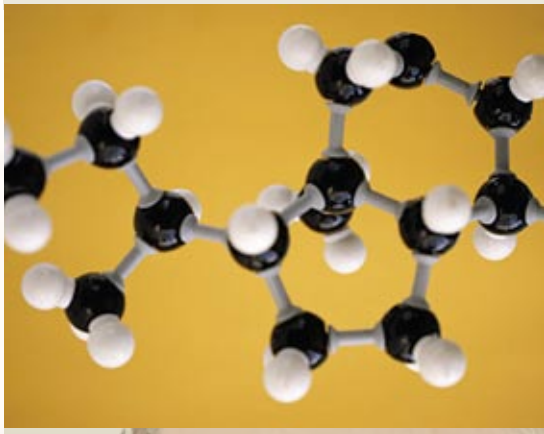
APS Bulletin



Steven H. Sanders, PhD, Editor ❊ Volume 19, Issue 3 ❊ 2009

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PRESIDENT'S MESSAGE

Charles E. Inturrisi, PhD

Speaking for You: APS Develops and Promulgates REMS Position

In February 2009 the Food and Drug Administration (FDA) sent a letter to 18 manufacturers of certain extended release opioids and methadone indicating that Risk Evaluation and Mitigation Strategies (REMS) needed to be developed for these drugs to "ensure that the benefits of these drugs continue to outweigh the risks." The risks as indicated by the FDA are misuse, abuse, addiction, and overdose deaths. In seeking REMS on these approved products, the FDA was exercising new authorities granted by Congress (FDAAA, 2007) which includes the power to remove a product from the market.

Months before, APS had become aware of the looming REMS issues through industry and FDA contacts. In May 2008 the FDA held a two-day meeting to obtain input from industry, healthcare providers, and patient advocates on REMS. Ed Michna, MD JD, chair of the Public Policy Committee, represented APS.

At the APS Mid-Year Board meeting in November 2008, the Board unanimously decided that APS should assume the role of patient/prescriber advocate. We committed ourselves to developing a position that struck a balance between the need to limit the risks associated with prescription opioid availability, and the possible unintended consequences of a REMS policy limiting access to opioids for patients who require these drugs as part of comprehensive pain management treatment. Board members David Craig, PharmD BCPS, and Greg Terman, MD PhD, agreed to prepare a REMs policy statement on behalf of APS. This statement was also intended to be the basis for a communication from APS to the FDA offering assistance and consultation on the REMS policy and its implementation.

The Pain Care Forum (a broad-based network representing patient advocates, nursing and physician associations, and medical institutes), of which APS is a member, prepared a position letter to be sent to the FDA concerning REMS and Drs. Craig and Terman both co-signed the Pain Care Forum letter and also sent a separate letter detailing the APS position.

In February 2009, just 4 days after the REMS letters were sent, the FDA sponsored a meeting discussing current regulatory processes for reviewing and approving opioid analgesics. Speakers at this meeting were largely federal agencies involved with opioid regulation and study (including the Drug Enforcement Administration, FDA, National Institute on Drug Abuse, and Substance Abuse and Mental Health Services Administration) and a number of individuals whose loved ones had been hurt by prescribed or diverted prescription opioids. APS was represented by Ed Michna and Greg Terman. That same week the APS/American Academy of Pain Medicine (AAPM) guidelines for opioid treatment for chronic noncancer pain were published in *The Journal of Pain* and copies of these guidelines were made available to the FDA in support of safe opioid prescription practices.

In May 2009 the FDA held a two-day meeting to obtain input from industry, healthcare providers, and patient advocate stakeholders concerning opioid REMS. Greg Terman gave testimony on behalf of APS highlighting five strong recommendations approved by the Board at the annual meeting earlier that month:

REMS should cover the entire class of opioid medications. Past experience has shown us that any attempt to regulate only a portion of the opioid class of medications will drive prescribers, users, and particularly misusers of these medications to other, less stringently regulated opioid medications, which may be less effective and in fact, pose greater addictive or toxicologic risks. Limiting REMs to certain opioids clearly will not significantly diminish opioid abuse or misuse and will almost certainly result in some patients not getting the medications that are most appropriate for their care.

There should be *no* registry requirements for patients using opioids included in the REMS. No evidence exists to suggest that a federal or state patient registry diminishes abuse or misuse of medications. Evidence does exist, however, showing that such an approach would stigmatize patients and impose significant burdens on all parties, resulting in stilted prescribing and, likely, inadequate pain management.

All implemented REMS components should be measurable and, when necessary, easily reversible. Whichever REMS elements are implemented should be designed so that they can be measured to determine their effectiveness in reducing opioid abuse, misuse, and overdose as well as their effects on appropriate access to opioids. APS provided specific recommendations—prepared by Aaron Gilson, MS MSSW PhD, and colleagues at the Board's request—that identified metrics that could be used for assessing effects of any implemented REMS.

Demonstrated prescriber and dispenser knowledge concerning opioid pharmacology should be expected of all who seek DEA licensure as a component of REMS. It is appropriate that clinicians be required to demonstrate a requisite level of knowledge and competence that supports safe and effective prescribing or dispensing of opioids for therapeutic purposes. Steve Biddle, APS education director, Roger Fillingim, PhD, and the APS Education Advisory Committee (together with input from APS president-elect Seddon Savage, MD) developed an outline of an educational curriculum for prescribers and dispensers which could improve safe opioid treatment.

REMS education programs should be aimed at the public as well. Educating the public about the dangers of sharing opioid prescription drugs and other drug abuse behaviors should be implemented to reduce diversion. Public education—particularly targeted to the youth—should facilitate recognition of the urgent need for healthcare treatment for excessive sedation after opioid use. APS has also been working on the problem of proper and legal disposal of opioids no longer required by the patient.

These points are more fully clarified in documentation submitted to the official FDA docket (public docket 2009-N-0143) concerning opioid REMS during the summer. Unfortunately, the recently approved REMS accompanying the new opioid products Onsolis and Exalgo have largely ignored the REMS suggestions made by APS (and the rest of the Pain Care Forum) and will almost certainly lead to limited access to these drugs for patients in pain. This has led to an additional letter to the FDA reiterating our previous concerns and recommendations and a renewed vigor in monitoring each new action of the FDA concerning analgesic drugs.

APS recognizes the importance of the REMS issues to pain management and we will continue to implement a proactive approach that utilizes the multidisciplinary expertise of APS members to develop a policy that both informs the FDA and the public, provides solutions to some of the critical issues raised by REMs, and should allow the balanced response we all seek.

Thanks to Greg Terman for his helpful comments.

APS 29th Annual Scientific Meeting

May 6–10, 2010 • Baltimore, MD

The APS 29th Annual Scientific Meeting promises to be a lively setting for interdisciplinary exchange among pain scientists and healthcare professionals. The 2010 meeting is one you won't want to miss!

At this meeting, you will

- learn the latest information and scientific updates on interdisciplinary pain management.
- hear from world-renowned experts who practice, teach, and conduct research at the most prestigious healthcare facilities.
- network with professional colleagues and discuss how emerging data from recent basic science research support your role.
- participate in special interest groups that meet to discuss topics and issues of common interest.

You'll get more from this meeting!

- More than 35 symposia
- More than 300 posters
- Corporate satellite symposia
- Paper presentations
- Workshops
- And more!

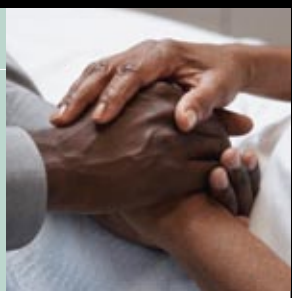
All of this is packed into 4 days in the exciting city of Baltimore! Visit **www.ampainsoc.org** or call 847/375-4715 for more information.

ERRATA

On page 10 in the Summer issue of the *APS Bulletin,* the content area should read Clinical Practice and the section should be Pain Clinic Perspectives. The department editor should be Steve Stanos, DO. This was a publisher error and we apologize for any confusion caused by this error.

Innovations in Practice

Debra Gordon, MS RN FAAN, Department Editor



Antidepressant Medications for Painful Conditions: Another Translational Success Story

By Jane Martinsons, Staff Writer, and Liz Newman, Managing Editor

Editor's Note: The current article is yet another one in our series highlighting successful translational research/application in pain. The application of antidepressant medications to painful conditions is a clear example of translational research at its creative best. This translation started some 30 years ago with the off-label application of tricyclic antidepressants. This was followed with the establishment of an evidence basis for this application and for some second and third generation antidepressants, leading to the current development of some newer antidepressant-based formularies specifically for primary use with painful conditions.

Experts in the field Edward C. Covington, MD, W. Michael Hooten, MD, and Miroslav "Misha" Backonja, MD, contributed their thoughts about the applications of antidepressant medications.

What role do antidepressants play in treating painful disorders?

Dr. Covington: **In recent years, we've learned that spine pain probably had as much or more to do with central sensitization as with nociception at the level of the disc and facets. It's useful to know that duloxetine also works in that model, and it suggests that all of the other SNRIs and tricyclics might also be useful for treating spine pain even though they haven't been studied in an effective way.**

Dr. Covington: About 32 years ago, tricyclic antidepressants started to be used fairly widely in treatment of neuropathic pain. In those days, there was a tendency for neurologists to use primarily carbamazepine (Tegretol™), and for psychiatrists to use primarily the tricyclic amitriptyline—so both were using tricyclics to treat neuropathic pain. In Europe, they were using a lot of clomipramine for that purpose.

There was a flood of early studies that tried to identify which drugs work for which pains. A large number of well-controlled studies clearly demonstrated that these drugs were useful for not only neuropathic pain, but also fibromyalgia, migraine prophylaxis, and other pain such as vulvodynia and functional bowel pain. What these painful conditions have in common is that they result primarily from a process of neurological sensitization rather than from acute nociception.

The tricyclics were largely eclipsed in psychiatry by selective serotonin reuptake inhibitors (SSRIs). In the pain field, we were very impatient for these drugs to reach the market because the tricyclics are 'dirty drugs' with a lot of side effects. They are frequently associated with orthostasis, especially in the elderly. They prolong the QT interval and cause cardiac arrhythmias. Many of them are anticholinergic and cause serious problems with dry mouth, blurred vision, and constipation. They were problematic enough that we were excited to have something without so many side effects. We eagerly anticipated the SSRIs only to find when they arrived that they were very poor analgesics. It seems that the more selective an antidepressant is for serotonin, the less likely it is to be a good analgesic. Some SSRIs have a mild analgesic effect, but in human and animal models they are clearly far inferior to the tricyclic antidepressants.

Next came serotonin norepinephrine reuptake inhibitors (SNRIs), of which venlafaxine was the first. Venlafaxine was shown to have some efficacy in migraine prophylaxis and neuropathic pain, and it has been used extensively off-label for treatment of fibromyalgia and for some other visceral hyperalgesias. Clinically, many pain specialists thought that it was a very good analgesic in these situations, but the manufacturer never supported sufficient studies to demonstrate this scientifically. [A recent addition is desvenlafaxine, or Pristiq®, a metabolite of venlafaxine. As far as I know, it hasn't been studied in pain, but I'm seeing some people prescribe it. It's considerably more expensive than venlafaxine and, as far I know, offers no advantage other than improved kinetics and interactions.]

The next drug that came out was duloxetine (Cymbalta), which was indicated for fibromyalgia but also widely used for such conditions as migraine prophylaxis and other neuropathic pains. Recently, a *European Journal of Neurology* study (Skljarevski et al, 2009) found it to be effective in treating spine pain, which is interesting because nearly all pain clinics spend a preponderance of their time treating spine pain or spine-related pain. Also, a study with maprotiline, a rarely used antidepressant, actually controlled for the presence of depression and neuropathic pain and showed that it was effective for treating axial spine pain.

In recent years, we've learned that spine pain probably had as much or more to do with central sensitization as with nociception at the level of the disc and facets. It's useful to know that duloxetine also works in that model, and it suggests that all of the other SNRIs and tricyclics might also be useful for treating spine pain even though they haven't been studied in an effective way.

The latest antidepressant marketed in the United States for pain indications is milnacipran (Savella™), another SNRI. Interestingly, they did not seek an indication for depression, but only for fibromyalgia, and they got it. It's a well-established antidepressant in Europe. "Milnacipran is a unique, dual norepinephrine/serotonin-reuptake inhibitor that has been used primarily for depression outside of the U.S. over the past 10 years" (Dellwo, About.com, 2009).

Pain specialists have always treated conditions that were not sufficiently common to warrant the expense for a pharmaceutical manufacturer to seek an indication. I don't anticipate that we'll see a company seeking an indication for vulvodynia, for example, even though many people suffer from it and these drugs have the potential to relieve it. It's usually not a good business decision to fund analgesic studies for uncommon conditions.

We're on relatively sound scientific ground when we use tricyclics for treatment of most of these conditions. Yet most of us prefer not to use tricyclics as drugs of first choice because they're likely to lead to either hazardous or uncomfortable side effects. So we face the dilemma of using drugs of demonstrable efficacy that have risks, or choosing drugs that are similar mechanistically for which studies have not been done, and relying on clinical judgment to assess their efficacy.

Dr. Hooten: **The newer agents, serotonin norepinephrine reuptake inhibitors (SNRIs) such as duloxetine, for instance, have similar effects as the tricyclics but with possibly fewer side effects. These medications might be more easily tolerated.**

Dr. Hooten: The tricyclics, such as nortriptyline and amitriptyline, have been the most widely used medications for neuropathic pain, including diabetic peripheral neuropathy and other neuropathic pain conditions. They are very effective medications, and they have good efficacy. However, they are limited by adverse side effects, including problems due to anticholinergics as well as weight gain. That's important considering that a lot of folks with neuropathic pain are older individuals who may be more susceptible, or at least more sensitive, to those adverse side effects.

The newer agents, serotonin norepinephrine reuptake inhibitors (SNRIs) such as duloxetine, for instance, have similar effects as the tricyclics but with possibly fewer side effects. These medications might be more easily tolerated.

Tricyclics might be beneficial for fibromyalgia; it's very clear that amitriptyline specifically has modest efficacy. SNRIs, such as milnacipran or Savella, may show some efficacy for fibromyalgia.

Dr. Backonja: Tricyclics are an older class of drugs and they were systematically studied about 20–30 years ago, which was many years before opioids were systemically studied for chronic pain disorders and that started only in the 1990s. In the early 1980s, a wide range of studies were conducted and the efficacy of tricyclics was demonstrated for relief of pain, which was independent of the effect of mood, and this was best demonstrated in the case of neuropathic pain and headaches. These observations were the basis of which other antidepressants were studied for treatment of neuropathic pain and headaches, and later other pain, such as muscoskeletal low back pain, and other painful disorders, such as fibromyalgia.

How strong is the scientific evidence for using antidepressants to treat neuropathic pain?

Dr. Hooten: There is very strong evidence [based on] multiple randomized placebo-controlled trials that tricyclics, at least, are very effective for neuropathic pain. Because SNRIs are newer drugs there are fewer trials available, yet those that have been done show strong efficacy. For back pain, there is moderate evidence with tricyclics, and the the majority of trials have been positive. Again, the treatment effect is modest, as it is for duloxetine. The SNRI data for low back pain is just emerging, and so there still needs to be more work there.

Dr. Backonja: Regarding the efficacy of tricyclics for relief of neuropathic pain, it's as strong as, if not stronger than anything else for chronic pain. The number of clinical trials is pretty large. One of the caveats, however, is that earlier studies that served as the foundation were smaller and conducted in single medical centers. Now the standard is to conduct large, multicenter studies.

Dr. Covington: I know of five randomized trials showing that tricyclics treat fibromyalgia, 11 randomized trials in functional GI disorders, and probably 10 or 11 controlled trials in back pain. So even though we don't have indications for these, actually the scientific evidence is very, very strong.

And as far as best practice protocols, are they available, and if so, what and where?

Dr. Backonja: The uses of tricyclics for treatment of neuropathic pain has been addressed in a number of published treatment guidelines, probably too many to start identifying one by one. Their role is fairly standard by now.

Dr. Hooten: In terms of practice guidelines, the Institute of Clinical Systems Improvement (ICSI), a large conglomerate based in Minneapolis, is developing algorithms and guidelines for a variety of scenarios, from asthma or coronary disease to chronic pain. Their chronic pain guidelines strongly support the use of tricyclics. They even lay out some algorithms about how to use them.

Dr. Covington: I don't know of any guidelines specifically targeted on the use of antidepressants for pain; however, numerous guidelines for chronic pain in general, rheumatologic pain, neuropathic pain, back pain, and others, do address antidepressants as part of their recommendations. These include the Institute for Clinical Systems Improvement (ICSI). Assessment and management of chronic pain (2008); Chou et al, Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society, published in the *Annals of Internal Medicine* (2007); Serge Perrot et al, Guidelines for the use of antidepressants in painful rheumatic conditions (from CEDR (Cercle d'Etude de la Douleur en Rhumatologie) a specific interest group of the French Society of Rheumatology), *European Journal of Pain* (2006); and EFNS guidelines on pharmacological treatment of neuropathic pain by Attal et al, *European Journal of Neurology* (2006).

On a personal note, the American Psychiatric Association and the United Kingdom's National Institute for Health and Clinical Excellence have issued guidelines that state that benzodiazepines are really not first-choice drugs for treating long-term anxiety. I think this is probably even truer in chronic pain patients who are likely to be taking opioids anyway. When you combine benzodiazepines with opioids, you risk impaired cognition, habituation, loss of efficacy, poor motor coordination, etc. As it turns out, a lot of the drugs that we use as adjuvant analgesics are extremely effective tranquilizers; they just aren't advertised for that. There are 30-year-old studies, for example, showing that several of the tricyclics—for example, doxepin—are as effective as Valium for treating anxiety, and not addicting, and excellent choices to use in patients who have a comorbid addictive disorder. This represents a significant portion of patients with chronic pain. A number of studies demonstrate that some anti-epileptic drugs also have strong anxiolytic effects. So we have drugs that demonstrably improve function, reduce anxiety, and also improve sleep, while at the same time reducing many pains. We can use these as an option to the benzodiazepine tranquilizers. It's problematic that there is a very large number of patients with chronic pain who are taking opioids, plus benzodiazepines, and then having to take stimulants so that they can maintain consciousness. It makes much more sense to use adjuvant analgesics that have anxiolytic and sedative properties to treat people's anxiety and insomnia, rather than adding on tranquilizers to their opioids.

continued on page 6

What are future trends for the next 5 or 10 years?

Dr. Backonja: SNRIs are newer antidepressants that have a dual mode of action, as opposed to SSRIs that have a single mode of action. SNRIs have primarily demonstrated efficacy in the treatment of a limited number of disorders, primarily neuropathic pain in fibromyalgia. However, a number of studies presented at meetings on duloxetine actually demonstrate efficacy in treatment of low-back pain as well. It pretty much follows the traditional previous observation of efficacy and treatment of the other chronic painful disorders. It's worth noting that one of the advantages of having medications like duloxetine on board for pain management is a number of frequently associated comorbidities, such as mood and sleep disorders, can be treated as well.

I'm hoping to see wider studies that demonstrate or confirm some of the other advantages of SNRI in treating headache disorders, including migraine headaches or chronic daily headaches. However, there are really no good studies providing evidence that these drugs fit within a realm of multi-drug therapy, otherwise known as combination therapy. Also, a question remains of how to identify patients who will be responders. Given that 40% or 50% of patients respond to a clinically-relevant degree of pain relief, the question is can we identify those patients up front and maximize their treatment, rather than exposing patients to side effects with potentially no benefit?

Dr. Backonja: **Given that 40% or 50% of patients respond to a clinically-relevant degree of pain relief, the question is can we identify those patients up front and maximize their treatment, rather than exposing patients to side effects with potentially no benefit?**

Dr. Covington: I'm not anticipating major developments in the area of antidepressants for pain; minor changes are likely, such as fast-dissolving, longer-acting, extended release preparations. Basically, we've got drugs that range from purely serotonergic to almost purely noradrenergic, and so we've got the spectrum fairly well covered. I would expect to see changes from the standpoint of convenience, but I don't expect to see major developments in the SNRIs that will enable us to treat people more effectively than we do now.

One needed change is not so much new drugs as new practice patterns. In our practice we see a lot of patients who have failed several treatments. It is surprising that most of the people with hypersensitivity/neuropathic/hyperalgesic sorts of pains have had thorough and appropriately administered trials of anti-epileptic drugs, but they've either not had trials of antidepressants or the [trials] have been too little, brief, and poorly done. This may relate to stigma—that clinicians are more comfortable telling the patient that an anti-epileptic, rather than an antidepressant, helps with pain. Either the patient doesn't like being made to 'sound psychiatric' or the provider doesn't want the hassle of assuring the patient that we want to use this because it treats pain effectively in animal models.

I think antidepressants are underused in treating these syndromes. We know that well-controlled studies with the anti-epileptic drugs demonstrate pain reduction, but they never demonstrate pain elimination. Often, a drug considered very successful reduces mean pain from 7 down to 5 on a 0–10 scale. Most of us, however, don't want to live with a pain of five, if we have a choice. By using both an anti-epileptic and an antidepressant, the patient may obtain a greater degree of pain reduction without increased side effects. I don't think people do enough of that. I think we're all holding our breath for new developments outside the SRNI family. We're looking for calcitonin gene related peptide antagonists, glial inhibitors, and drugs that modify a host of other transmitters and receptors.

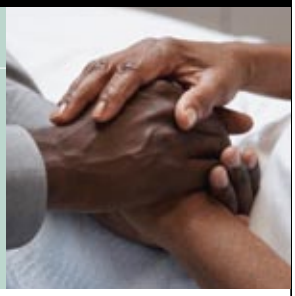
Edward C. Covington, MD, founded the Chronic Pain Rehabilitation Program at the Cleveland Clinic in 1979 and has served as its director since that time. He developed a hospital pain consultation service for the diagnosis and management of problematic acute, chronic and malignant pain.

W. Michael Hooten, MD, is assistant professor of anesthesiology at the Mayo Clinic in Rochester, MN. He works in the departments of anesthesiology, pain medicine, psychiatry and psychology, and in the Pain Rehabilitation Center.

Miroslav Backonja, MD, is a neurologist with special interests in pain physiology and the treatment of pain syndromes. Dr. Backonja is associate professor of neurology and anesthesiology at the University of Wisconsin Medical School.

Pain Clinic Perspectives

Steven Stanos, DO, Department Editor



CCOE Spotlight: Beth Israel Medical Center

By Liz Newman, APS Managing Editor

APS honored five U.S. programs that exemplify the provision of outstanding clinical care and presented the awards to those programs at the 28th Annual Scientific Meeting Clinical Centers of Excellence (CCOE) and Awards Gala. These programs provide patient-centered, state-of-the-art, evidence-based, cost-conscious, culturally appropriate care; provide appropriate access to interdisciplinary and multimodal care and other specialists from a variety of disciplines to ensure expert care; act as local champions to improve pain management; demonstrate innovation and serve as models of excellence for pain management; actively work with other healthcare organizations and the community to improve the quality of pain management; and demonstrate a commitment to advancing scientific knowledge related to pain.

The Department of Pain Medicine and Palliative Care (DPMPC) at the Beth Israel Medical Center in New York, NY, was honored for its comprehensive impatient and outpatient pain program. Vice-Chairman of the DPMPC Ricardo Cruciani, MD PhD, regards the CCOE program very highly. "The creation of the CCOE award is nothing but another very creative effort by APS to promote the values that have characterized its mission since its creation some 30 years ago. APS helps its members and healthcare providers to deliver the best possible patient care, and also to navigate some unchartered waters in difficult ethical and legal conundrums that are so unique to this discipline."

The DPMPC was established 11 years ago as the first department in the nation of its kind, devoted to pain management and palliative care. It has created a unique model that links two clinical divisions (pain and palliative care) and three academic divisions (Research, Institute for Education, and Pain and Emergency Medicine Institute) under one leadership that reports directly to hospital senior management.

The team at the DPMPC strives to use creative strategies to deliver the best care during the economic downturn. Dr. Cruciani says, "In these difficult financial times for the healthcare industry, where funds have been slashed or cut for many services that are perceived as superfluous, but that are essential for a multidisciplinary approach to pain management, we saw a need to become more creative and develop partnerships to decrease cost, avoid redundancy of services, and secure the care that patients deserve and need."

The DPMPC oversees interdisciplinary inpatient consultation teams for acute perioperative pain, chronic pain, and palliative care; an 18-bed inpatient unit for pain, palliative care, and hospice patients; and outpatient practices in pain management and in symptom control and palliative care. Among the innovations are a nurse practitioner-led fast track program to expedite appointments, a program in transcranial direct current stimulation, on-site acupuncture, and a Pain and Fatigue Study Center. It collaborates with other organizations, providing pain care to the HIVB/AIDS clinic and to a nearby ambulatory rehabilitation facility, and physician coverage to a home care program in palliative care.

Academically, the DPMPC is home to two accredited physician training programs (pain management, and hospice and palliative medicine); a nurse fellowship and social work fellowship; a caregiver program and Web-based public and professional education (www.StopPain.org); and a large clinical research program. It maintains a unique Asian Family Caregiver Program, has a faculty that educates and volunteers in national and international committees, and publishes the *Journal of Pain and Symptom Management.*

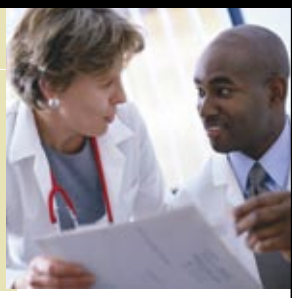
Members of the DPMPC receive the CCOE Award in San Diego, CA.

The team from the DPMPC.

Reminder: 2010 CCOE Awards Program Deadline December 31, 2009

The Clinical Centers of Excellence in Pain Management (CCOE) Awards Program now includes two categories: a university-based track and a community-based track. Applications for the 2010 CCOE Awards are being accepted through December 31, 2009. To learn more about the award, recent changes, and to submit an application, please go to www.ampainsoc.org/awards/ccoe. If a program is unsure of how to apply under the revised CCOE guidelines, please contact the APS national office for clarification.

APS Announces the 2010 Rita Allen Foundation Award in Pain



The Rita Allen Foundation and the American Pain Society announce a call for applications for the 2010 Rita Allen Foundation Award in Pain. The RAF and APS may award two grants in the amount of $50,000 annually, for a period of as many as 3 years to those research proposals demonstrating the greatest merit and potential for success.

Candidates must have completed their training and provided persuasive evidence of distinguished achievement or extraordinary promise in basic science research in pain. Candidates should be in the early stages of their career with an appointment at a faculty level.

The entire award is to be allocated to projects specifically chosen by the recipient. Overhead is not supported.

Deadlines

Applications may be submitted online by visiting www.connect2conferences.com/aps4/ws_member/member_login.php and will be due by midnight January 15, 2010. Grant awards will be announced by April 1, 2010. Funds will be awarded for the initial 12 month grant period that will begin upon satisfactory execution of the grant agreement between the RAF and the recipient's institution. Applications will be reviewed by a Scientific Advisory Committee of APS and RAF. The committee will not provide a review of unsuccessful applications.

Research Topics

Proposed research projects should be directed toward the molecular biology of pain or basic science topics related to the development of new analgesics for the management of pain due to terminal illness.

General Information

The application must include a written proposal in English of no more than seven pages including references and a curriculum vitae including the candidates address and telephone numbers. The candidate's application must include letters of support from five people acquainted with the candidate's research. At least two of the support letters should come from individuals outside of the candidate's institution. In addition, a letter from the appropriate administrators and the department chair or institute head is required and must demonstrate strong support for the candidate's proposed research and career development. The candidate will provide the e-mail contact information for the individuals who support the candidate's proposed research. Individuals will be contacted by the online system requesting that their letters of support be uploaded directly into the candidate's application.

The candidate should list current and pending research support from all sources. The application process, including the electronic submission of all letters, is online at www.connect2conferences.com/aps4/ws_member/member_login.php.

Eligibility

To be eligible for the Rita Allen Foundation Award in Pain the applicant:

- must demonstrate the strong support of the appropriate administrators and Department Chair or Institute Head
- should have been on a tenure track for no more than 3 years and support will be reconsidered if a Rita Allen Foundation Scholar is awarded tenure.
- must conduct the research and be appointed at an institution in the United States or Canada.

Grant Budget and Grantee Obligations

Eligible grant expenses may include Principle Investigator salary but not institutional overhead.

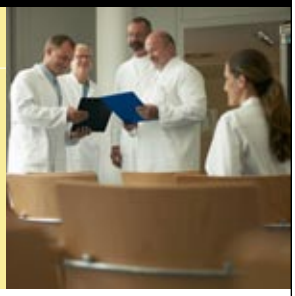
Recipients are required to submit a 500-word annual progress report and a financial report to the RAF in accordance with the terms of the grant agreement.

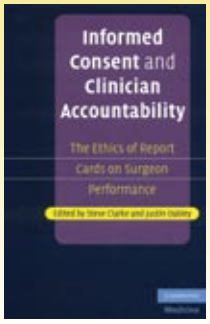
Investigators are required to present an abstract presentation of the sponsored research at a future Annual Meeting of the APS.

For additional information contact APS at 847-375-4715 or info@ampainsoc.org.

Resource Reviews

John D. Loeser, MD, Department Editor





Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance

Steve Clarke and Justin Oakley (Eds). New York, Cambridge University Press, 2007. Hard cover 320 pages. ISBN 978-0-521-86507-4. $120. Paperback, ISBN 978-0-521-68778-2. $48.

Reviewed by Robert Goodkin, MD

The motivation for writing *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance* appears to have been kindled by the Bristol Royal Infirmary Scandal; the British Royal Infirmary Inquiry began in 1998 and culminated with the Kennedy Report 2002 and the changes imposed by the National Health Service in the United Kingdom. Informed consent assumed that the patient or consenting person was informed of the treatment options, nature, risks, complications, and potential outcomes as well as the patient having had 'all' questions answered and that the patient or consenting person understood the information presented. Informed consent had not traditionally included performance statistics of the individual provider or institution, although the publication of cardiac surgeons' performances has been available in the United States since the 1990s. The preamble to this book notes the reporting of physician report cards is "being driven by various factors, including concerns about accountability, patients' rights, quality and safety of medical care and the need to avoid scandals in medical care."

The chapters are well-written and thoroughly referenced. The book is divided into three parts with the introduction by the editors covering the "ethical arguments for reporting clinician performance information," "historical background to surgical outcomes reporting," "modern developments," and "further issues in reporting surgeon performance information." Part I deals with accountability; Part II deals with informed consent; and Part III deals with reporting performance information. Each section has a short introduction outlining the chapter topics, which helps the reader appreciate the material presented by the various authors.

In general, there appears to be a bias toward the inevitability of report cards, not only for surgeons, but all physicians. The arguments for acceptance of report cards and the need for surgeons to inform patients of their individual mortality and morbidity statistics as part of the informed consent process is presented as if it were an ethical edict. The opposing view is primarily based on the presumption that the incorporation of report cards into the informed consent process will lead to surgeons avoiding difficult and high risk patients to keep their ratings at an acceptable score. In addition, opponents cite patients' difficulties in interpreting the significance of the scores. Obviously, patients will want the surgeon with the highest rating, but not all patients will have access to the highest rated surgeon for a particular operation and will have to settle for "second" best. Long waiting times may result as patients demand the "best" surgeon based on reports cards. One important question that arises: Should the surgeon or the hospital and team form the basis of report cards?

Many of the authors reference the same material to forge their arguments. Although some of the authors claim that there is no evidence that report cards will result in a deleterious effect, one article not seen in the cited references of the book notes that there was a strong association between poor performance and cardiac surgeons' decisions to relocate or cease practicing within 2 years of the release of the New York State Coronary Artery Bypass Surgery Report Card System.[1] This might be interpreted by many as a favorable outcome. Although performance data has been available, apparently there is no evidence that this has affected market share for the hospitals or surgeons unless one considers relocation or ceasing to practice a deleterious effect. Accurate assessment based on adequate risk adjustment and sufficient sample size is a major concern of those questioning public reporting of surgeon or physician report cards.

The book is highly recommended to all physicians who should acquaint themselves at least with the arguments—both pro and con. Readers also may find of interest more recent publications.[2–4] This subject will certainly be an issue of continued discussion. In the attempt to improve the system, one should remember that "The perfect is the enemy of good" (Voltaire).

References

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2. Guru, V., Fremes, S. E., Teoh, K., Tu, J. V. (2009). Publicly reported provider outcomed: the concerns of cardiac surgeons in a single payer system. *Canadian Journal of Cardiology*, *25,* 33–38.
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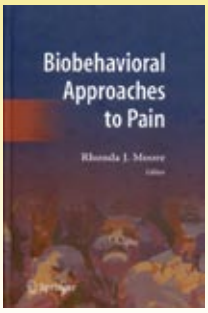

Biobehavioral Approaches to Pain

Rhonda J. Moore (Ed) New York, Springer, 2008. Hard cover, 568 pages. ISBN 978-0-387-78322-2. $79.95.

Reviewed by John D. Loeser, MD

This book contains 21 chapters that have no inter-relationship other than they all address some aspect of pain. Most of the chapters are useful topic reviews and have extensive reference lists. There are rare figures and tables and a good index. The unsigned introduction gives a one-paragraph summary of each chapter. A wonderful chapter by Howard Spiro—"The Narrative Approach to Pain"—is the highlight of this volume. There are many other very good reviews of recurrent themes in pain research and practice, including "Pain and the Placebo Effect" by Pollo and Benedetti, and "Pain and the Use of Health Services among Persons Living with HIV" by Dobalian, Tsao, and Zeltzer.

It disturbs me that a book with this title can completely omit any reference to multidisciplinary pain clinics and the evolution of pain management based upon the recognition that cognitive and behavioral factors played a significant role in the clinical phenomena seen in patients with chronic pain. In the era of evidence-based medicine, multidisciplinary pain management has the best available data for efficacy. The book seems to suggest that "biopsychosocial" is a term to be avoided, yet chapter after chapter clearly encompasses this framework for thinking about pain and pain patients.

The span of the chapters in this book ranges from genetics to epidemiology, economics to imaging, and covers three specific syndromes: phantom limb pain, chemotherapy-induced neuropathy, and whiplash. More authoritative sources on each of these are available. In summary, there are many worthwhile chapters but there is no integration into a meaningful whole. Comprehensive review of pain management is not a feature of this volume. Pain experts may find the information and prolific references in some of the chapters to be useful.

Dr. Loeser is Professor Emeritus of Neurological Surgery and Anesthesiology and Pain Medicine at the University of Washington, Seattle, WA.

Pain Review

Steven D. Waldman. Philadelphia, Saunders, 2009. Soft cover, 761 pages. ISBN 978-1-4160-5893-9. Includes full text online searchable. $79.95.

Reviewed by John D. Loeser, MD

This is a superb resource book for anyone who wants an overview of the field of pain management. The first section covers general anatomy and is followed by sections on neuroanatomy, painful conditions, diagnostic testing, interventional techniques, physical and behavioral techniques, pharmacology, special patient populations and ethical and legal issues in pain management. These are followed by review questions and their answers and then a complete index. The individual chapters are brief and very well illustrated with figures and imaging studies when appropriate. The figures have a consistent style throughout the book and emphasize the salient points of the text.

For someone studying for a certification exam, this is an ideal text. The information is limited to the key points and is easy to glean from the text and figures. I congratulate the author and the publisher on a job very well done.

Dr. Loeser is Professor Emeritus of Neurological Surgery and Anesthesiology and Pain Medicine at the University of Washington in Seattle, WA.

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Advances in Chronic Pain Management
Sponsor: *British Journal of Hospital Medicine*
Location: Institute of Physics, London
Contact: Lisa Freeman, lisa.freeman@markallengroup.com or +44 (0) 20 7501 6768

March 7–12, 2010
NYSORA World Anesthesia Congress (NWAC) on Regional Anesthesia and Pain Medicine
Sponsor: New York Society of Regional Anesthesia (NYSORA)
Location: Dubai
Contact: patpokorny@nysoraworld.com

April 7–10, 2010
31st Annual Meeting & Scientific Sessions of the Society of Behavioral Medicine (SBM)
Sponsor: Society of Behavioral Medicine
Location: Seattle, WA
Contact: info@sbm.org or 414/918-3156

May 6–8, 2010
American Pain Society 29th Annual Scientific Meeting
Sponsor: American Pain Society
Location: Baltimore, MD
Contact: info@ampainsoc.org or 847/375-4715

May 27–30, 2010
3rd International Congress on Neuropathic Pain
Sponsor: Special Interest Group on Neuropathic Pain (NeuPSIG) of the International Association for the Study of Pain (IASP)
Location: Megaron Athens International Conference Center, Athens, Greece
Contact: neuropathic@kenes.com