mps
MIDWEST PAIN SOCIETY
A REGIONAL AFFILIATE OF THE AMERICAN PAIN SOCIETY

Midwest Pain Society
UPDATE

Summer 2010

Steven Krause, Ph.D.
Psychologist

PRESIDENT'S COLUMN

BARRIERS TO PAIN CARE: THE REST OF THE STORY

No doubt most of us are familiar with the literature on "barriers to pain care." These studies focus on impediments to the use of pain medications, mostly opioids. Many studies focus on the internal barriers to pain medication use, such as fear of addiction, medication tolerance, fatalism, passivity with health care providers, medication side effects, and similar matters. Other reports address professional barriers, such as provider reluctance to prescribe and insufficient training in pain medicine among non-specialists. Finally, a third stream of research looks at societal roadblocks, such as economic, racial, ethnic or gender disparities in prescribing, regulatory sanctions against prescribing, the need to balance adequate analgesia with regulatory policies, and the concerns regarding prescription drug abuse and pharmaceutical diversion.

All of these issues deserve thoughtful attention, and continued study. The recent cancer death of my step-father, Tony, reminded me once again to be grateful for those who successfully struggled to free us from the "dark ages" where the dying were often denied pain medication. The limited pain medication options offered Tony by his well-intentioned rural hospice service also reminded me how far we still have to go in educating both professionals and the public about the full range of possibilities in pain care. Nonetheless, I confess an enduring discomfort when the discussion of "barriers to pain care" is reduced to "barriers to medication use" or even "barriers to opioid use." The implication, likely unintended, is that pain care is completely synonymous with pharmaceuticals, and that other barriers to care are either absent or unimportant. Certainly medication issues matter, but many other barriers to effective pain care may inhibit our efforts. Perhaps we would do well to address these others also:

THE ENDURING INFLUENCE OF RENE DESCARTES (1596–1650).

Perhaps no individual in human history has so thoroughly informed the commonplace understanding of pain as Descartes, and yet few among the public would recognize his name. Sickly as a child, Descartes applied his considerable intelligence to mathematics, physics and philosophy, and developed innovations such as the rectangular coordinate system. He rejected received wisdom, emphasized rationality, and attempted to base his philosophy solely on what he could deduce for himself.

Descartes' *Mediations on First Philosophy,* published in 1641, consisted of six essays in which he first emphasized the need to question all previously held beliefs, even the belief in his own existence. Nonetheless, he eventually concluded that his ruminations were themselves proof of his existence, culminating in his famous remark Cognito ergo sum "I think, therefore I am." Descartes argued that the mind has no physical component and consists solely in its ability to think, while the body occupies space, moves, and transmits sensations to the mind. He eventually developed the notion of the human body as "a machine" with the mind as its governor, and the

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INSIDE

President's Column continued

pineal gland as the exact point of intersection between the two.

While substantial research and clinical experience has led most pain professionals to reject this mind/body dualism, the belief remains common among the general public that pain can be distinguished between "real pain" arising from somatic malfunctions explainable by chemistry and physics, and "in-your-head pain" explainable by emotional stress or Freudian theory. Among many patients and some physicians, only the former is legitimate, while the latter is shameful. Unexplained pain thus becomes an embarrassment, with maladaptive activity patterns, depression, distorted relationships, pain behavior, litigation and other forms of suffering following in its wake as patients' attempts to justify the "reality" of their pain. In the interests of maintaining rapport with our patients, we may fear to address these pain-amplifying factors unless all reasonable medical interventions have already been tried without benefit. We thus narrow our focus, and may intervene overly aggressively, even to the point of creating iatrogenic complications. The patient then perceives the subsequent referral to a psychologist as "giving up" or as an indictment of their veracity or sanity. Somehow, this does not enhance therapeutic rapport.

CONSUMERISM AND THE "RIGHT TO PAIN RELIEF"

From *You deserve a break today* forward, Madison Avenue has worked hard to convince us that we deserve all that we desire, and they stand ready to serve our endless but legitimate needs. I searched Amazon.com for the phrase *you deserve*, and was rewarded with 295 titles promising to help me get the raise, respect, relationship, body, job, love, social security benefits, health care, success, satisfaction, results, sex life, help, abundance, peace, happiness, death, image, recognition, soul, Christmas, power, customer satisfaction, joy, sales, birthday, lifestyle, rewards, man, hugs and kisses, top healers, dessert, adoption, financial advisor, beautiful home, retirement, truth, people, grace, printing staff, tax deductions, service, feedback, interior design, profit, dog, sleep, housework, fulfillment, promotion, government benefits, credit, prosperity, car repairs, hormonal health, vitality, and yes, pain relief to which I am so very entitled.
When our nation affirmed a set of civil rights within our constitution, these consisted largely of restrictions on the government's ability to punish us for unpopular speech, publications, associations, or complaints, to take our property or liberty from us without cause, to compel us to house soldiers, or to search our homes. The bill of rights also defined due process for those involved in criminal and civil litigation. The language and legal structures surrounding civil and human rights have been used to mobilize our country to overthrow slavery, prohibit legal discrimination against racial, religious, ethnic, gender, political, and other minorities, and otherwise limit the ability of the majority to suppress those unlike itself. We can be justly proud of these accomplishments, while still recognizing the remaining work needed to create a fully just and equitable society.

However, what happens when we overlay the language of entitlement and civil rights onto health care decisions? A world without pain would be wonderful, but we currently have only a very limited capacity to deliver this. Can there be a "right" to pain relief in a world without the ability to relieve all pain? It is certainly good to draw attention to the value of providing pain relief whenever possible, and to advocate for those who suffer. However, I fear we only confuse the issues and create frustration for ourselves and our patients when we treat complete freedom from pain as if it were an entitlement. Overly aggressive treatment to relieve pain can exacerbate rather than relieve the patients' distress, and the expectation of a right to pain relief can leave providers trapped between their apparent duty and their actual limitations. We are obliged to do the best we can, but no more.

SKEWED REIMBURSEMENT SYSTEMS

Several years ago, *The New York Times* published a series of articles about innovations in health care delivery. One of these profiled a multidisciplinary diabetes management clinic at Beth Israel Hospital in New York City. This program emphasized ongoing management of blood glucose and other diabetes markers, provided extensive paraprofessional counseling regarding diet, insulin use, and exercise, and rigorously evaluated its clinical and financial outcomes. By any measure, the treatment was successful in keeping patients healthy. Obesity dropped, laboratory markers of diabetes normalized, complications were few, and patients' quality of life was dramatically better than under standard care. After some initial start-up costs, the program provided all these benefits at substantially lower cost than standard care, largely because its patients had far fewer expensive diabetic complications.

This clinic, which might serve as a model for creative health care improvement efforts, went bankrupt and closed. The business model of the program had assumed that a percentage of those treated would fail, and their subsequent need for surgeries, nerve blocks, and other technologically sophisticated treatments for diabetic complications would provide enough revenue to support the program as a whole. When treatment outcomes exceeded expectations, the clinical victory became a business defeat, because the preventative care emphasized by the clinic was so poorly compensated.

We face similar dilemmas in the treatment of pain. Some of our least invasive procedures have the best research support, yet they are also the least compensated. This makes economic sense, because the relief of current pain motivates both patients and providers to a degree that the prevention of potential future pain does not. We are willing to pay more for what we value, and humans do not respond well to slowly moving threats. We need to reprogram our amygdalae to value pain prevention at least as much as pain relief.

Perhaps we cannot count on patients to value prevention, but why do insurance companies not recognize the financial benefits of preventive interventions? Would they not reap the eventual benefits of lower costs, even as patients enjoy higher quality of life? In the aggregate this may be true, but at the level of the individual company it makes no financial sense to cover most preventative services. The average American changes jobs every seven years. Therefore, under employer-based health insurance, the costs of preventative care accrue to the current health insurance provider, while the expected cost reductions

have only a random chance of benefiting that company. Would you place a bet at Las Vegas if the cost of losing was entirely your own, but your winnings might be given to anybody at the table?

As this is the final MPS newsletter before my term as President expires in October, I would like to thank the membership for the opportunity to serve the Midwest Pain Society for these last several years. At this year's American Pain Society meeting in May, Dr. Nathan Rudin and I had the opportunity to meet with the leadership of the other regional pain societies affiliated with APS. The stable membership, financial health, and breadth of activities of MPS were the envy of the other groups, and Nate and I were peppered with questions about "How can we do what MPS does?" The enduring vitality of MPS is a testament to those who have gone before us, our dedicated board of directors, and ultimately of our membership. Thank you for your support, and please let me know if we can serve you better.

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ADOLESCENT CHRONIC PAIN MANAGEMENT

Gadi Revivo, D.O. and Diane Amstutz, Ph.D.
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Center for Pain Management

Few centers in the United States offer interdisciplinary rehabilitation that incorporates psychological therapies for the treatment of chronic pain in children and adolescents. The purpose of this article is to review the factors that contribute to the development of chronic pain in children and to discuss state of the art treatment for such pain.

The prevalence of chronic pain ranges from 8–15% as reported in the literature. Children experiencing chronic, recurrent pain include those with diffuse musculoskeletal pain, recurrent abdominal pain, headache, and neuropathic pain syndromes. The incidence of these diagnoses in the pediatric population is the same as that in the adult population (Rogers, 2008). Girls report more pain than boys at and after puberty. Factors that may contribute to the development of chronic pain after insult include cultural learning, family experience, cognitive-emotional well being, genetic contributions, and neural-hormonal mechanisms as described by the neuromatrix. It is the complexity of the interaction among the cognitive, somatosensory, and neural hormonal systems that determine the multifaceted dimensions of the pain experience (Melzack, 2001).

Musculoskeletal pain is quite common in children, with less than 1% developing persistent chronic, widespread body pain. Predictors include presentation with cervical and or thoracolumbar myofascial pain, commonly seen in teenage girls with associated depression. Those presenting with a diagnosis of juvenile fibromyalgia syndrome often have a maternal genetic association and high familial conflict. Functional abdominal pain in the pediatric population presents as poorly localized, crampy, dull pain with somatic complaints including headache and extremity pain. These patients often present after extensive negative gastroenterologic work up. Headaches are the third most common pain complaint, affecting up to one quarter of school age children. Migraine headaches are often undiagnosed and undertreated in the pediatric population. Current criteria for diagnosing headaches in adults do not effectively apply to the pediatric population. Chronic daily headaches can be subdivided into new daily persistent headaches (abrupt onset of an unremitting headache) and chronic tension type headaches (episodic in nature) and chronic migraines (often bifrontal and shorter in duration) (Kung and Tepper, 2008). Complex regional pain syndrome often affects the lower extremity more than the upper in pediatric patients.

It is important to provide a comprehensive assessment of the adolescent, both medically and psychologically, before embarking upon treatment. Understanding the factors that contribute to and maintain the pain facilitates the development of an accurate and comprehensive treatment plan. Family stressors, difficulties in school, and potential problems with peers all need to be evaluated. It is not uncommon for children with chronic pain to have a learning disability (Zeltzer and Schlank, 2005), and the existence of such can affect treatment and must be considered in school re-integration plans. Although there is yet no gold standard for a paper and pencil assessment of adolescent pain, the Bath Adolescent Pain Questionnaire (Eccleston, Jordan, McCracken, Sleed, Connell and Clinch, 2005) is a comprehensive snapshot of physical and emotional functioning that can provide valuable information about the child's and the family's status. This questionnaire can be readministered at discharge to evaluate changes in the adolescent's functioning as a result of treatment interventions.

Although pain in children can have multiple etiologies, patients all face similar challenges. Pain can add to the difficulties any child faces growing up. These children often develop physical limitations, emotional distress, sleep disturbance, school absences, and social isolation. Parents typically report significant stress, and dysfunctional family roles can develop. Family activities may cease or be significantly changed, one parent may stop working, siblings may feel ignored, and parents may wind up sleeping in separate rooms or allowing the adolescent to sleep with them in an attempt to cope with the pain (Rogers, 2008).

The importance of family intervention in these programs is critical (Zeltzer and Schlank, 2005). It is vital to acknowledge parents' feelings of frustration, and to help them move to encourage their child to learn to manage the pain independently. Parents can be reminded of other independent skills they have fostered in their child in the past (e.g., shoe tying). Parents need to see themselves as "coaches" who encourage the child to develop healthy ways of thinking about and coping with chronic pain, and helping to problem solve ways to manage it. In family therapy, parents are asked to not inquire about the child's pain, but to listen if the child needs to talk about it. Both parents and the patient are told that focusing on the pain experience can actually increase the sensation of pain. Instead, attention and praise should be given for any positive changes that are demonstrated in coping with the pain and, parents are urged to help the adolescent focus on strengths and abilities.

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Adolescent Chronic Pain Management Continued

The first step in fostering change comes in having adolescents identify what they value, and how pain has interfered with these values (Greco and Hayes, 2009). This sets the stage for an agreement by both the parents and the adolescent that things need to change, in order for the adolescent to return to valued activities. The focus is on meeting goals and returning to valued activities, rather than on pain cure.

The goals of an interdisciplinary chronic pain treatment program for adolescents are to improve mobility and return the child to physical activity, return to school and social activities with accommodations as needed, and improve pain coping skills for both the child and the parents. Such a program requires active participation by both the child and the family. The patient and family need to understand and accept that previous attempts to control pain by limiting activity have not been successful, and that the goal is increased function with better pain management, not pain cure. The emphasis must be on self (versus medical) management of the pain.

Children and their parents need to understand how guarding, deconditioning, poor sleep, and stress can all play a role in exacerbating existing pain. It helps for both patients and parents to understand that there are things they are doing that are actually "turning up the volume" on the pain (Culbert and Kajander, 2007) and things that they can learn to do that will "turn down the volume" on the pain. Things that turn down the volume include distraction, biofeedback/relaxation, cognitive intervention to manage catastrophizing, and improving physical fitness and sleep. Young patients benefit from group therapy and education, where they can all share their experiences. It helps them to see and understand that they are not alone, and that others are learning to manage their pain as well.

Children should be encouraged to interact with peers as much as possible. Parents are urged to set up interactions with peers and to help the child know how to talk to others about his or her condition. Further, the child should be expected to maintain responsibility for household chores and not be exempt from making a bed or picking up the room because of pain. When these responsibilities are met, the child should be recognized for the positive behavior.

It is not uncommon for children with chronic pain to have siblings with other special needs, either emotional or physical. It is important for parents to balance the needs of all their children, and to do the best they can at reinforcing healthy behavior, so that pain does not become a way to hold a parent's attention.

As a clinician, you will know if the program has been successful if the child is able to verbalize that they are no longer "afraid" of their pain, but feel that they have tools to manage it. When the patient and family feel more in control, the pain becomes easier to manage, and in some cases, actually decreases significantly. Another measure of success is the ability to return to school and other desired activities. Further, when families demonstrate confidence in the patient to manage the pain, and support this action, rather than focusing on illness and symptoms, this can be counted as a measure of success.

Dr. Gadi Revivo (grevivo@ric.org) directs the Adolescent Pain Management Program, which is part of the Center for Pain Management at the Rehabilitation Institute of Chicago (www.ric.org/paincenter). Dr. Diane Amstutz (damstutz@ric.org) is the psychologist for this program.

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TOWARD A BETTER UNDERSTANDING OF ETHNIC GROUP DIFFERENCES IN PAIN PERCEPTION

Justin T. Matsuura, MS
Rosalind Franklin University of Medicine and Science, Rehabilitation Institute of Chicago Center for Pain Management

Individual differences inherent in the experience of pain have perplexed yet fascinated scientists and clinicians alike. Over the decades, investigators have continued to scratch their heads over the question "why does pain affect each person differently?" The bio-psycho-social model of pain attempts to answer this question by arguing that the experience of pain is influenced by a set of complex interactions among biological, psychological, and social factors (Turk, 1996). There is some evidence that ethnicity is one of these factors and studies have found that ethnic groups differ in their perception of pain (Edwards et al., 2001). Edwards et al. (2001) conceptualized ethnicity as a way to describe and differentiate groups of people, based not only on their ancestry, but also on their behaviors, culture, history, experiences, and beliefs. Understanding ethnic differences in the perception of pain is critical because it may help investigators to further understand why certain ethnic groups adjust to pain better than others.

In this article, I provide an update on the ethnicity and pain literature and evaluate research that has examined ethnic group differences in pain perception. Additionally, I will provide a brief review of the literature on psychosocial mechanisms that may underlie the ethnic differences in pain perception.

ETHNIC GROUP DIFFERENCES IN PAIN PERCEPTION

The literature suggests there is some evidence for ethnic group differences in pain perception across a number of different types of pain. Edwards et al. (2001) conducted a review of the literature and found that African Americans tend to report greater pain sensitivity to experimental pain stimuli, postoperative pain, and persistent pain associated with chronic

medical conditions (e.g., chronic low back pain, arthritis), compared to Caucasians. However, the focus of this review was limited in that it only examined group differences between African Americans and Caucasians.

More recent studies have examined ethnic differences in pain perception across a wider range of ethnic groups. For example, Rahim-Williams et al. (2007) conducted a study on healthy normals and found that African Americans and Hispanic Americans each demonstrated lower tolerance to heat and cold acute pain compared to Caucasian Americans. Watson et al. (2005) found that healthy normal South Asian (Indian, Pakistani and Bangladeshi) males demonstrated lower heat pain thresholds compared to healthy normal white British males. However, other studies found no differences in pain perception between ethnic groups. For instance, Edwards et al. (2005) compared African American, Hispanic, and white patients who had chronic musculoskeletal pain and found no group differences on pain severity. Although ethnic group differences in acute pain perception emerge when using groups of healthy normals, evidence for ethnic differences in chronic pain perception has been inconsistent. Such inconsistency may be due to the fact that the experience of chronic pain is considerably different from experimentally induced acute pain.

POSSIBLE MECHANISMS FOR ETHNIC GROUP DIFFERENCES IN PAIN PERCEPTION

Edwards et al. (2001) highlighted potential psychosocial mechanisms which may contribute to differences in pain responses across ethnic groups. The proposed psychosocial mechanisms included: differences in exposure to stress, pain coping styles, and appraisals of pain. At the time of their review, empirical evidence on the mechanisms underlying ethnic group differences in pain perception was scant. Since then, other studies have provided additional support for these mechanisms.

Recently, a review by Anderson et al. (2009) reported that, compared to Caucasians, ethnic minorities may be more likely to be exposed to a number of stressors including: decreased access to health care, low socioeconomic status, and being uninsured or underinsured. These life stressors may result in a number of negative consequences that can directly as well as indirectly impact pain. For example, if patients have decreased access to healthcare or are of low socioeconomic status, then it may be difficult for these individuals to receive appropriate medical treatment, which may result in more pain. In addition, chronic stress may create long periods of physical and emotional discomfort, which may, over time, shape one's perception of pain.

The literature suggests the use of certain coping strategies predicts how individuals perceive pain. In their comprehensive review of the pain coping literature, Jensen et al. (1991) found that active coping strategies, where individuals initiate behaviors to manage pain, have been linked to lower levels pain severity. Conversely, use of passive coping strategies, including relinquishing control to external forces, has been associated with greater pain severity. More recently, research has shown that individuals from different ethnic groups do not use the same coping styles to manage their pain. Edwards et al. (2005) found African American and Hispanic chronic pain patients reported more use of praying and hoping (passive coping strategies) compared to Caucasians. This coping strategy was also found to be more strongly linked to pain severity for African Americans and Hispanics than for Caucasians (2005). These findings suggest that African American and Hispanics' use of passive coping strategies may partially explain the discrepancy in pain severity among ethnic groups.

There is some evidence that ethnic groups differ on their beliefs about pain. Specifically, Anderson et al. (2009) report that African American and Hispanic groups often endorse beliefs about pain that could influence pain severity. Some of these beliefs include: belief that one should be stoic in the face of pain, belief that pain is inevitable or uncontrollable, fear that medication use will lead to addiction, and beliefs that one will be discriminated against based on ethnicity or gender. These beliefs could influence whether one decides to seek treatment for their pain as well as treatment compliance. To my knowledge, only one study has examined whether ethnic differences in beliefs about pain actually contribute to differences in pain severity (Bates et al., 1993). This study examined locus-of-control style in Hispanic Americans and European Americans. The results of this study indicated Hispanic Americans endorsed a higher external locus-of-control style, or belief that life situations are beyond one's control, compared to European Americans. Additionally, external locus-of-control was linked to greater pain severity. More research is necessary to examine whether other differences in pain beliefs contribute to pain severity. Further, disparities in health care clearly exist, and it is important to consider not only the beliefs themselves, but the causes of these beliefs.

Some argue that ethnic identity, or one's knowledge about their ethnic group and their sense of belonging to that group, affects the degree to which cultural factors influence each individual (Rahim-Williams et al., 2007). In other words, ethnic identity may moderate the relationship between ethnicity and pain. So far, research examining the link between ethnic identity and pain perception has found that one's sense of belonging to their ethnic group may in fact lead to increased pain sensitivity for certain ethnic groups. Rahim-Williams et al. (2007) conducted a study on healthy normals and found that African Americans and Hispanics appeared to identify more strongly with their ethnic group compared to Caucasians. More importantly, ethnic identity was linked to lower pain tolerance across a number of pain induction tasks for African Americans and Hispanics, but not white participants. It may be that, in certain cultures, identifying closely with one's ethnic group may predict behaviors and thought patterns that lead to increased pain. Additionally, the construct of ethnic identity is useful in examining not only differences between ethnic groups but also within groups.

The conceptual equivalence of psychosocial constructs across cultures is another issue to consider when conducting research with different ethnic groups. The issue of

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Toward a Better Understanding Continued

equivalence is critical due to the serious impact it may have on the validity of self-report measures of psychosocial factors as well as the constructs themselves (Tsai et al. 2004). For example, the meaning of the word "dependency" may vary across cultures; some cultures may attach negative appraisals to the word while others may view it more positively. Thus, researchers must do their part to ensure the validity of psychosocial constructs across cultures. Specifically, self-report measures should be validated across ethnic groups to ensure the measures are psychometrically sound. Researchers should also consider whether the meanings of psychosocial constructs are consistent across ethnic groups.

CONCLUSIONS

Research to date provides some evidence that ethnic differences in acute pain perception exist between healthy normal groups of Hispanics, Asians, African Americans, and Caucasians. However, these findings were not consistently replicated when chronic pain patients were examined. Mixed findings suggest that the experience of chronic pain may be different from acute pain and each type of pain may have unique psychosocial factors affecting it. Further, there still is a relative dearth of research examining groups other than African Americans and Caucasians. Research has also provided some evidence that specific psychosocial processes contribute to ethnic differences in the experience of pain. Additional empirical evidence is needed to more fully understand the mechanisms underlying group differences in pain perception. Knowing why people from different ethnic backgrounds respond differently to pain may assist health care providers in developing culturally sensitive ways of assessing and treating pain. It may also help health care providers understand culturally influenced behaviors and thought patterns they might otherwise misinterpret. Such awareness allows health care providers to build rapport and effectively communicate to patients about the impact certain behaviors may have on their pain. At the same time, health professionals must also be mindful of intra-group differences so as to not overgeneralize one person's behavioral patterns to all individuals within that ethnic group.

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CALENDAR OF EVENTS

AUGUST

PAIN REVIEW COURSE 2010– AN INTENSIVE PAIN BOARD ORIENTED REVIEW
DATE: August 21–26
SPONSOR: Dannemiller
LOCATION: Chicago, IL
HOTEL: Fairmont Hotel
CONTACT: Karla Anzola
Email: karlaa@dannemiller.com

13TH WORLD CONGRESS ON PAIN
DATE: August 29–September 2
SPONSOR: International Association for the Study of Pain
LOCATION: Palais des Congres de Montreal, Montreal, PQ, Canada
CONTACT: Ph: 206-283-3011
Email: iaspdesk@iasp-pain.org
For more information, go to www.iasp-pain.org/Montreal

SEPTEMBER

19TH ANNUAL PAIN RESOURCE NURSE (PRN) COURSE
DATE: September 1-3
SPONSOR: City of Hope
LOCATION: City of Hope Platt Conference Center, Duarte, CA
CONTACT: Maggie Johnson
Ph: 636-256-4673 x 63202
Email: mjohnson@coh.org
For more information, go to: http://sccpi.coh.org/PRN19%20.htm

PAINWEEK '10
DATE: September 8–11
SPONSOR: American Society of Pain Educators
LOCATION: Las Vegas, NV
HOTEL: Red Rock Resort Casino and Spa
CONTACT: Ph: 973-415-5100
Email: info@PAINWeek.org
For more information, go to: www.painweek.org

MANAGING PATIENTS WITH CO-EXISTING ADDICTION AND PAIN
Barbara Sr Marie, RN, ANP, GNP, PhDc
DATE: Monday, September 13, 2010
5:30 p.m.–7 p.m.
SPONSOR: Northern Illinois Pain Resource Nurses
LOCATION: White Pines Inn, Mt.Morris, IL
CONTACT: Karen Sikorski
Ph: 815-335-7081
Email: KASikorski@aol.com

OCTOBER

MIDWEST PAIN SOCIETY 33RD SCIENTIFIC SESSION
DATE: October 22–23
LOCATION: Northwestern University Medical Center, Chicago, IL
For more information, go to: www.ampainsoc.org (regional societies)

WHEN MOVING HURTS–NURSING CHALLENGES OF MUSCULOSKELETAL PAIN
DATE: October 27, 2010 7:00 a.m.–4:30 p.m.
SPONSOR: Northern Illinois Pain Resource Nurses
LOCATION: Giovanni's Conference Center, Rockford, IL
CONTACT: Char Carlson
Ph: 815-398-0500
Email: KASikorski@aol.com

NOVEMBER

16TH ANNUAL CONFERENCE THE SCIENCE & ART OF PAIN AND SYMPTOM MANAGEMENT
DATE: November 20
SPONSOR: Continuing Education & Professional Development, Faculty of Medicine, University of Toronto
LOCATION: University of Toronto, Health Sciences Building, Toronto, Ontario, Canada
CONTACT: Ph: 416-978-2719
Toll Free: 1-888-512-8173
Email: info-fcm1004@cepdtoronto.ca
For more information, go to: https://events.cepdtoronto.ca/website/index/FCM1004

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34TH ANNUAL SCIENTIFIC MEETING

The 34th Annual Scientific Meeting of the Midwest Pain Society (MPS) will be held October 22–23 at Northwestern University in Chicago. Multiple sessions are planned on the understanding and the treatment of pain. Additional activities include a poster competition and opportunities to network with colleagues. Please plan to attend this exceptional opportunity to keep up-to-date on pain research and treatment close to home. For further information, see the MPS website at http://www.ampainsoc.org/societies/mps/. We look forward to seeing you in Chicago!

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CALL FOR POSTER ABSTRACTS

34TH MIDWEST PAIN SOCIETY SCIENTIFIC MEETING
OCTOBER 22–23, 2010
NORTHWESTERN UNIVERSITY, CHICAGO, ILLINOIS

The Midwest Pain Society (MPS) invites you to submit abstracts for posters to be presented at the annual meeting, October 22–23, 2010. Posters will be displayed Friday, October 22, and all interested parties are encouraged to submit abstracts. Authors of accepted posters will be notified in late September, and will receive further information about presentation guidelines. Posters accepted for display can be entered in the 2010 MPS poster competition, and will be independently rated by the program committee members, including nurses, physicians and psychologists. Award winners will be announced during the breakfast presentation Saturday, October 23.

INSTRUCTIONS: Abstracts may be submitted electronically or via mail. Submitted abstracts must be 300 words or less and include the name, address, phone number, fax number, e-mail address and MPS membership status for each author. Also, please indicate if the corresponding author is other than the first author. At least one author must have agreed to attend the MPS meeting. MPS will not waive the registration fee for poster presenters.

SUBMISSION DEADLINE: September 17, 2010

SELECTION CRITERIA: Each poster submission will be reviewed and rated by the poster selection committee for the following elements:
1) Scientific quality
2) Broad appeal to the interests of the membership
3) Timeliness of the topic

SUBMIT ABSTRACTS TO:
Dr. Ray Tait at taitrc@slu.edu

MIDWEST PAIN SOCIETY MEMBERSHIP APPLICATION

Members receive the semiannual MPS newsletter and discounted conference fees at the annual MPS meeting. Please complete the information and send with a check, via U.S. Postal Service, to MPS or fax to MPS at 1-888-809-6849. We accept Visa, MasterCard and American Express.

Name: _____
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Type of Membership Desired (check one):
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Midwest Pain Society, 4700 W. Lake Avenue
Glenview, IL 60025-1485.
Who recruited you to join the MPS? _____

SAVE THE DATE

October 22–23, 2010

Mark Your Calendars and Plan to Attend the Next MPS Scientific Meeting

The next Scientific Meeting of the MPS will be held at Northwestern University Medical Center, Chicago, Illinois.

Midwest Pain Society Update is published by the Midwest Pain Society, 4700 W. Lake Avenue, Glenview, IL 60025-1485, (847) 375-4730, fax (888) 809-6849, e-mail mps@amctec.com. **ARE YOU INTERESTED IN SUBMITTING AN ARTICLE FOR THE MPS Newsletter?** *Contact Karen Frizelis, MSN, NP, at karen.frizelis@dupagemd.com and Sara Dittoe Barrett, Ph.D., at sbarrett@ric.org.*

Are you interested in submitting an article for the Midwest Pain Society Newsletter?

Contact Karen Frizelis, MSN, NP, at karen.frizelis@dupagemd.com and Sara Dittoe Barrett, Ph.D., at sbarrett@ric.org

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