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One of the most popular member-led activities is the APS Special Interest Group (SIG). SIGs provide a forum for the expression of common interest topics, generate projects that become symposia at our annual meeting, conduct surveys and develop position papers that inform APS members, foster interactions that lead to collaborative NIH grant applications, and inform the Board on matters related to their special expertise.

The SIGs are listed on the APS Web site at www.ampainsoc.org/member/specent.htm. Each SIG has its own Web page that lists the SIG cohcairs’ contact information, a mission statement, and the focus of the SIG. SIG membership is included in your annual dues and any APS member can join one or more SIGs, regardless of discipline. To join a SIG or to learn more about forming a SIG, contact APS at info@ampainsoc.org or call 847/375-4715.

SIGs provide a forum for the expression of common interest topics, generate projects that become symposia at our annual meeting, conduct surveys and develop position papers that inform APS members, foster interactions that lead to collaborative NIH grant applications, and inform the Board on matters related to their special expertise.
A Few Changes

Hello everyone. I hope your summer has been enjoyable and you have had some time to relax. The APS Bulletin has undergone some changes in its sections and editors. After many years of service and significant contribution to the Bulletin and APS, John L. Reeves, PhD ABPP; Mark Sullivan, MD PhD; and Norman Harden, MD, will be leaving as section editors. These individuals have played an instrumental role in the development and evolution of the Bulletin as a valuable resource for APS members. On behalf of all of us at the Bulletin, I want to thank and praise John, Mark, and Norman for all they have done. Without them, the Bulletin would not be what it is today. The Past President Perspectives and Pain as Pathogen sections edited by John and Mark will be combined under a new Special Topics section, which I will edit in future issues of the Bulletin.

We are quite fortunate to have other talented and dedicated APS members to pick up the remaining section editor duties. David Williams, PhD, will be moving from his Special Interest Groups and Regions section editor position and assuming the Research Update section editor role. In addition, Raymond Tait, PhD, has graciously agreed to become the new Special Interest Groups and Regions section editor. I want to welcome Ray as the newest member of our team, and thank Dave for his willingness to take on the Research Update section.

Speaking for all the section editors, managing editors, and staff members, I would also like to take a moment to recognize and thank APS leaders and members for your continued support and interest in the Bulletin. Please know that everyone associated with the Bulletin will continue to strive for innovation and excellence on behalf of all of you. If you have any questions, comments, or suggestions for the APS Bulletin, please feel free to contact me at enewman@connect2amc.com.

Steven H. Sanders, PhD
Editor-in-Chief, APS Bulletin

Together, we’re transforming research into relief.
**A Biopsychosocial Model Discussion: From a Fragmented History to a Streamlined Future**

*Jane Martinsons, Staff Writer*

**Editor’s Note:** This article is the next in our series focusing on successful translational research in pain. Using a more expanded definition of translational research to include explanatory and/or descriptive models and methods of treatment that have a solid research basis and have been translated, researched, and now routinely applied to clinical pain, the biopsychosocial model is certainly one of these success stories.

The APS Bulletin recently spoke about the past, present, and future of the illness model with the following individuals who have pioneered and led this very important transitional research process: Robert Gatchel, PhD ABPP of the University of Texas in Arlington, TX, and John D. Loeser, MD, and Dennis Turk, PhD, both of the University of Washington in Seattle, WA. **Past**

**Gatchel:** It’s a fragmented history. Medicine in the 1970s was very traditional and slow to move. There was increased awareness that things like smoking and cardiovascular disease were major causes of mortality in this country and that lifestyle changes were really important in terms of weight loss and exercise. The fields of health psychology and behavioral medicine grew at this time, as did the pain field. In 1977, George Engel introduced the concept of illness behavior and called for a new medical model, indicating that this was more than just a physical problem. Years earlier, Bill [Wilbert] Fordyce, PhD, was the first to introduce a specific psychological process involved in chronic pain, operant conditioning, and to indicate that reinforcement contingencies were quite significant in maintaining certain types of chronic pain behaviors. By the early 1980s, Drs. Fordyce and Loeser started to pull away from the traditional medical model toward a more comprehensive behavioral medicine model. Also at that point, techniques such as biofeedback and stress management were introduced, and there was a lot of research showing how psychosocial factors such as anxiety affected pain threshold. During the 1980s and 1990s, Dennis Turk and I started using the term biopsychosocial to emphasize that pain is just not a biological problem, but that you have to deal with the psychosocial components, especially when pain becomes chronic. Interdisciplinary pain management programs based on a BPS model integrated both pure science and clinical applications. In 1985, Tom Mayer, MD, and I introduced the notion of functional restoration. Basically, we demonstrated that an interdisciplinary team comprising a physician/nurse team, a physical therapist, an occupational therapist, a psychologist, and a psychiatrist needed to focus on every aspect of an individual with pain—not only the pain itself—and deal with all of them simultaneously.

**Loeser:** How was the BPS model originally applied to clinical pain? Actually, I would turn it the other way around: Dr. Fordyce’s pain as learned behavior came long before Dr. Engel’s BPS model. Dr. Fordyce’s first paper on operant conditioning in pain in 1968 preceded the widespread recognition of Dr. Engel’s BPS model. Although not termed biopsychosocial, Dr. Fordyce’s original work directly challenged the biomedical model by taking into account the role that factors outside the patient, including environmental factors, play in pain. His approach, however, never had the panache of Dr. Engel’s later BPS model, which spread rapidly among intellectual circles throughout the medical community. I developed a BPS model based in large part on Dr. Fordyce’s concepts, but it never really took hold outside the pain community.

There’s no question in my mind that the BPS model has played a very important role in pain by calling people’s attention to the fact that the biomedical model, which basically ignores the fact that human beings are human, doesn’t adequately explain pain behavior.

**Turk:** There have been parallel advances both in the biology and physiology—neurophysiology of pain from the basic science perspective—and there have been parallel developments in the areas of psychosocial factors as they relate to the experienced perceptions, response to pain, and response to treatment. These are two parallel tracks that evolved and built off of each other. Both sides, biological and the psychosocial, have learned from each other. **A Paradigm Shift?**

**Gatchel:** The shift from a pure traditional biomedical approach to a BPS approach was really a major paradigm shift in science and medicine.... The biomedical approach served its function; that’s all we knew at that time. It had a big grip on medicine until illnesses became more chronic and the prevalence of pain and chronic pain problems continued to grow. Then, that old system didn’t work. If you operated on a person many times, he or she didn’t get better but instead developed more pain problems. With chronic pain, a whole new approach needed to be taken.

**Loeser:** This was a major paradigm shift. The Gate hypothesis, published in 1965, basically said that the perception of pain was modulated by both afferent and downstream activity from the brain. That’s sort of a biologic way of saying affective, emotional, and environmental factors influence the perception of pain. The Gate theory laid the groundwork for Dr. Fordyce to argue that environmental factors influence the way people think and feel, and that is what gets the downstream modulation altering the perception of pain. It fits together and that is how we got to the popularity of the BPS model, although there were components that preceded it that played an important role. **Present**

**Turk:** Today, psychosocial factors can be the best predictors of how well people respond to treatments such as surgery or the likelihood that an acute injury will develop into a chronic problem. It’s drummed into people’s heads that we can’t rule out the importance of psychological, social, and economic factors in what’s happening on a physiological basis. The insurers are seeing it; the research demonstrates this to them. National Institutes of Health (NIH) is seeing it. There is a movement in the direction of accepting this.
Loeser: The BPS model is the foundation upon which most contemporary pain research is built. For example, it’s become widely recognized that patients’ fears about what will happen if they move or use a [body] part that hurts is a major determinant of outcomes for therapy. More and more, funding agencies and surgeons themselves are saying that we need to get a psychological assessment before making decisions about surgery, which means they recognize that something, [for instance,] other than the patient’s back plays a role in the complaint of back pain.

Insurance: A “Swinging Pendulum”

Turk: In the 1960s, when Drs. Engel and Fordyce were talking about and developing this model, there was a lot of distress in the insurance industry because they had all these people with pain problems and they didn’t know what to do with them. All of the sudden, researchers said they had a new treatment model, so there was a lot of enthusiasm among insurers who thought their prayers had been answered. That was before they realized that these programs were expensive, they didn’t have much outcomes data, and there were still many people with pain problems. So the pendulum swung in the other direction. “Let’s go back to treating these things and forget all the psychological stuff,” the insurers said. “We’ll fix the broken body parts and everything will get better.” The reality was that that didn’t work. Now I’m starting to see the pendulum swing back, but [we have] very expensive treatments. Implantable devices—including spinal-cord stimulators, drug delivery systems, and morphine pumps—cost between $40,000 and $60,000—and that’s just for the procedure itself, not the follow up.

Gatchel: In the 1980s and 1990s, not everyone had the capability or resources to put together a true interdisciplinary program. There is a lot of overhead involved with having multiple disciplines under one roof, so it was difficult getting insurance authorization. Places struggled with that, but they continued to embrace the concept because the data being published demonstrated its efficacy. That struggle still continues today and insurance companies are the chief culprits of it, ...We keep publishing results demonstrating efficacy, but insurers are very reluctant to cover treatment. There is no doubt it’s the most effective treatment approach for chronic pain.

Insufficient Funding for Pain

Loeser: There’s a huge problem in the NIH when it comes to pain. The bottom line is there is not nearly enough funding. I served 4 years on the Advisory Council of the National Institute of Neurologic Disease and Stroke, and they didn’t like me very much because I kept saying to them, “The legislative mandate of the NIH is to reduce the burden of illness on the American public.” By far the most common neurologic disorder in the American public is chronic pain, and they do virtually nothing in the realm of chronic pain research—it is a fraction of a percent of their funds. There’s no question that the pain community feels that the NIH has been woefully inadequate in addressing the problems of chronic pain.

Turk: Actually, there is a little bit of interest in combination treatments at NIH, as seen in their latest request for challenge grant submissions. For the first time—that I’ve seen—about a dozen of 200 suggested areas for applications targeted combination treatments. NIH has never been interested in clinical trials; it’s far more interested in facing mechanisms underlying these processes. I think the word at NIH may be that we need to do something in this area.

“Right now the NIH is funding grants at the ninth percentile. What that means is that many very good proposals are not funded, and that’s a killer. It’s demoralizing, but it’s not unique to the world of pain by any means.” —John D. Loeser, MD

Future

Gatchel: Brain imaging is a big area now. We are gaining a better appreciation of areas of the brain that are responsible for different brain syndromes. Clinicians are using, vis-à-vis a biofeedback-type paradigm, real-time imaging to have patients modify those areas—to either turn them on or off, depending on where the pain centers are. That’s very exciting. There also are a lot of new advances being made in genetics; we’re just experiencing the tip of the iceberg. If we can do genetic screening more easily in the future, hopefully we’ll be able to more specifically prescribe certain drugs that will work better for certain people.

Turk: We’re going to see a lot more predictions of who responds to different kinds of treatments. It’s not just genetics, however; there are also individual variations we’re seeing in coping patterns and in the types of symptoms onset. I work in fibromyalgia, which tends to be a repository for a combination of different signs and symptoms. We have tended to treat these patients as a homogenous group, but our research is showing there are different characteristics of patients that may be important as we consider the best treatment. In the future, we are going to see combination treatments and responder analyses to find out the physical, psychosocial, and behavioral characteristics of patients who respond to a given treatment. It will be clinically more effective, and definitely more cost effective. How far off are customized treatments? Close. I actually have NIH grants to look at this.

Loeser: In this and every other area of medicine, genetic issues are going to come to the forefront. We’re beginning to learn, for example, that genes determine whether or not you respond to narcotics, whether it’s metabolizing the drug or binding the drug. We’re going to come to an era soon where we will conduct genetic analyses of patients to make predictions as to outcome and to determine what kinds of therapies are going to be relevant. As we learn more about what genes do, what genes there are, and what different alleles at the same locus do in response to various kinds of treatment, it would not surprise me at all if in the near future we will literally have patients tell us their genome and we’ll tell them what drug to use, which is a big improvement. Ironically that is very biomedical, not biopsychosocial. But just as we develop genetic understanding, we are also going to continue to develop an ability to diagnose and predict outcomes based on psychosocial factors.

Message to APS Colleagues

Gatchel: Push for the dissemination of the BPS model whenever you can. Mention it to government officials at state and [national] levels. Talk to medical colleagues to let them know there is a wealth of good scientific research out there that they can gather articles and demonstrate to it. Also, be very aggressive with insurance companies. It takes time, but we all need to keep pushing in that direction.

Turk: We tend to forget that people have two things: They have a medical history and they don’t live in isolation; they live in a social context. We need to pay more attention to how people and their significant others affect each other. The “social” in BPS tends to start with a small s, but let’s not forget that social factors are very important. The “bio” “psycho” and “social” need to be in balance if you’re to have optimal outcomes.

“We call it ‘chronic’ pain because there is no cure, despite big advances in neurophysiology and pharmacology. Some new advances in opioid variants reduce the pain, but they don’t eliminate it and cure the problem. Just like diabetes, people have to learn a lot of self-management and self-control.”

—Dennis Turk, PhD
Following surgery, as many as 80% of adult patients report pain, and it is mostly moderate to extremely severe (Apfelbaum, Chen, Mehta, & Gan, 2003). These figures have barely changed since the 1950s (Berry & Dahl, 2000) and come, mostly, from the United States, where about 73 million patients undergo surgery annually (Hutchison, 2007). In addition to causing needless patient suffering, unrelied pain produces short- and long-term physiological and psychological adverse consequences. It degrades patient and family quality of life, increases healthcare utilization, and drives up associated costs. Bonica (1990) related the problem of insufficient pain management to “inadequate or improper application of available information or therapies.” At the root of the problem is pain professionals’ ongoing failure to generate, evaluate, and disseminate adequate evidence about postoperative pain management.

In the field of pain, as in many fields of medicine, randomized-controlled trials (RCTs) and meta-analysis of published RCTs comprise the gold standard for evaluating interventions in support of best practice. RCTs use select patient samples in order to test the impact of interventions under ideal conditions. But their findings do not generalize well to everyday practice where patients are heterogeneous, often elderly, and burdened with comorbidities (Liu et al., 2006; Parkin, 2006). Although the results from RCTs are valuable for regulatory authorities and for pharmaceutical research, their benefits are limited for clinicians making bedside decisions (McQuay & Moore, 2007) or for shaping best practice. Furthermore, RCTs are usually powered to test treatment effects, and sample sizes are typically too small to characterize the prevalence of the serious adverse events associated with these treatments (Liu et al.). Additionally, RCTs provide only a single snapshot of a situation because they do not update continuously. Clearly, the field of pain would benefit from an additional methodology that not only evaluates interventions, but also provides data that can facilitate best practice (Liu et al.).

Medical Registries

“A patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure and that serves a predetermined scientific, clinical, or policy purpose(s).” The science of registries is in an active state of development (Gliklich & Dreyer, 2007, 1).

Medical registries have surprisingly deep historical roots. The ancient Egyptians categorized types of injury, treatments, and their outcomes. Florence Nightingale’s achievements in treating soldiers in the Crimean Wars derived from her use of statistics and not only her personal dedication to patients (Moore & Clark, 2008). Early registries in modern times have mostly targeted the epidemiology of a disease or assessed quality improvement in an institution. More recently, registries have developed in many fields of medicine, most notably in cancer (since the 1920s) and in trauma (since the 1960s). During the last 20 years the role of registries has evolved so that they now support planning and evaluating on regional, national, and international levels (Parkin, 2006). In some fields the term surveillance now modifies registry to denote that the program must not only collect data but also work actively to integrate the new evidence into public health programs (Parkin, 2008). The expanded role of registries today includes the following.

Quality Improvement

Registries provide audit and feedback to providers about their daily practice. Registry information has high exchangeability because it does not exclude difficult patients and can be used to identify regional, national, and international best practices (i.e., benchmarking) while allowing for individualized medical treatment. Registry information can help develop, assess, and refine treatment protocols and create teaching tools for providers and patients.

Research

A registry provides opportunities for investigators to plan, design, and conduct epidemiological and clinical research that contribute to scientific knowledge regarding prevention and management. A large and constantly growing database, comprised of data from multiple sites using a common formation of variables, permits powerful data analyses and modeling for prediction, hypothesis testing, and data mining. When a registry grows to a large size, it becomes possible to characterize otherwise elusive rare adverse effects. Different researchers can use the data repeatedly for varied purposes. Interfacing with other databases minimizes duplicate data collection. Registries permit, in principle, genetic profiling, study of gene by environment interactions, and evaluation of epigenetic influences.

Economics

Registries can provide a platform for estimating costs of services and can facilitate rational allocation of resources. This allows effective forecasting for service demands at hospital, national, and international levels. The National Trauma Data Bank (2007) uses hospital length of stay to assess costs but this is a proxy variable confounded by issues such as institutional discharge practices (Moore & Clark, 2008). Another approach is to use registry-derived data to carry out direct-cost-effectiveness analysis by quantifying each component involved in the treatment such as manpower, equipment, and treatments provided (McKenna et al., 2009). Developing methodology for carrying out cost analysis remains an important area for future research (Gabbe, Williamson, Cameron, & Dowrick, 2005).

Information Consolidation

Technological and Internet advances now make the consolidation of hospital-based registries into regional, national, and international databases possible (Moore & Clark, 2008). They also enhance communication between national and international medical and research centers. Some registries now collect data without paper records using key entry in order to sustain a continuous bidirectional stream of information between a single site and multiple local and international sites over the Internet (Mel-loh et al., 2008).

The Impact of Registries

Assessing whether registry data has an impact on the healthcare patients receive is not straightforward. Indirect evidence of the value comes from studies looking at clinical outcomes data in the form of a decrease in trauma mortality following the introduction of trauma systems that include a registry (Moore & Clark, 2008). These results gain support from similar findings in various countries (e.g., United States [Mullins et al., 1994], Australia [Brennan et al., 2002], and Israel [Peleg et al., 2004]). On the other hand, Jamtvedt, Young, Kristoffersen, Thomson O’Brien, and Oxman (2006)
carried out a systematic Cochrane review, assessing the effect of audit and feedback on the performance of healthcare professionals (i.e., looking at process data). They found that, when effective, the impact of audit and feedback was generally small to moderate. The effectiveness increased when the baseline adherence to the recommended practice was low and the feedback was delivered more intensively (e.g., verbally given to individual recipients). The Cochrane review does not support mandatory or unevaluated use of audit and feedback as an intervention to change practice.

**Challenges Facing Medical Registries**

Starting and sustaining a medical registry can be a formidable task. Administrators of contemporary medical data registries, such as cancer and trauma, face cost and data challenges. Pain registries will surely encounter many of the same barriers as they develop.

**Costs**

Lack of financial support can present a major hurdle in the creation and upkeep of medical registries. Insufficient funding and low levels of participation can threaten the quality and integrity of the data and, consequently, the registry. Thus, obtaining secure funding from government, private foundations, or other sources remains one of the critical operational imperatives of every registry.

**Data**

Given the expanding role of registries, there is a growing demand for an increase in the number and types of variables. Yet, there is a clash between the aim to obtain more data and the information it will yield versus the need to minimize or streamline data cores, which eases the load of obtaining the data and so promotes integrity of the database. In addition, hospital-based registries often differ markedly from one another in structure and content. This makes comparisons across registries difficult and challenges registry administrators working at the national or international level to create standard data dictionaries that ensure consistency across registries. A third concern is that although registry administrators need to develop mechanisms for collecting data, they also need mechanisms for data analysis and evidence dissemination to the various end users so that the database will be fully exploited.

**Informed Consent and Protection of Privacy**

Potential conflict exists between creating large representative, de-identified electronic databases and current health information privacy standards, namely the Health Insurance Portability and Accountability Act (HIPAA). This conflict needs to be resolved to maintain public support for studies that use medical record data (Parkin, 2006). Some institutions and professional societies have found ways to allow access to researchers while still protecting confidentiality (Moore & Clark, 2008).

**Pain Databases and Registries**

In the field of pain, recording data over time and analyzing chronological records is a relatively new methodology for evaluating evidence. Two terms, registry and database, are common in the literature. A number of subspecialties are in the process of developing registries or databases for assessing postoperative, neuropathic, and other types of chronic pain conditions. Here we limit the discussion to projects in the incipient field of postoperative pain. As terminology varies across projects, we employ the terminology that the founders use to describe their work.

**Single-Center Databases Assessing Acute Pain Service Patients**

Acute Pain Service (APS) teams in many hospitals have created single-center, computerized databases. They use the information to document their activities over time as well as to assess the effectiveness and safety of treatments they provide (Cheung et al., 2008; Esteve Pérez et al., 2008; Goldstein, van den Kerkhof, Sherlock, Sherlock, & Harper, 2001; Pöpping et al., 2008; Rawal & Berggren, 1994; Shir, Shavelzon, Rosen, & Cotev, 1997). Follow up of patients treated by the APS is well suited for database development with standard methodology because the number of variables assessed for each patient is relatively small and well defined (at least per institution), and the team assessing patients is small. Institutions that have created their own APS database have tended to depend upon local initiatives to develop appropriate software programs.

**Multi-Institutional Databases for Follow Up of Postoperative Pain**

Concern about the meager published information for assessing performance and optimizing postoperative pain management led Liu and colleagues (2006) to propose that the American Society of Regional Anesthesiology develop an Acute Postoperative Pain (AcutePOP) database. The goal of this project is to create a national Internet-based, HIPAA-compliant database for tracking APS patients. Participation will be open to all individuals and institutions in the United States. Currently the group is working on issues such as consensus on the data elements and developing software for the project.

Thomas Volk, at the Department of Anesthesiology and Surgical Intensive Care at the Charité Medical Center in Berlin, Germany, initiated a specialized registry for data about complications associated with regional anesthesia, the Network for the Safety of Regional Anesthesia. Centered on neurologic and infectious complications, this registry attempts to prospectively define clear numerators and denominators for complications, to identify risk factors for developing complications, and to provide a framework for a benchmarking system. The project operates under the sponsorship and direction of the German Society of Anesthesiology, the Professional Association of German Anaesthetists, and the German Research Foundation (German Society of Anaesthesiology & Professional Association of German Anaesthetists, 2008).

Existing registries designed for other purposes are proving useful for investigating pain-related issues. For example, Wu and colleagues (2006) used a Medicare-claims registry to examine whether the type of intervention—epidural versus systemic analgesic medications—can influence mortality after a high-risk procedure, such as a colectomy. According to the authors, an RCT with standard-hypothesis testing would not have been feasible for this rare endpoint, as adequate power would require 24,000 high-risk patients and 1.2 million low-risk patients. Instead, the authors performed a cohort study from the Medicare-claims registry, which contains relevant data from millions of patients. They analyzed data from 12,817 Medicare beneficiaries who underwent elective partial excision of the colon from 1997 to 2001. The researchers decided on inclusion and exclusion criteria and randomly selected 5% of patients from the database, thereby forming a nationally representative sample of Medicare beneficiaries. Using multivariate regression, they assessed and compared the odds ratios for death 7 and 30 days post-procedure. Epidural analgesia was associated with significantly lower odds of death at both time points.0

**European and Other International Pain Registry Development**

Three acute pain registry projects, Quality Improvement in Postoperative Pain Management (QUIPS), International Pain Registry (IPR), and PainOut, are similar in that they are Web-based projects for follow up of outcomes and processes of postoperative-pain patients, continuously do not restrict data accrual to APS patients, and the same nucleus of people run them. The proof-of-concept work for these projects began with postoperative patients. However, ultimately this approach will apply to any hospitalized patient in pain, adult or child, whether in oncology, general medical wards, or the emergency department, and will also apply to other related fields of medicine. Currently, the projects stand apart because they involve different

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medical centers. QUIPS operates in Germany, Pain-Out focuses on Europe, and IPR is international. The latter two are still in development. Ultimately, we expect the three projects will merge into a single project that will open the consolidated registry to institutions worldwide under supervision of a scientific society.

QUIPS (Figure 1) began in 1998 in one center and today about 100 hospitals throughout Germany contribute data, with three to four hospitals joining the project every month. Today, the database includes records from more than 64,000 patients, and increases by more than 2,000 data sets per month. Participation from hospitals is voluntary. The third author initiated this project, and it now operates under the joint direction of the German Society of Anesthesiology and German Society of Surgeons (Meissner et al., 2008; www.quips-projekt.de). Local quality assessment and benchmarking is supported by immediate Web-based feedback to each of the participating sites. QUIPS also provides a platform for discussion and research.

The IPR receives support and guidance from an interdisciplinary working group of the International Association for the Study of Pain (IASP). IASP aims to promote better treatment of pain in the developed countries and developing regions. Suboptimal management of pain is a worldwide problem, but most of the information about the problem comes from developed nations. In addition, resources for changing practices are allocated within the developed world. As a result, IPR plans to involve developing countries in this effort, too.

During 2008, the IPR carried out a pilot project to demonstrate feasibility of collecting data about management of postoperative pain internationally, in 10 developed countries—the United States, Australia, the United Kingdom, Germany, Switzerland, Sweden, Italy, France, Spain, and Israel—and three developing countries—Romania, Kenya, and Palestine. Professor Arthur Lipman from the University of Utah, led the project in the United States. From April 2008 to October 2008, participating institutions collected data from 688 adult surgical patients. Each participating hospital site entered their anonymized data into a password-secured, Web-based server and could then obtain immediate feedback about their site compared to others. This pilot study demonstrated that it is feasible to collect, analyze, and provide feedback about management of pain internationally from countries with high and low healthcare resources. Further developments in the IPR will take place in close cooperation and in parallel to Pain-Out.

Pain-Out is a 4-year project that was launched in 10 European countries in January 2009 by the European Union’s 7th Framework Program to create a European internet-based Pain Registry (www.pain-out.eu). Data about costs related to treatment and quality of life will be collected in addition to data about outcomes and processes. The registry data will serve several purposes:

1. Feedback for individual sites and benchmarking on regional and national levels will be available, including data that will identify gender- and age-related differences in treatment and outcomes in postoperative pain.
2. Clinicians faced with a patient who has a recalcitrant or rare painful condition will be able to query a case-based clinical decision support system for similar cases and determine which interventions are likely to be most effective in this type of case. This information will guide the clinician in treating the current patient.
3. An electronic knowledge library on acute pain will summarize evidence and guidelines for treating postoperative pain and deliver the information in a user-friendly electronic format.

**Summary**

In fields such as cancer and trauma, registries are well-established, proven resources. Registry data serve many purposes including quality improvement, research and planning, and allocation of resources on regional, national, and international levels. Though difficult to assess, registry methodology appears to exert a positive influence on healthcare outcomes. This remains to be demonstrated definitively. In the field of postoperative acute pain, projects for collecting data over time are less established and may carry the label of either database or registry. Single-center databases on postoperative pain have existed since the 1990s, mainly for local quality assurance programs and for assessing interventions. Over the last 10 years, nascent national and international acute-pain databases and registries have emerged. We hope that as these grow to maturity, this methodology will prove to have a positive impact on management of postoperative pain and our knowledge of the field.
References


Dr. Zaslansky and Meissner work in the department of anaesthesia and intensive care at Friedrich-Schiller-Universität Jena, in Jena, Germany. Dr. Chapman is professor and director of the Pain Research Center in the department of anaesthesiology at the University of Utah in Salt Lake City, UT.
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 in San Diego, CA. 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 CCOE in Pain Management awards program began in 2007 to acknowledge and honor U.S.-based, multidisciplinary healthcare teams who provide the most distinguished, comprehensive pain care. The Pain Management Center in the M. D. Anderson Cancer Center at the University of Texas, Department of Pain Medicine, in Houston, TX, was one of the five programs that received this great honor in 2009. The team decided to apply for the award because of their hard work throughout the past year. “Our team had worked very hard on improving the way we work together to benefit our patients. We also realized the importance of our unique mission, which is to help patients manage cancer pain. Our team is uniquely qualified to address that mission,” said Diane Novy, PhD, professor at the Pain Management Center.

The Pain Management Center in the M. D. Anderson Cancer Center provides a full spectrum of multidisciplinary care for both acute and chronic cancer pain. To carry out this mission, the program utilizes interdisciplinary chronic pain team members who provide comprehensive pain evaluation and treatment, medical management, psychological evaluation and therapies, and more. The Pain Management Center believes adequate pain relief for cancer patients is integral to cancer treatment. The team oversees the assessment and management of cancer pain from the time of diagnosis, through curative treatment, during survivorship, and at the end of life. In order to focus on this continuity of care, the group utilizes anesthesiologists, physical medicine and rehabilitation practitioners, neurologists, nurses, psychologists, social workers, and chaplains. Novy said, “Our institution has so many wonderful resources for patients and we have so many different healthcare teams to work with as we help our patients.” In addition to being a multidisciplinary group, the center is uniquely focused. “We are a separate department within the division of anesthesiology at M. D. Anderson Cancer Center that focuses solely on clinical care, training, and research in pain,” Novy added.

The center also focuses its efforts on advancing scientific knowledge related to pain and providing information to colleagues through clinical research, peer-reviewed articles, and presenting in-service programs and lectures. The center’s clinical research focuses on chemotherapy-induced neuropathic pain, fatigue, breakthrough pain, and noninvasive and interventional procedures for pain control. Basic science research tackles cellular and molecular mechanisms of pain and the development of novel analgesics. Educational research is highly concentrated team training.

In addition, the center hosts visiting medical and nursing colleagues from throughout the world. They train six fellows and 50 residents in clinical care annually. Twenty basic science and graduate students receive training each year, too. They are very active with state pain management initiatives, leading acute and chronic cancer pain care workshops for health organizations in Texas. The center’s team wrote a pain medicine guidebook, which was distributed to more than 30,000 physicians in Texas. In addition, they contributed to the Texas Pain Society Opioid Agreement/Informed Consent. The team members at the center are the founders of the Gulf Coast Cluster for Translational Pain Research and will host the 2nd Annual Coast Translational Pain Research Symposium in 2009.

The team from the M. D. Anderson Cancer Center received their award at the APS Awards Gala in San Diego, CA.
APS has a new special interest group (SIG) dedicated to pain education. After several years of growing interest in pain education, the SIG was formed with a virtual tidal wave of support from APS members! The first meeting of the Pain Education SIG was held at the APS 28th Annual Scientific Meeting in San Diego, CA, and those in attendance expressed interest in a variety of topics.

We have formed a group of people dedicated to creating improvements in pain education. The primary goals of this SIG are to help APS members gain access to pain education resources, enhance professional skills in the area of education, and strengthen pain education through interprofessional collaboration. We would be delighted to have your participation.

One of the core commitments of the Pain Education SIG is to foster interprofessional collaboration. In one sense, this may seem like a substantial challenge for those of us working in traditional healthcare education settings where there may be resistance to interprofessional education. It is new and relatively untested, is representative of a change from the historical norms of separate educational pathways, and it may require additional effort to design new material that meets the needs of multiple professional paths. We spent time discussing how to capitalize on the richness of APS’s interprofessional membership—how we can work together, how we can model interprofessional collaboration, and how we can springboard from the society’s strength to advocate for improved pain education within our respective specialties. Clearly, future discussion is necessary.

It was apparent from the discussion at the first SIG meeting that APS has educators who envision themselves focusing their efforts on specific groups of learners. These groups would include: healthcare trainees at the level of primary education (medical, nursing, physical therapy, and psychology schools, and the residency and fellowship levels); practitioners already in practice (postgraduate and continuing education); and patient educators. It is important to note that there are already organizations dedicated to providing patients with educational materials about pain. Pain Education SIG members envision a focus on aiding practitioners to become better teachers, rather than in the development of patient resource materials. Those interested in postgraduate education raised the topical issue of the educational components of Risk Evaluation and Mitigation Strategy (REMS) programs, which will be an important area of effort for APS in the year ahead. Those working on primary education recognized the important challenges in promoting interdisciplinary pain education at specific institutions. More efforts are planned in this area regarding improved access to teaching materials and gaining insight into advocating for more pain education at the local, regional, and national levels.

Finally, a pressing need was identified for connecting APS members with existing educational resources. We plan to provide links to exceptional, educational Web resources through our SIG Web page and welcome your submissions.

We hope you will join us in the Pain Education SIG—your enthusiastic participation is most welcome! For more information, please see the Pain Education Web site at www.ampainsoc.org/member/sigsites/pain_education.
The APS 28th Annual Scientific Meeting in beautiful San Diego, CA, offered wonderful networking opportunities for multidisciplinary professionals. The APS Scientific Program Committee, chaired by Knox Todd, MD MPH, created an appealing program for all attendees from a wide variety of disciplines. More than 130 distinguished faculty members shared their expertise and research findings.

More than 1,300 attendees represented 21 countries at this year’s meeting. Members and nonmembers traveled from 49 states. Medical specialties represented included anesthesiology, neurology, physical medicine, internal medicine, family practice, pediatrics, and others. Additional professional disciplines represented included psychology, pharmacy, nursing, basic science, behavioral science, and others in which clinicians, researchers, educators, consultants, and administrators work.

Attendees had the option of eight corporate satellite symposia, numerous plenary sessions, more than 300 poster abstracts, and special events such as the Pain Paradox corporate educational program, the Clinical and Basic Science Data Blitz, the Awards Gala, and an Evening with the Pain Sensations.

The preconference data blitz was held again this year after a successful debut last year. Authors were encouraged to submit “hot topics” for presentation and submissions from young investigators and junior faculty were particularly encouraged. Selected presenters had 5 minutes to present data and 5 additional minutes to answer questions. The blitz was expertly moderated by Robert Yezierski, PhD, and Marie Hoger-Bement, PhD PT. Ten abstracts were selected for presentation covering topics from the influence of contextual clues on nurses’ pain judgments to pain, fatigue, and sleep/wake patterns in children and adolescents with cancer.

For the first time, APS offered a corporate educational program onsite in the exhibit hall. The live-action CME/CE activity entitled “The Pain Paradox: Providing Effective Relief While Mitigating Risk” allowed attendees to earn hands-on continuing education in an expert-guided learning experience consisting of a multimedia gallery featuring a presentation of practical information coupled with a live patient and peer-to-peer interaction.

APS hosted its second annual awards gala to recognize the accomplishments of leaders who have made extraordinary contributions to the field of pain. More details about the gala are on pages 11–13.

In past surveys, more than half of the respondents rated the annual meeting as a very important component of their membership. APS is committed to ongoing educational innovations at this meeting. The annual meeting is an excellent way to stay current and tap into the multidisciplinary resources APS has to offer. Join us May 6–8, 2010, in Baltimore, MD!
APS Celebrates Excellence and Achievements at Awards Gala

Together, we’re transforming research into relief. APS promotes professional excellence within the scientific and clinical communities through our awards programs. Each year, APS presents seven prestigious achievement awards at the annual meeting. Since 2005, APS has awarded The APS Future Leaders in Pain Small Research Grants to young investigators who have not yet been awarded major research funding. The program encourages research in pain that will add to the body of knowledge in the field. Since 2007, the Clinical Centers of Excellence (CCEO) in Pain Management Awards Program has honored the achievements of healthcare teams who have truly had an impact on the state of multidisciplinary, direct-patient care and the treatment of pain.

For the second time, APS hosted an awards gala to recognize the accomplishments of leaders who have made extraordinary contributions to the field of pain to inspire and cultivate the leaders of tomorrow.

Annual Awards

Each year APS rewards excellence in the field of pain management and research by presenting awards for career achievement, pain scholarship, education and public service, advocacy on behalf of children, outstanding service to APS, and early career achievements.

John and Emma Bonica Public Service Award
Ada Rogers, RN

Wilbert E. Fordyce Clinical Investigator Award
Roger Fillingim, PhD

“I would like to thank the Awards Committee for bestowing upon me this tremendous honor. Also, I would like to thank my mentor Bill Maixner, who continues to be an invaluable role model, colleague, and friend. In addition, I express my sincerest appreciation to the outstanding students, fellows, and colleagues with whom I have been privileged to work with over the years. Finally, I owe my deepest gratitude to my wife, Lori, whose unconditional love and support have energized and inspired me—I can’t imagine this journey without you.”

Frederick W. L. Kerr Basic Science Research Award
Joyce DeLeo, PhD

“I would like to thank the nominating committee for selecting me to receive the 2009 Kerr Basic Science Research Award. This prestigious honor would not have been possible without the many talented past and current members of my lab, who include research staff, undergraduate and graduate students, post-doctoral fellows, residents, and junior faculty. I have been most fortunate to work with these researchers. I am similarly grateful to be a part of the international pain community, many of whom are close friends and colleagues. Finally, I am deeply indebted to my early mentors who encouraged me to investigate the wonderful world of glia as it proved to be a most fruitful and fascinating research direction.”

Jeffrey Lawson Award for Advocacy in Children’s Pain Relief
Patrick McGrath, PhD

“This award is a tribute to the short life of Jeffrey Lawson. His life was not in vain. His mother, Jill Lawson, had the courage and perseverance to ensure that the prevention and management of pain became a priority. Jeffrey’s life and Jill’s actions have been a catalyst for the multitude of changes we have seen in children’s pain [management] over the last 25 years.

I wish to thank the APS and the Canadian Institutes of Health Research—who funds much of my research; my colleagues, especially Allen Finley and Christine Chambers; my many students and staff; my daughter, Mika; and my wife and colleague, Anita Unruh, for their inspiration and support. Finally, we must never forget the plight of the many children who suffer needless pain.”

John C. Liebeskind Early Career Scholar Award
Steven George, PhD PT

“I would like to thank the American Pain Society and its awards committee for recognizing my work. As a pain researcher, it is a tremendous honor to be affiliated with John C. Liebeskind.

I would like to thank those who have mentored me along the way. These individuals include Drs. Julie Fritz and Tony Delitto when I was at the University of Pittsburgh and Dr. Michael Robinson at the University of Florida. I would like to especially recognize Dr. Robinson for mentoring me during the critical transition from post-doctoral fellow to junior faculty. Dr. Robinson profoundly influenced my career and I greatly appreciate his time and effort in my development as a pain researcher.

I would also like to thank Drs. Roger Fillingim and Donald Price, two collaborators from the University of Florida. These two accomplished scientists have pushed me in different directions and I have been very fortunate to work with them. Thank you also to Dr. Kathleen Siuka, who has been supportive of me from afar.

Last, I would like to thank my wife, Rebecca George. She has been a tremendous source of support for me, personally and professionally. I am extremely lucky to have her in my life.”

American Pain Society Annual Awards 2009
Elizabeth Narcessian Award for Outstanding Educational Achievements in the Field of Pain

Carmen Green, MD

“Unfortunately, I never had the privilege of meeting Dr. Elizabeth Narcessian. She was a true scholar, talented teacher, and trailblazer whose work touched the lives of many, including mine. I am truly honored and humbled to receive the Elizabeth Narcessian Award for Outstanding Educational Achievements in the Field of Pain. I thank the many patients who entrusted me with their stories. They sparked my curiosity and inspired me to look into the shadows and illuminate what I saw, providing the impetus for change and healthcare justice. I thank my research team for their commitment and willingness to hear the unheard stories and see the unequaled burdens of pain. I thank those friends, colleagues, and mentors who provided unwavering support, wise counsel, and believed in me. Lastly, I thank my family for encouraging me to have the courage to dream big, chase rainbows, and to create a path. I am indeed fortunate.”

Distinguished Service Award

Sandra Ward, PhD RN FAAN

“I am so pleased to be receiving this award. In the more than 15 years that I have been involved with APS, my service has never felt like a burden. That is because the APS people are so wonderful. They have made it rewarding to join with them, working steadily to move the bigger effort along. The AMC staff has always made my work as easy and pleasant as possible. Thanks in particular to Cynthia Porter and Amy Sherwood, who have provided absolutely outstanding support to the Small Grants Committee.”

Kathleen M. Foley Journalist Award

Atul Gawande, The New Yorker

“The topic was intriguing to investigate for many reasons—because I didn’t understand how itch really worked, because the case of the patient who scratched through her own skull was irresistible, because the topic seemed relatively unplumbed, and because I had long been interested (and periodically written about) the physiological basis of neuroperception. My hope in writing as both physician and journalist, however, is that I do more than ‘inform’ the lay public. If I am lucky, I have attacked questions we all puzzle over...and found at least a few surprises for any of us.”

Future Leaders in Pain Research Small Grants

The 2008 Future Leaders in Pain Research Small Grants Program offered funding for five researchers in the amount of $20,000. To be eligible, grant applicants must be APS members who are within 6 years of completion of their terminal degree and have not yet been awarded major NIH or foundation grant funding. There were 20 competitive applications for funding this year. Members of the Small Grants Committee reviewed and scored the applications to prepare for grant recipient selection.

APS Small Grants Committee

Sandra Ward, PhD RN FAAN, Chair
Karen O. Anderson, PhD
Jim Campbell, MD
Michael Caterina, PhD
C. Richard Chapman, PhD
Patrick M. Dougherty, PhD
Roger Fillingim, PhD
Gerald F. Gebhart, PhD
Michael Gold, PhD
Jennifer Haythornthwaite, PhD
Keela Herr, PhD RN
Jianren Mao, MD PhD
Gayle Page, RN DNSc
Kathleen Sluka, PhD
George Wilcox, PhD

Small Grant Recipients

APS is proud to announce the following 2008 grant recipients. Each of the recipients will attend the Annual Scientific Meeting to report on the progress of their research studies to members of the Small Grants Committee.

Patrick D. Braun, PhD
University of Minnesota
Minneapolis, MN
Signaling Mechanism of Novel Peptides in the Pain Pathway

Gregory O. Dussor, PhD
University of Arizona Health Sciences Center
Tucson, AZ
Cutaneous Nociceptors Respond to Mediators Released from Skin Cells

Tara A. Macey, PhD
Washington State University
Vancouver, WA
The Role of Akt Signaling in Morphine Tolerance

Khara M. Ramos, PhD
University of Colorado
Beyond Astrocytes and Microglia: The Role of Oligodendrocytes and Endothelial Cells in Exaggerated Pain States

Edgar Alfonso Romero-Sandoval, MD PhD
Dartmouth-Hitchcock Medical Center
Lebanon, NH
Cannabinoids and Glial Interactions in Acute and Chronic Pain

American Pain Society Annual Awards 2009
Clinical Centers of Excellence in Pain Management Awards Program

The CCOE in Pain Management awards program awards U.S.-based, healthcare teams who provide distinguished, comprehensive pain care. This year’s recipients of the CCOE in Pain Management awards were selected from an incredibly strong field of applicants from healthcare settings, both large and small, from around the country.

CCOE Program Committee
Michael E. Clark, PhD, Chair
James A. Haley Veterans Hospital
Elsayed Abdel-Moty, PhD
Rosonoff Comprehensive Pain Center
Miles J. Belgrade, MD
Fairview Health Services
Gilbert J. Fanciullo, MD MS
Dartmouth Hitchcock Medical Center
Christopher Gharibo, MD
New York University Medical Center
Kenneth R. Goldschneider, MD
Cincinnati Children's Hospital
Charles E. Inturrisi, PhD
Weill Cornell Medical College
Robert N. Jamison, PhD
Brigham & Women's Hospital
Mark P. Jensen, PhD
University of Washington
Jeffrey L. Koh, MD
Oregon Health & Science University
Sean C. Mackey, MD PhD
Stanford University
Judith A. Paice, PhD RN FANN
Northwestern University Medical School
Nathan J. Rudin, MD MA
University of Wisconsin, Madison
Dennis C. Turk, PhD
University of Washington
Christine Dorothy Zampach, PT MED DPT
University of California, San Francisco

2009 Award Recipients
- M. D. Anderson Cancer Center, The University of Texas, Department of Pain Medicine, Houston, TX
- Beth Israel Medical Center, Department of Pain Medicine and Palliative Care, New York, NY
- University of Virginia, Division of Pain Medicine, Department of Anesthesiology, Charlottesville, VA
- Rehabilitation Institute of Chicago, Chicago, IL
- University of California, Los Angeles, Pediatric Pain Program, Mattel Children's Hospital, David Geffen School of Medicine, Los Angeles, CA

Honorable Mentions
Honorable mentions were awarded to University of California, Davis Division of Pain Medicine; the University of California, San Diego Center for Pain Medicine; Minnesota Head and Neck Pain Clinic, University of Minnesota; and the University of Pittsburgh, Interprofessional Program on Pain Research, Education and Health Care.

Special Commendation for Innovation in Pain Management
Acute & Chronic Pain Management, Walter Reed National Military Medical Center

Other Highlights

The author-attended poster sessions featured more than 300 posters.

Above: Sandra Ward, PhD RN FAAN, receives the Distinguished Service Award.

Above right: Attendees and guests enjoyed the beautiful Awards Gala.

Right: Ricardo Cruciani, MD PhD, accepts a CCOE Award on behalf of Beth Israel Medical Center.
**NEW Clinical Resource from APS!**

The American Pain Society has developed a PDA version of *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain, 6th Edition*. Now this important clinical reference is mobile.

PDAs have been shown to aid diagnosis and drug selection.

*Data capture and retrieval using a PDA by physicians, nurses, and allied healthcare professionals enhance patient care and improve efficiency.*

“Having the resources at my fingertips has definitely helped make me a better doctor, and as a visual learner, helped me learn more quickly. When I’m on the go, I rely solely on my PDA resources.”

**Members: $9.95**
**Nonmembers: $14.95**
Managing Pain Before It Manages You, 3rd Ed.
Reviewed by Joan Romano, PhD

This popular, self-help manual for patients with chronic pain has many admirers and it is easy to see why. It is clear, easy to read, and user-friendly. The book communicates an empathetic understanding of the experience of chronic pain in a comforting and validating way for patients. It helps to demystify the process of developing chronic pain and how one might cope with it successfully. The third edition features a variety of updates, including new chapters regarding the role of nutrition in pain management and on complementary and alternative pain medicine treatments. Also new to this edition are appendices providing resources from the Federal Agency for Healthcare Research and Quality to help consumers choose among non-steroidal anti-inflammatory medications, and a list of Internet resources for pain- and health-information support groups and research studies. Caudill does a very good job of outlining how patients can use mind-body techniques (e.g., diaphragmatic breathing and cognitive therapy techniques) and problem-solving and communication strategies to help reduce suffering and increase their ability to manage and control pain. Overall, it is a valuable resource for patients living with chronic pain and seeking a way to reduce suffering and improve quality of life.

However, there are some significant limitations to this work. My main reservation is the relative lack of emphasis on using techniques of reactivation and physical exercise as part of an overall pain management strategy. Like any other technique, exercise and physical reactivation must be evaluated in the context of individual patient circumstance. Patients need to work with their physicians to determine the appropriateness and level at which exercise or physical therapy can be a part of their pain management efforts. Perhaps, the self-help focus of this book may have resulted in the de-emphasis on these techniques, but I think it leads to an imbalanced result. While there is an entire chapter on nutrition and an appendix devoted to complementary and alternative medicine techniques, there are barely two pages on the topic of aerobic exercise. While I have no argument with encouraging healthy nutrition as part of an overall plan of improved fitness, the priorities appear misplaced. Compared to these other topics, relatively little attention is devoted to understanding the effects of deactivation in chronic pain disability; the role of structured progressive physical therapy in an overall pain management program; or to helping patients, whose self-help efforts fail, become aware of the concept of multidisciplinary pain treatment, one of the more empirically supported and effective interventions in the pain management arsenal. In fairness, Caudill does state that she “strongly encourages people to do some type of aerobics, stretching, and strengthening exercise on a regular basis.” However, the relative emphasis is clearly elsewhere.

Overall, there is much to celebrate in this book and in the fact that it has become popular. The application of techniques of relaxation, cognitive restructuring, problem solving, and effective communication can all be highly useful for patients as they deal with long-term pain. However, the relative paucity of detailed information regarding the role of active therapies designed to not only manage discomfort but also to push back limitations of function when possible through progressive activating therapies and multidisciplinary pain treatment prevents me from recommending this book wholeheartedly.

Dr. Romano is Professor of Psychiatry and Behavioral Sciences at the University of Washington in Seattle, WA.
The Diagnosis and Treatment of Breakthrough of Pain

Reviewed by John D. Loeser, MD

This pocket-sized text is part of the Oxford American Pain Library series edited by Perry Fine, which addresses various aspects of pain management. Two other volumes in the series have been published and three are in press, with many other proposed topics not yet underway. The approach seems to be to provide a portable reference volume that has a specific-topical focus and is replete with references, tables, and figures.

The unwritten theme of this volume is to make breakthrough pain (BTP) a part of all chronic-pain management, not just pain associated with cancer. The last three of the 10 chapters lose the focus on BTP and address more general aspects of the treatment of pain and problems with long-term opioid therapy. As a resource for the topic of BTP with excellent literature citations, tables, and treatment suggestions, this is a superb book. However, I have reservations about the wisdom of extending the management of BTP in cancer patients to people with other forms of chronic pain. I think drug manufacturers, particularly those with a transmucosal fast-acting preparation, are eager to see such an expansion, as they can use it to pummel the Food and Drug Administration to provide much greater indications for their products. Opioid problems are now bedeviling chronic-pain management to no small degree because of the unrecognized differences, not in pain mechanisms, but in the psychosocial aspects of chronic pain due to cancer and nonmalignant diseases. I fear that the same physician behavior that has resulted in massive doses of opioids for patients with opioid-insensitive pain without regard for functional improvement or measures of pain relief will take over the prescribing for BTP. Every acute pain can be considered a BTP.

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

Functional Pain Syndromes: Presentation and Pathophysiology

Reviewed by John D. Loeser, MD

This is a timely and fascinating compilation of epidemiology, symptomatology, theories of mechanisms of pain, and a dollop of treatment recommendations. A struggle is going on in the pain world involving those who believe that neuropathic pains must have a lesion or disease in the nervous system versus those who believe that dysfunction in the nervous system is all that is required for the diagnosis of neuropathic pain. This book is firmly in the latter camp. Each chapter is concise and highly focused upon a specific syndrome. Evidence is marshaled in each argument to support the thesis that all of the functional pain syndromes are correlated with changes in the peripheral and central nervous system, and that these are all disorders of central neural processing.

Interrelationships between functional syndromes are emphasized, as are the ties to affective states. The final chapter, authored by the editors, attempts to synthesize the wisdom contained in the preceding 24 chapters and provides a complex set of hypotheses about these all-too-common reasons to seek health care. This book is a good starting point for those who wish to know the current state of thought about these puzzling and costly human conditions.

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

Current Therapy in Pain: Expert Consult

Reviewed by John D. Loeser, MD

This is a large-format volume that is well populated with tables and figures to accompany the text. It also has a searchable, online version that is accessible with an activation code printed in each book. There are more than 130 contributors to the 89 chapters, with the editor’s hand in more than 10% of them. Some chapters are long enough to be authoritative; others are too brief to thoroughly examine their subject. The book is rationally organized with introductory chapters on taxonomy, basic science, and pain assessment. Following the introductory chapters are chapters on acute pain, cancer pain, and chronic noncancer pain. Brief chapters on the young and the old with pain and then palliative care and substance abuse populations comprise the next section. A large section on pharmacologic therapies is followed by briefer chapters on behavioral medicine, physical medicine, neuro-modulation, CAM, and neurosurgery for pain. The book concludes with a long section on intervention pain treatments.

The index contains no citation for evidence-based medicine and this is reflected by most of the chapters that contain little in the way of outcomes evaluation. Indeed, as I perused the book my thoughts shifted to a lovely chop suey—small pieces of lots of things, some of which were enticing and others just filler. The scope of this book is broad, but the reader gains no perspective on when to do what therapy with how much likelihood of success. Of course, with a multiauthor text the chapters bear no relationship to each other and they are not integrated to make a coherent whole. This book is a quick way to look up a specific topic, find some key references, and get a snapshot of the subject. It competes with other textbooks that highlight the gamut of pain, but as its title suggests, is focused upon treatment. It could be a useful addition to the pain specialist’s library.

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

Current Topics in Pain: 12th World Congress on Pain
Reviewed by John D. Loeser, MD
This book consists of 17 essays derived from invited plenary lectures at the 12th World Congress on Pain in Glasgow in August 2008. Each essay is appropriately illustrated with figures (some in color) and tables and a thorough bibliography. The book is dedicated to the late Mitchell Max, whose lecture (and the included essay) on the importance of genome-wide association studies was one of the highlights of the meeting. The majority of the essays highlight basic science topics, but important clinical topics such as the validity of randomized clinical trials and pain in the developing world are also included. This book is a marker of the progress in some of the sciences that underlie pain research and management. Our field continues to develop and IASP compiles an exciting array of lecturers for its Congress.

 Calling All Authors!
Have you written a book and want it reviewed in the Resource Reviews section of the APS Bulletin? We need your books!
Send your book or the publisher's contact information to APS and we will review it in an upcoming issue.

Please send all books to:
APS Bulletin
Attn: Liz Newman
4700 W. Lake Avenue
Glenview, IL 60025
**CALENDAR OF EVENTS**

**August 27–30, 2009**
**16th Annual Hands-on Workshop: Regional Anesthesia & Pain Medicine 2009**  
**Sponsor:** University of Toronto  
**Location:** White Oaks Conference Centre, Niagara-on-the-Lake, Ontario, Canada  
**Contact:** christine.drane@uhn.on.ca

**September 2–4, 2009**  
**18th Annual Pain Resource Nurse (PRN) Course**  
**Sponsor:** City of Hope & Southern California Cancer Pain Initiative  
**Location:** City of Hope Platt Conference Center, Duarte, CA  
**Contact:** Maggie Johnson at mjohson@coh.org or 626/256-4673 ext. 63202; http://scpi.coh.org

**September 9–12, 2009**  
**6th Congress of the European Federation of IASP Chapters**  
**Sponsor:** European Federation of IASP Chapters  
**Location:** Lisbon, Portugal  
**Contact:** www.kenes.com/EFIC or efic2009@kenes.com

**October 1–2, 2009**  
**Strategic Planning Summit for Pain and Palliative Care Pharmacy**  
**Sponsor:** Southern Illinois University Edwardsville and the Mayday Fund  
**Location:** Edwardsville, IL  
**Contact:** dboyer@siue.edu or 618/650-5126

**October 2–4, 2009**  
**Multidisciplinary Pain Management: Delivering Evidence-Based Effective and Efficient Care**  
**Sponsor:** Emory University School of Medicine and Southern Pain Society  
**Location:** Atlanta, GA  
**Contact:** mboone2@emory.edu

**October 4–7, 2009**  
**Intensive Update with Board Review in Geriatric and Palliative Medicine**  
**Sponsor:** Mount Sinai School of Medicine, Brookdale Department of Geriatrics and Adult Development and The Lilian and Benjamin Hertzberg Palliative Care Institute, and endorsed by the American Geriatrics Society, the Center to Advance Palliative Care (CAPC), the Bronx VA GRECC and the Consortium of New York Geriatric Centers (CNYGC)  
**Location:** Baruch College Vertical Campus Conference Center; New York, NY  
**Contact:** Kristine Kime at 212/241-6353 or kristy.kime@mssm.edu

**October 22–24, 2009**  
**CAPC National Level I/II Seminar: Innovative Solutions for Tomorrow’s Palliative Care Program**  
**Sponsor:** Center to Advance Palliative Care (CAPC)  
**Location:** Atlanta, GA  
**Contact:** capcevents@mssm.edu or 212/201-2680

**October 23–24, 2009**  
**Midwest Pain Society 33rd Scientific Session**  
**Sponsor:** Midwest Pain Society  
**Location:** Northwestern University Medical Center, Chicago, IL  
**Contact:** Chris Gagnon at cgagnon@ric.org