Encouraging a pain rethink

Dear Editor,

Re: Dr Majedi's column *Suffering vs Resilience* (March, P11), pain is essentially the body's way of protecting itself from further or potential damage. It is a signal of danger sent to the brain through a complex series of chemical processes through the nervous system, and interpreted by the brain as pain.

The most important part of the story is that the brain produces the feeling of pain. This occurs even without apparent reason – such as when an injury has healed and the 'danger' has passed – and in limbs that do not exist – a phenomenon known as 'phantom pain' in amputees.

The pain experience – such as the level of pain, the amount of catastrophising and the potential for recovery – is also related to numerous other factors relevant to each individual such as their personality, belief system, history, ethnicity and even the people around them.

Pain is an entirely individual and subjective experience. Two people with the same kind of injury or condition can have marked differences in the way they perceive that pain and in their capacity for rehabilitation.

As doctors and specialists it is important to understand the whole individual and the factors likely to influence pain rather than focus on mechanical problems, especially in cases of chronic pain, in order to encourage behavioural change.

For chronic pain, real potential for improvement starts when patients learn to perceive pain differently. For example, by learning that pain is not 'dangerous' and exercising will not harm the body, patients' mobility can improve with no increase in the experience of pain.

Evidence shows a multidisciplinary approach to pain management results in less pain, less disability and better quality of life. A team of health professionals working together can focus on different aspects of the pain experience. Physiotherapists or other movement specialists and psychologists trained in pain management are important in this team approach.

When patients rethink their pain and learn to manage themselves differently, they have the greatest chance of recovery.

Ms Carol Bennett, CEO PainAustralia (www.painaustralia.org.au)

Article objection

Dear Editor,

The recent article *Spinal pain procedures: who and when?* by Prof Eric Visser (March edition, p35) was disappointingly backward looking. The treatments we've been offering have been largely ineffective. Endorsing more of the same is surely not appropriate.

The statement that 20-40% of chronic neck and back pain is associated with facet joint arthropathy and 20% of back pain is due to sacroiliac joint arthropathy or cluneal nerve entrapment over the iliac crest must be challenged.

The population that does not have significant back pain has as much arthropathy, degenerative change and pathology of all grades of severity as the population that does have disabling back pain.

Therefore, facet and sacroiliac joint arthropathy cannot be interpreted as causative. Assessment of causation by injecting anaesthetic into the suspected structure is severely confused by placebo effects which we now know to be powerful and enduring in many patients.

Carefully orchestrated double-blind injection protocols give more reliable information but are quite impracticable in clinical practice.

The evidence supporting sustained efficacy from facet injection and radiofrequency denervation of facet joints and sacroiliac joints is said in the article to be 'limited' but in fact it is almost entirely lacking as far as high-quality evidence is concerned. A recent large multicentre randomised controlled study of radiofrequency denervation of lumbar facet joint and sacroiliac joints compared to exercise therapy demonstrated absolutely no advantage for these denervations at the one-year follow up. In fact, the exercise-only group did better!

Current thinking is that disabling back pain has more to do with the nervous system and vicious circular psychosocial interactions than degenerative and structural pathology of the spine.

Longitudinal neurological profiling including sensory testing of over 100,000 back-pain patients in Germany documents that while spinal pain may be initiated by nociceptive mechanisms, over time neuropathic or neural sensitisation mechanisms become dominant.

The biomedical model of treatment of presumed nociceptive dominant spinal pain remains firmly entrenched but has largely failed.

For the most disabled and intractable back-pain patients with predominant neuropathic or neural sensitisation pain patterns, strong evidence now supports implanted neuromodulation therapy. High-quality randomised control studies have

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"If you are going through hell, keep going."
Sir Winston Churchill (1874-1965)

Alcohol floor price

WA Health hosted a day-long seminar in March with a gallery of local and national experts from ED physicians to academics tackling the hot health topics around obesity and alcohol abuse. Everyone was singing from the same song sheet and with the Minister Roger Cook in the audience he was very much the focus of their attention. In February we reported Australasian College of Emergency Medicine's snap survey of ED patients affected in some way by alcohol, revealing WA was the worst in the country. Former Perth physician now head of emergency medicine research at Monash Medical Centre Dr Diana Egerton-Warburton used the survey to call for political action. Many of the speakers mentioned introducing a minimum floor price for alcohol as the NT government has done. So what is the minister waiting for? When *Medical Forum* caught up with him afterwards, he said it was not as simple as that. "What the seminar showed was that the health community was unified in its opinions, and that accounts for a lot, but it's also their job to bring the community along with them. We didn't have tobacco legislation because the health community said smoking kills you, it happened because the health community was able to convince the community how harmful it was. Risky alcohol consumption is the same. We have to get the community behind the restrictions and the laws will follow."

Flu blues

Is there a more political season than the flu season! We have been inundated with updates regarding when to vaccinate for the best protection (not too soon and not too late, which is somewhat empty advice); which serum is the best – Superman v Batman – and of course the hoary old chestnut, who should give the patient the jab. Is little wonder the punters pick up their bat and head to the vitamin C shelf. Keeping the focus on getting people vaccinated in a timely fashion is probably all we need to worry about.

Skyping high

Continuing on message is a theme the folks at Qoctor take seriously. Qoctor is a web-based GP clinic based in Melbourne, though when you think about that, does it matter where it's based. We heard from their bugles that Qoctor delivered its 10,000th sick note recently. Patients access a doctor by filling an online form and booking in a Skype session with a registered GP. We recently spoke to one of the directors of Qoctor, Dr Aifric Boylen, who took umbrage at the suggestion the service was opening itself up to unscrupulous doctor shoppers. As far as she was concerned, Qoctor provided the same level of service as a bricks and mortar surgery. Kalamunda GP Dr Sean Stevens, when asked his opinion, voiced probably a majority GP view that it sounded terrible for continuity of care and chronic disease patients. Dr Boylen said the world was changing and it was not only doctors' time that was precious. It launched Dr Sicknote in 2015 and has issued 10,678 certificates online. They claim to have saved patients 16,017 hours and saved Medicare $491,188. The Qoctor team is now made up of eight qualified GPs and one pharmacist.

AHPRA triage complaints

We read with interest a media report of the 2018 Medico Legal Congress in Sydney which quoted Kym Ayscough, executive director of regulatory operations at AHPRA, announcing that a recent trial which triaged complaints against doctors to reduce time lags. WA was a participant, and apparently it was a huge success. So successful in fact the system will be rolled out nationally. She told the meeting that triaging increased the proportion of assessments within 20 days from 8% to 37%. The system involves a committee with a smaller quorum than usual, but at least one health practitioner and one community member, who will decide whether a complaint can be closed early. We shot off a query to AHPRA to discover who was on the WA committee. The spokesperson said that medical board members from WA, SA, and NT were eligible to participate in the triage assessment in those three jurisdictions. So it is feasible that a WA case may be triaged by board members from both SA and NT.

After-hours shrinkage?

National Home Doctor Service announced that it would be curtailing some of its after-hours services in Bunbury, Mandurah and Rockingham when the Federal Government imposed a 30% cut in the Medicare rebate for after-hours visits by non-VR GPs and an advertising ban. The changes took effect on March 1. The GP rebate will stay at $129.80, while non-VR GPs' rate has been cut to $100. The *Medical Republic* reported that non-VR GPs accounted for 60% of the after-hours workforce. Whether it is a reduced volume of calls due to the advertising ban or workforce issues, it is a development that will have the watchers watching.

Anxiety and heart attack

Anxiety around heart attack is a good thing according to German researchers. Those patients with anxiety disorder and symptoms of a heart attack sought medical treatment sooner, thus improving their chance of survival. Women took action two hours sooner and men 48 minutes, which is not statistically significant in terms of cardiac improved outcome for men. What's the solution, we wonder – a lot of anxious people bedded down in EDs across Germany?

Who's phased?

GlobalData sent Medical Forum two media releases around oncology trials. The first around immune-oncology Phase II trials showed they increased 57% during 2008-17. Phase III or IV trials increased little or remained the same. They concluded: "This shows the fast pace immune-oncology features with regard to the development of new drugs. It also highlights the relatively early stage the field is in, considering that 88% of the trials are in Phase II or below." The second said that most oncology clinical trials in China (2012-17) failed to meet the planned enrolment targets, particularly Phase II clinical trials. In fact, the greatest

beneath the drapes

- WA's Chief Medical Officer **Prof Gary Geelhoed** is vacating the chair to take up the position of Executive Director of the WA Health Translation Network. The acting CMO in the short term is paediatric gastroenterologist **Prof David Forbes.**
- The Perth Bone and Tissue Bank, trading as PlusLife, has appointed St John Ambulance deputy chief **Anthony Smith**, Former DonateLife WA state manager **Hal Boronovskis**, Gumala Enterprise's director **Bart Boelen** and Wealth Management Partners **Steven Perica** to the board. Peel Health Campus CEO **Dr Margaret Sturdy** has resigned from the board.
- **Jane Muirsmith**, non-executive director of Australian Financial Group and Healthdirect Australia, has been appointed to the board to the Telethon Kids Institute, replacing former WA Attorney-General **Jim McGinty. Fiona Drummond** was appointed to the board in December.
- Urologist and co-founder of Perth Urology **Dr Trenton Barrett** has won a *Business News* 40Under40 Award.
- **Mr John Pease**, SJGHC's group director of governance will be interim CEO while the SJG board decides on a permanent replacement for **Dr Michael Stanford** who left on March 21 after 16 years.
- Biogen Australia, in consultation with the TGA, will withdraw Zinbryta (daclizumab) from the Australian market following cases of serious inflammatory brain disorders in Europe.