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PAIN NEWS

A PUBLICATION OF THE BRITISH PAIN SOCIETY



The 2024 BPS Annual Scientific Meeting issue

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Robert, HFX SCS Patient

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THE BRITISH PAIN SOCIETY
PAIN NEWS

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President's message: Autumn 2024

Roger Knaggs



I trust that you have found time over the summer period for some rest and relaxation. If this has not been possible, then I hope that you are able to enjoy a break from your usual routine in the not-too-distant future.

Annual Scientific Meeting

Given the production timescale for *Pain News*, this is the first column that I have written since the Annual Scientific Meeting held in Nottingham in early June. The weather was kind, and people were able to enjoy the green and wide spaces throughout the University of Nottingham campus. The meeting was a great success, and I have received many positive comments. There are some picture highlights included in this issue of *Pain News*.

The meeting truly represented a vibrant multidisciplinary society with a focus on greater learning opportunities and demonstrating the world's leading research that is undertaken in the UK. It was also a pleasure to meet members and delegates that came together from over 20 countries. I would like to thank everybody who contributed to the success of the meeting, including the Scientific Programme Committee, plenary speakers, workshop organisers and contributors, poster and oral presenters, sponsors, Council colleagues and the secretariat and meeting organisers.

For the second year, we held a public outreach event at Nottingham Central Library, where we joined with representatives from local pain services and universities, Versus Arthritis and the Patient Voice Committee. This initiative has already resulted in further collaborations locally.

At the Annual General Meeting as well as while updating members on the work of the BPS, it was a pleasure to award honorary membership recognising the outstanding work of two individuals namely Paul Evans, Producer of the Airing Pain Podcast, and Dr. Benjamin Ellis MBE, a consultant rheumatologist and Senior Policy Advisor for Versus Arthritis. The citations presented are reproduced later in this issue of *Pain News*.

We recognise the increasing financial and time difficulties that some people have in attending the ASM and that the format has not changed over recent years. In addressing these issues, I have asked Cathy Price and Raj Munglani to lead a review of the ASM as and to make both the short- and long-term recommendations. As part of this process, we will be asking for members opinions and views. You will hopefully see some changes for next year, but it may take a little longer for more substantial changes due to the complexities of planning such a large meeting.

Next year, the ASM is going to be held in Wales for the first time in many years at the International Convention Centre Wales, in Newport between 3rd and 5th of June. This conference centre is surprisingly easily accessible to the rest of England, and so I look forward to seeing as many of you as possible there. Watch out for regular updates will be provided in the monthly e-newsletter.

SIGs

I have written before about the importance of the SIGs within the BPS and that they are the lifeblood of the society. Earlier in the summer I had an invitation to attend and speak at the Philosophy and Ethics SIG retreat at Rydal Hall in the Lake District. The overarching theme for the meeting was pain and addiction. Interspersed within the varied programme, there were numerous opportunities to enjoy the beautiful

surroundings and scenery. I left feeling physically and emotionally refreshed and rejuvenated. If you have thought about attending the Philosophy and Ethics SIG but not made it before, I would thoroughly recommend considering it in the future. Recognising the importance of the SIGs, I will strive to attend events organised by other SIGs over the next few years.

As always, I remain interested to hear from all members about any pain-related issue, however small or large. Please do

not hesitate to reach out if there are issues that you feel the BPS should be aware of or addressing. I commit to responding to all contacts.

With best wishes,



(Email: roger.knaggs@nottingham.ac.uk)

Reflections on the 2024 British Pain Society Annual Scientific Meeting



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Sage

Jo Brown *Executive Director, British Pain Society*



Attending the British Pain Society (BPS) Annual Scientific Meeting for the first time as a new Executive Director was an enriching experience. The vibrancy and energy of the conference were palpable from the moment I arrived. It was inspiring to talk to so many dedicated professionals gathered with a shared passion for advancing pain management.

One of the most striking aspects of the meeting was the evident commitment to multidisciplinary research and collaboration. Experts from various disciplines came together to

exchange ideas, share their latest research, and discuss innovative approaches to pain management. This diverse convergence of knowledge highlighted the importance of multidisciplinary working and the power of coproduction to not only understand pain better but to improve the quality of life for those affected by it.

The enthusiasm and dedication of the attendees reinforced my belief in the crucial role that the BPS has in integrating professionals working in pain from diverse disciplines, and people of lived experience, to continue to advance effective pain management for all. It was particularly exciting to chat with the early career professionals and hear their fresh perspectives and ideas. I am confident that with their involvement with BPS, they will drive forward the future of the Society, bringing new energy and insights to our work.

Looking ahead to 2025, I am excited about the potential for what we can achieve as a society. By continuing to prioritise collaboration, education, and patient-centred care, we can continue to support each other and our members facilitating the exchange of knowledge that drives our field forward.

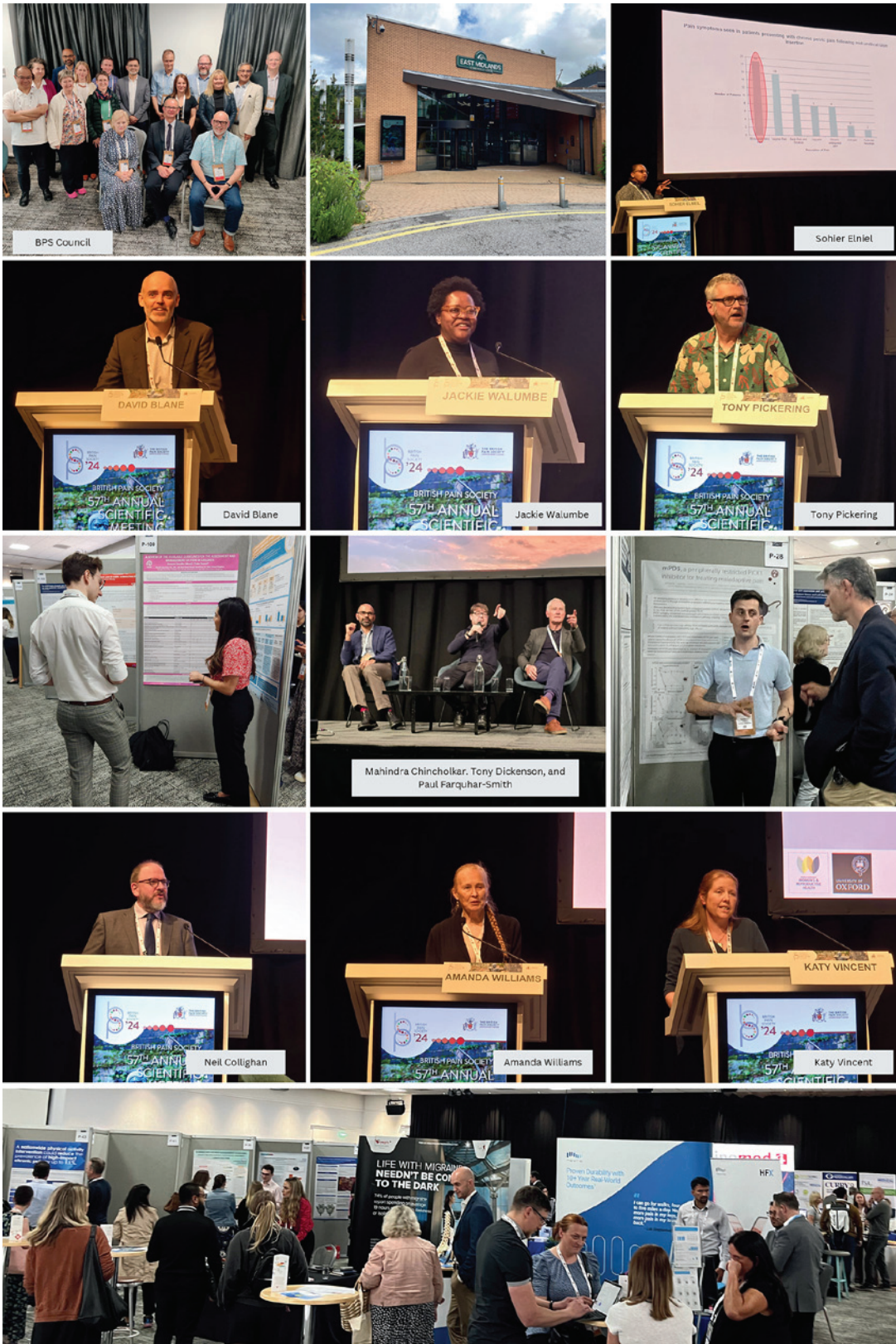
BPS ASM 2024



Nottingham 2024
Annual Scientific Meeting

Over 400 delegates gathered for the British Pain Society's Annual Scientific Meeting, creating a vibrant atmosphere for networking, knowledge exchange, and advancing the field of pain management.









Citation for Benjamin Ellis

Cathy Price *Vice-President, British Pain Society*



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My first encounter with Benjamin was a mysterious phone call with someone who just asked a lot of questions about pain management. He wouldn't say who he was or who he worked for, so I wondered if he was a bit of a scammer. Eventually he convinced me that he was serious, and so I gave him all the information I could (he especially wanted to know what data I had on pain clinics) and some contacts. A few weeks later, I emailed him to ask if the information I had given was useful (I was curious!). He replied to say yes, and then I was very surprised to get back an email from Sir Liam Donaldson saying, 'Actually Benjamin is working for me, he is compiling a report on chronic pain for my annual report, please could you help him with this and P.S. don't breathe a word'. How could I say no! This included finalising recommendations while parked in a layby the night before the report was due. It was then I began to appreciate Benjamin's ability to get things done.

I was so pleased with how it was received and the chutzpah with which Benjamin deftly wove his way through the politics that

followed to get the report implemented. I began to understand his unique skills at bringing people together, getting them to agree and firing them with the passion that he had for the plight of people with long-term pain. Even more so when it was proposed that an English Pain Summit should be held. He managed to cajole and persuade disparate groups to work together to agree a long-term strategy for the management of pain.

Beverly Collett, Former BPS President and Chair of the Chronic Pain Policy Coalition, has this to say:

Dr Benjamin Ellis was a breath of fresh air when he started to interact with the BPS.

At that time, he was a Clinical Advisor to Sir Liam Donaldson and took a strategic Public Health approach to improving services involved in the management of pain and supporting people with chronic pain.

The BPS was developing relationships inside Parliament to raise public awareness of the problem of persistent pain, and Benjamin worked closely with Jean Gaffin OBE to develop strategies to empower people with pain and to put the patient voice at the heart of the agenda.

He was tremendous fun to work with. His ideas regarding health service policy were always sensible, and his knowledge regarding relationships and how to get things done was second to none. The first Pain Summit was held in Westminster Hall in 2011. It would not have happened without his input, knowledge and connections, and this report was pivotal in transforming services involved in the management of persistent pain.

I watched him grow from a feisty intern into a considered, tactful, effective leader through achieving a Master's in Public Health from John Hopkins University, a heavy registrar job in Brighton and finally to a consultant post in Imperial College Hospital. Along the way, he added in working for the Patient Safety programme at the WHO in Geneva.

Benjamin has always put the voice of patients first, and I believe, this is why pain is so important to him. His passion for promoting the importance of sound, effective pain management was carried through into policy work for Arthritis Research UK, based on the feedback from patients that this was the most important thing for ARUK, and then Versus

Citation for Benjamin Ellis

Arthritis, to focus on. This led to pain being a research priority and then an important publication in 2019, 'A road map for pain'. He has also established an MSK data group which acts as a shop window for research into musculoskeletal conditions. He has also managed to be part of the NICE GDG on chronic pain.

Benjamin's sense of fun and thoughtfulness is never far away – from making me follow him around London on a bike just to get an ice cream to setting up a meet in an art deco café with some senior civil servants just so I could enjoy the design (we didn't tell them that) – but you still owe me a pancake! I have never stopped enjoying the experience.

Benjamin has along the way put his tireless energy into being a founding trustee of KeshetUK – an organisation aiming to ensure that Jewish LGBT+ people in the UK and their families are included in every aspect of Jewish life. Being part of the LGBT+ community and being Jewish have never been easy bedfellows, but he has tackled this head-on. Following on from this, at the start of 2024, Dr Ellis was named Member of the Order of the British Empire (MBE) in the 2024 New Year Honours list for services to healthcare, equality and the Jewish community.

In writing this, I inevitably googled Benjamin to check if I had missed anything. Boy, is he up to a lot! His focus is relentless on improving the lives of people with chronic pain, reducing disease progression in osteoarthritis and improving personalised care for people with rheumatoid conditions.

I'm going to finish with some words from Sir Liam Donaldson who kindly sent in this piece:

In the mid-2000s, Benjamin Ellis was part of a decisive move to raise the profile of chronic pain and pain services in this

country. At the time, he was one of a number of young doctors working in the office of the Chief Medical Officer. The annual reports of the Chief Medical Officer of the time, Liam Donaldson, were highly influential and attracted wide attention. For example, one of them contained recommendations which led to the creation of smoke-free public places. The 2008 Chief Medical Officer's annual report contained a chapter called Pain: breaking through the barrier. Benjamin was the driving force in the work of this seminal chapter. It put the spotlight on chronic pain in a clear and compelling way and directly showed how poor current service provision was.

Three years later, Benjamin Ellis played a major part in organising the country's first Pain Summit. It took place on 22nd November 2011. It was attended by leading clinicians, NHS leaders and health ministers. What was striking, though, is how central patients were to the discussions of the day.

They showed that although pain is a symptom, it is the consequences of pain that are the most profound: on work, on home life, on personal finance, on social activities, on happiness. One patient at the Summit spoke of having to carry out a 'mini cost-benefit analysis' before deciding whether a social activity is worth the ordeal that pain turns it into.

What shines through Benjamin's work, as an advocate, practitioner and leader in the field of chronic pain, is how patients and families are always central to his thinking. The real-life impact of the condition that is the subject of this honour today is what drives him.

Benjamin: I am super stoked to be presenting you with honorary membership of the British Pain Society. On behalf of patients and clinicians, a big 'Thank you', and please continue to breathe energy and life into everywhere you go and everything that you do.

Pain news update Autumn 2024

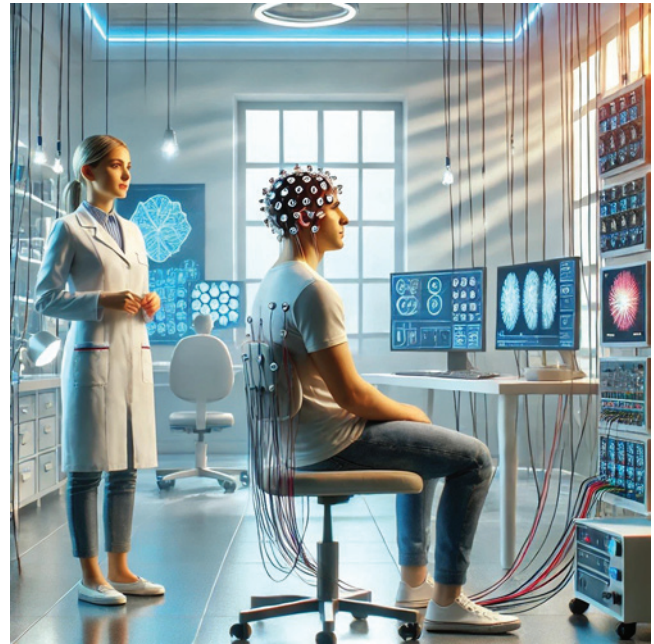
Margaret Dunham *Associate Editor Pain News*

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View from the southeast of Marienburg Castle. In the autumnal evening light, the treetops on the Marienberg shine against the slightly overcast sky. PD

As I write the summer Paris Olympics are well underway, and sadly Andy Murray has seen his last appearance on the world tennis stage. He and many elite athletes have struggled with painful health problems as they push their bodies to the boundaries of their aspirations. Even the wonderful and revered world champion US gymnast, Simone Biles, has suffered an injury falling off a beam. So, let us remind ourselves that when the injury is visible, we are generally sympathetic, there is an attributable cause, with the exception of footballers. And for people with such pain experiences, funds are not an issue, especially when there is a profitable sporting consideration. The inequality of health care cannot be seen more starkly between the waiting lists of the current National Health Service (NHS) and the immediacy of private health care. Indeed, pain as a particular specialism always seems to be having to justify the necessary resources – ordinary people, not just the elite or wealthy, need access to pain services. So, in anticipation of a new Government's plans to be fully actioned, I optimistically hope that the money is made available to resource the pain services that help to keep the UK working, active and well.



The brain and pain continue to be areas in need of considerable research if we are to appreciate the intricacies and synergies of the painful manifestation of living with pain. What if we could connect directly with the pain, via electroencephalogram (EEG), for example, to understand and validate another's experience. A concept enabling such activity, called BrainGBT, has been explored by Australian researchers at the Sydney University of Technology.¹ The implication is that a cap filled with sensors will do some 'mind reading' related to people's pain experiences. It could provide a portable brain scan which would provide an alternative to magnetic resonance imaging (MRI) and with the development of suitable software enable identification of pain.

August is notoriously the silly season for news, and what better way to explore this than via the emerging study of the pain and other psychogenic properties of magic mushrooms.² Can hallucinogenic/psychogenic properties of magic mushrooms make people feel better? This has been a topic of interest and review at the University of Leiden in the

Pain news update Autumn 2024

Netherlands.³ Van Elk and Fried identified a lack of consistent, valid and reliable reporting of all effects, including the adverse ones, as a frequent issue. Volume of data does not equate to evidence and, just as with the cannabinoid lobby, statistical outliers in the form of individual case studies do not equate to evidence for safe effective use. I agree with the authors³ that a



healthy dose of scepticism is required to ensure that these agents are considered with extreme caution and full rigorous evaluation is conducted prior to their promotion.

On a gentler note, walking is good for you. People who walk gently five times a week were researched by a team at Macquarie University,⁴ Australia. The team identified 700 people with back pain: half were instructed to go for a walk five times a week and offered physiotherapy sessions and professional support. The ones walking regularly has less pain and generally fared better – nice to have a practical and cheap intervention validated. So, the race-walking sport of the Olympics is not a sport to be sneered at, in fact it should be promoted and celebrated!

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Citation for Paul Harvard Evans

Heather Wallace *Pain Concern*



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Airing Pain: Bringing together the pain community

My connection with the British Pain Society goes back to Michael Bond's Presidency. Beverly Collett was Vice President. I was invited to join a Steering Group led by Beverly to draft terms of reference for the first ever Patient Liaison Group, which I went on to join. We needed to reach people, educate, tell them about science and research, offer hope, and tackle isolation and despair. Internet Radio held promise and from the start it was natural to involve the British Pain Society, and the Welsh Pain Society, where a contact put us in touch with Paul, a multi-award-winning senior radio producer with over three decades at the BBC behind him, who was taking early retirement.

Paul has lived with fibromyalgia for over half his working life. It's that experience, combined with his professional skill, that brings a unique quality and authenticity to *Airing Pain*. In 2011, Paul attended the first of many ASMs, interviewing speakers, researchers and members of the society about their work. There are now over 144 podcasts available. Some are special editions such as edition 96, made to celebrate 50 years of British Pain Society.

Paul says that clarity and accuracy of up-to-date information and advice is at the core of each edition. They neither patronise the man or woman in the street, nor the healthcare professionals and researchers with 'dumbed down' explanations, thus 'bringing the two extremes of the pain community together in a common language and goal'.

Airing Pain is held in high standing within the professional and patient bodies.

The Faculty of Pain Medicine recognises the educational value of *Airing Pain*, awarding CPD points for listening accompanied by written reflection. Research needs to be broadcast or published in order to have an impact. Because of Paul, more people know about the science that is undertaken for the benefit of patients.

His skilful interviewing lets us hear the voice of those who once were voiceless, unheard and too often 'at the end of the road with their pain'.

He says, 'Of the many people I've interviewed who live with chronic pain, there's been a strong undercurrent of desperation and anger that they feel excluded'. He gives examples,

- Information on supported self-management is available so why, *still*, are people not guided to it?
- Despite buzz words such as 'collaborative decision-making', 'people who should have been able to have a meaningful conversation with their health professional have yet to achieve it!'.

Citation for Paul Harvard Evans

He's captured the experience of exclusion in *Airing Pain* because, as a professional journalist, his vision is to embrace all members of this, our Pain Community. And in each edition, Paul changes lives:

*So much more information than I got from the consultant.
That's why we need Airing Pain*

*Talking about the difficulty of pacing resonated with me
and encouraged me to persist*

A lifeline of information in my own time

*Almost comforting because I lose the isolation of living
with people who do not fully understand*

Really informative but not dumbed down

It gave me hope

In 2015, when Paul won the Radio Independents Award for his programme on female genital mutilation, the judges described it as a 'stop what you are doing moment'. They went

on to say, 'This incredibly powerful production dealt with the subject with great honesty and sensitivity. This is really important programme making'.

Airing Pain achieves 1,000 listens every month and 500 more read the transcripts. All-time listens are hard to determine because how the data is captured has changed, but conservatively all-time listens (2011–2023) are 265,925.

Airing Pain is in the top 25% for listener numbers, of 5 million podcasts globally.

Bridging the gap between professional and public education is a challenge, but Paul through *Airing Pain* shows how we can work together for the benefit of patients. That is why the Council of the British Pain Society are proud to offer Paul Harvard Evans Honorary Membership of the Society. And I commend their decision.

Airing Pain: bringing together the pain community

Gareth Parsons *Associate Editor*

Figure 1. Paul editing an *Airing Pain* episode



In this article, Paul Evans talks about the setting up and running of *Airing Pain*, a radio show that aims to benefit the pain community. I first met Paul at the British Pain Society and was a willing interviewee for *Airing Pain* on two occasions. Once, when Paul very gently interrogated me about my PhD and was able to provide insights that I had not considered at the time, that later informed my ideas. On the second time, Paul came to report on an education day, and my colleagues and I ran for our student nurses. He has a wonderful way about him for putting people at ease and allowing them to fully explain their ideas and experiences, which is rather unique in these times. *Airing Pain* is a fantastic resource; I use it to keep up to date with current ideas and as an education resource for my students. I would wholly recommend listening to *Airing Pain*; it will open you up to different ideas and approaches, and if, like me, you have something to say to people about pain, it is a fantastic way to disseminate and share ideas.

Paul Evans, Producer and Presenter of the *Airing Pain* radio programme

Paul Evans is producer and presenter of Pain Concern's radio programme, Airing Pain. He is a multi-award-winning radio producer with over three decades at the BBC behind him. He has no medical or scientific training, but 36 years ago, he was

diagnosed with fibromyalgia. In 2010, he had to take early retirement, age 52, on medical grounds when managing a demanding job as a BBC Senior Radio Producer became incompatible with managing his condition and family life.

He recalls a very stressful and depressing 12-month process, in which he had to convince independent occupational health doctors that he really was ill.

It is this lack of two-way communication and cooperation between the health professionals and the patient that drives him to make a success of Airing Pain.

In 2012, he was invited to speak about Airing Pain at a meeting on Professional and Public Pain Education at the International Association for the Study of Pain's World Congress in Milan, to talk about how the Airing Pain project came about.

In this article, he reflects on that 2012 talk and how things have moved on over the following 12 years.

It all started with a fantastic idea. Heather Wallace, the driving force of Pain Concern, wanted to create a series of radio programmes to support people living with persistent pain and those who care for them. This was before podcasts came into vogue, so it really was innovative.

Furthermore, Pain Concern had actually received a grant to produce them!

But, as with all great ideas, conception is one thing, fulfilment is another.

So, while Pain Concern had boundless energy and enthusiasm, they didn't have the experience or expertise or, indeed, the first idea of how to get a radio programme off the ground.

When my retirement from the BBC on medical grounds finally went through, I was depressed and pretty much broken. The thought, then, of returning to radio production was inconceivable!

However, my forced retirement coincided with Pain Concern's successful grant to make *Airing Pain*. A good friend

Airing Pain: bringing together the pain community

and former colleague who'd been on a residential pain management programme was the link that connected me with Heather.

We talked, and talked, and talked again, and I have to say that at times I felt guilty of dampening down any enthusiasm by pointing out impracticalities or the downright affordability of many excellent ideas.

The chasm between large corporate thinking (how many producers does it take to change a light bulb? . . . None, it can't be done!) and small third-sector organisations, albeit with a huge footprint, is massive!

I have always been of the mind-set that looks for solutions rather than barriers, so freeing myself from corporate thinking would give me my mojo back, turning some of those negative ideas into positive ones.

One comment that crossed my path on several occasions was that programmes don't need to 'sound professional' and that, to save money, we should explore the option of engaging a 'keen amateur' rather than a 'professional'.

I believe that a programme expertly produced, taking in all considerations of audience, language, content and structure, has greater authenticity than a thrown-together potpourri of poorly conducted, technically inferior interviews.

I would say that, but it's my background, and I hope always will be. I can't un-learn it!

I told those IASP delegates in 2012 that 'there is no point in broadcasting if no one is listening', so there are some things we really need to understand about audiences.

Figure 2. Paul in action recording for the BPS at 50 editions

**So, who is *Airing Pain's* target audience?**

It's every member of the so-called 'Pain Community' – people with pain, their family, supporters and carers, including the healthcare professionals who help manage our pain.

So, to state the obvious, with no audience there's no point in going on.

And the audience is a fickle breed. If they don't like, understand or are just bored with you, they can, and do, get rid of you with the flick of a switch or the click of the mouse.

So, as a programme maker, it is my job to make sure they stay with me right to the end of the programme; they must not be given an excuse to turn elsewhere.

That's as true in 2024 as it was in 2012. But there is a caveat and a dilemma:

Caveat: Even though each edition will have information on self-management techniques and general advice common to all persistent pain conditions, a programme focussing on one condition, let's say endometriosis, will not necessarily attract the attention of someone with another condition, say arthritis.

Dilemma: Pain Concern relies on outside funding from predominantly charitable trusts for each edition of *Airing Pain*. Prospective funders will need to know the obvious statistics – how many downloads, how many people it will help, impact and so on.

Personally, I get more satisfaction from just one person saying how helpful the programme is, than more people listening with only a vague, passing interest. So, download statistics need to be taken with caution, and an 'appreciation index' would be much more valuable.

My aim is to try and move everyone within the pain community, including healthcare professionals, closer to each other. I'm a firm believer that our programmes should not exclude segments of the pain community, or indeed anyone outside it.

There is no point in making the most informative radio programme in the world if everyone has switched off after hearing Professor So-and-so droning on interminably about his latest research in a language that no one outside his lab can understand. I want my listener to feel part of the programme, not an outsider.

Airing Pain: bringing together the pain community

As a patient myself, I ask those questions that I have always wanted to ask but been too timid to do so. I'm not afraid of using humour or indeed of showing my considerable level of ignorance; and I show empathy.

Do I have advice for potential interviewees?

Enthusiasm is priceless; don't regurgitate facts and figures as if from an academic paper; don't patronise; think conversation, not lecture and listen to yourself as if through the ears of the listener and patient.

So, Professor So-and-so does not need to patronise or dumb down to speak to the person in the street. And that person in the street should be able to say, 'I don't know what on earth you're talking about, it's all gobbledegook; speak in language that I can understand'. My job is to help you do that in as friendly and natural a way as possible!

To date, I've made 144 editions of *Airing Pain* that is over 72 hours of listening!

In June 2024, I'll have attended 12 BPS ASMs to record interviews – I prefer to call them conversations! – and we are incredibly grateful to the BPS for their support in giving us the facilities to make *Airing Pain* work.

One of many highlights was celebrating the 50th anniversary of the British Pain Society back in 2017. You can hear it here: <https://painconcern.org.uk/airing-pain-programme-96-british-pain-society-50/>

Of the many people I've interviewed who live with chronic pain, there's been a strong undercurrent of desperation and anger at feeling excluded from the pain community. We've

heard the honest, open views, the frustration, desperation even, of people who should have been able to have a meaningful conversation with their health professional but have yet to achieve it!

One person was desperate to share their experience with our listeners: 'The first doctor you get, he can either make you or break you. . . he didn't see me as a person, he saw me as a brain'.

Back in 2010, I was daunted by the enormity of the task of making the *Airing Pain* project a success. What drove me and continues to drive me is that I've learnt more about my own condition, fibromyalgia, and how to manage it through Pain Concern's resources, of which I'm now a proud contributor, than I did in the previous 25 years. I want to share this knowledge with others going through their own pain journey.

What frustrated me in 2012, and still does, is that all the information on supported self-management and how to live well with persistent pain is available and accessible, but people are still not guided to it.

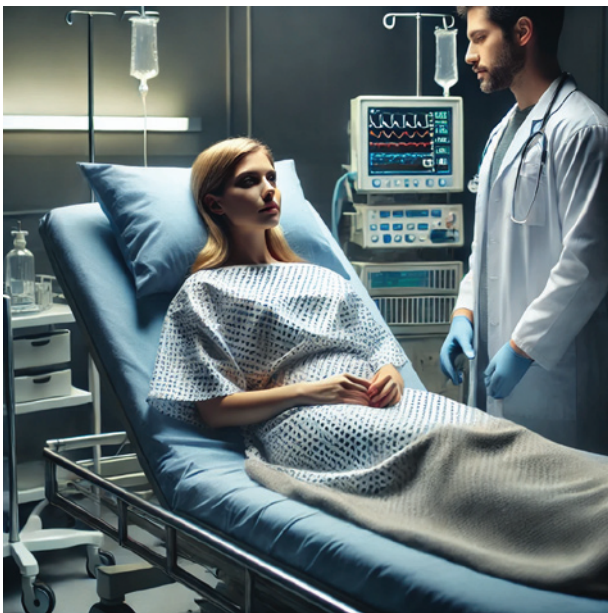
Bridging the gap between professional and public education really is a challenge, but Pain Concern through *Airing Pain* is showing that we can work together.

To me, it shows that what we have achieved on *Airing Pain* is a huge step forward in embracing all members of this, our Pain Community.

This article has previously been published in Pain Matters a Pain Concern publication and is reprinted here with permission.

Could clinical hypnosis be first-line treatment for pain?

Dr Maureen Tilford *Secretary, Philosophy and Ethics Special Interest Group, British Pain Society; Council Member, Hypnosis and Psychosomatic Medicine Section, Royal Society of Medicine; Trustee, British Society for Clinical and Academic Hypnosis*



Let's say you are a clinician working in a pain clinic and a drug rep offers you a new drug that has no harmful side effects, works as well as – if not better than – many of the drugs you already prescribe and has a number of benefits other than just pain relief . . . might you be tempted to give it a try?

Welcome to clinical hypnosis!

It has been a surprisingly neglected intervention despite a huge research base. For a variety of reasons, including its image as entertainment and various incorrect myths, some clinicians avoid looking any closer. Consequently, they stick to the traditional approach largely based on drugs and cognitive behavioural therapy (CBT), and so on.

Of course, hypnosis has been used for many years for a variety of applications such as painful procedures in children, palliative care, childbirth, as well as managing anxiety and depression and pain. Just enabling the person to completely relax is a first step in so many scenarios such as going into a magnetic resonance

imaging (MRI) scanner or facing a serious operation. Also, teaching the person self-hypnosis gives them a sense of agency and control in what may be a threatening situation.

However, I see signs that things may eventually be changing in the medical world. Increasing numbers of dentists, doctors, nurses and psychologists are seeking training and find the techniques simple, quick to learn and easy to administer. They sometimes express surprise that they had not come across clinical hypnosis earlier in their training.

Those of us who have used clinical hypnosis for many years are keen to spread the word, both to our colleagues and to the wider community about its benefits. Of course, as with all treatments, it is not a panacea but a tool that should be available to our patients and, in my experience, an extremely useful tool.

Dr Mark Jensen, University of Washington, author, researcher and former President of the International Society of Hypnosis suggests hypnosis could soon be first-line treatment for chronic pain. Perhaps the world is about to change.

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Further reading

Hypnosis for Chronic Pain Management: Therapist Guide by Dr Mark Jensen
Clinical Hypnosis for Pain Control by Dr David Patterson

Further training

At www.bscah.co.uk there is information about training for health care professionals.

Practical clinical hypnosis for pain session at the ASM



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Maureen Tilford

This year's ASM was extremely well attended and our small team of enthusiasts on behalf of the Philosophy and Ethics Special Interest Group presented a parallel session entitled 'Practical Clinical Hypnosis for Pain'.

Clearly this subject is of increasing interest within the field of pain: the room was full, over 60 people came to our session. We are all aware that drugs have an increasingly limited value in persistent pain and clinicians are searching for other ways to help their patients.

Our chair was Dr Maureen Tilford, former GP. She is the secretary of the Philosophy and Ethics Special Interest Group of the British Pain Society, trustee of the British Society of Clinical and Academic Hypnosis (BSCAH)* and a council member of the Hypnosis and Psychosomatic Medicine Section of the RSM. She used hypnosis extensively for anxiety and for pain in her practice.

Our speakers were Dr Sarah Partridge, Consultant Oncologist at Imperial College, president of the Hypnosis and Psychosomatic Medicine Section of the RSM and founder of Tranceform-Medical.com** . In her talk, 'Clinical Hypnosis in Oncology', Sarah explained how she uses hypnosis to help her head and neck cancer patients deal with pain and other issues such as claustrophobia. This can be a barrier to radiotherapy planning when using a thermoplastic mask or 'shell' which is made to immobilise the face and head to ensure accurate delivery of radiotherapy. Over 80% of patients respond to individualised hypnosis in merely one session, saving time and resources within her department. She pointed out that hypnosis is a much underused resource due to the paucity of education about the substantial evidence demonstrating its efficacy, including randomised control trials and meta-analyses. Sarah encourages her patients to learn self-hypnosis via the hypnosis audio files she produced, accessible on www.Tranceform-Medical.com, so they are empowered to manage their symptoms through treatment, as well as learning a versatile life skill that also delivers durable emotional and immunologic benefits long after treatment is completed.

Our second speaker was Dr Caron Moores who is a consultant paediatric anaesthetist at Alder Hey Hospital in Liverpool and has experience in managing pain in children. Caron's talk was entitled 'Hypnosis for Pain Management in Children'. She explained how easy it is to engage with children using her hypnosis skills in an informal way and to use the child's imagination to reduce fear and pain. She mentioned the 'Magic Glove technique' where the clinician can quickly enable the child to numb the hand and arm, so making blood taking and cannula insertion much easier. In adults, in an interesting study monitoring depth of anaesthesia, hypnosis generated the same EEG changes as propofol/fentanyl anaesthesia! Also, when patients experience acute pain, drug-induced pain relief and hypnosis produce the same changes on the EEG.

Our third speaker was Dr Amelia van Manen, medical anthropologist and an anaesthetic registrar at Oxford University Hospitals. She is a council member of the Hypnosis and Psychosomatic Section of the RSM and accredited member of British Society of Clinical and Academic Hypnosis. Her talk, 'Clinical Hypnosis and Therapeutic Language' covered how to use simple, effective hypnotic communication in clinical practice. She looked at the benefits of positive suggestion and risks of negative suggestion. She pointed out that studies show that if the patient is warned that the procedure is going to be painful, they will experience more pain. Also, therapeutic suggestions during general anaesthetic can significantly reduce post-operative morphine use. People on ventilators can also benefit from positive suggestions to reduce the incidence of psychoses. The Royal College of Anaesthetists recognises the value of using suggestion to prepare people for operations and has a range of audio files available on their website. Many anaesthetists are now training in hypnosis.

So during the session we explained that clinical hypnosis presents an easy-to-deliver intervention, simply using language. For health professionals it is extremely easy to learn and only takes a few days of training with BSCAH to become able to use the skills straight away.

Practical clinical hypnosis for pain session at the ASM

In summary

Clinical hypnosis is helpful in the management of acute, procedural and chronic pain.

There is good theoretical and research evidence to support its use.

The use of language is key in all clinical interactions.

Don't say 'Sharp scratch' and definitely don't say 'This is going to hurt!'

Online Training courses for health professionals are available from British Society of Clinical and Academic Hypnosis

*www.bscah.co.uk

Online free hypnosis audio files and other resources for patients and professionals

**www.tranceform-medical.com

Recommended reading:

Patient Sedation Without Medication by Elvira Lang

Hypnosis for Chronic Pain Management: Therapist Guide (Treatments That Work) by Mark Jensen

Author's note

Held on 5 June 2024 at British Pain Society Annual Scientific Meeting, Nottingham 2004

Hosted by the Philosophy and Ethics Special Interest Group of the BPS

Outcomes and benefits of supported self-management for those living with chronic pain and the added value learning experience within multi-disciplinary working for students

Sonia Cottom *Professor, Director, Pain Association Scotland*

Philip Sizer *Lead Trainer, Pain Association Scotland*



Introduction

This article explores the benefits of a self-management intervention for those living with chronic pain in the community of Bradford. This project, in collaboration with Bradford University, pioneered a new approach in the self-management of chronic pain, providing a community-based group within a university environment. As far as we are aware, this is a world first.

Pain Association Scotland is a national charity and delivers professionally led supported self-management education and training providing key coping strategies and helping people explore new ways forward leading to an improved quality of life. These groups have enabled chronic pain sufferers to make changes to their everyday lives in a positive and practical way, resulting in improved levels of coping and well-being:

Pain is not just pain. It is a complex experience that affects people and not just bits of bodies. Anything that affects you affects pain and anything that affects pain affects you.

Whatever pain is or isn't, it is the experience of living with it that counts. Anything we can do to improve life will improve pain in one way or another.¹

The project had the following aims:

- To help people in the community (including university staff) with chronic pain and long-term conditions including long covid, by providing professionally led, supported self-management sessions.
- To provide students with a practical experience of therapeutic group work combined with a reflective seminar. This was a theory into practice experience and as way of giving students a vocationally relevant qualification.
- To provide a practical person-centred bio-psycho-social approach that was of interest to all disciplines.

Methodology

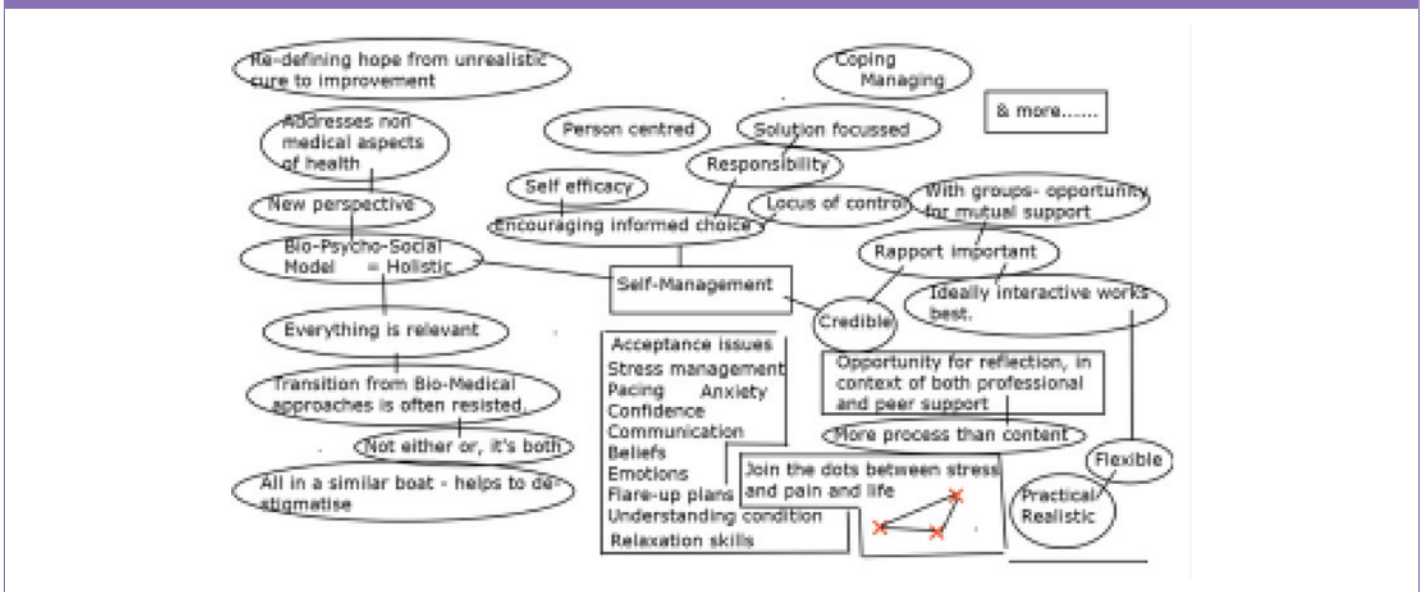
The project consisted of a two-hour professionally led group session which would be observed by students. The group sessions examined classic self-management topics, including understanding pain, stress, anxiety, emotions, pacing, acceptance, flare up, confidence, problem solving, changing habits and communication. These were delivered in a lively interactive co-creative way.

Following the group session, a seminar was given to students who had observed the group session. Topics and themes were discussed, and links were made to their studies. Both undergraduate and post graduate students attended.

Figure 1. What helps pain.



Figure 2. Self-management is.



Experience

Initially, there was considerable interest from both psychology and physiotherapy, but ultimately funding meant that the

project was purely for psychology students. A cohesive group formed quickly with new people coming every month. Members came from both the community and the University and were

Outcomes and benefits of supported self-management for those living with chronic pain and the added value learning experience within multi-disciplinary working for students

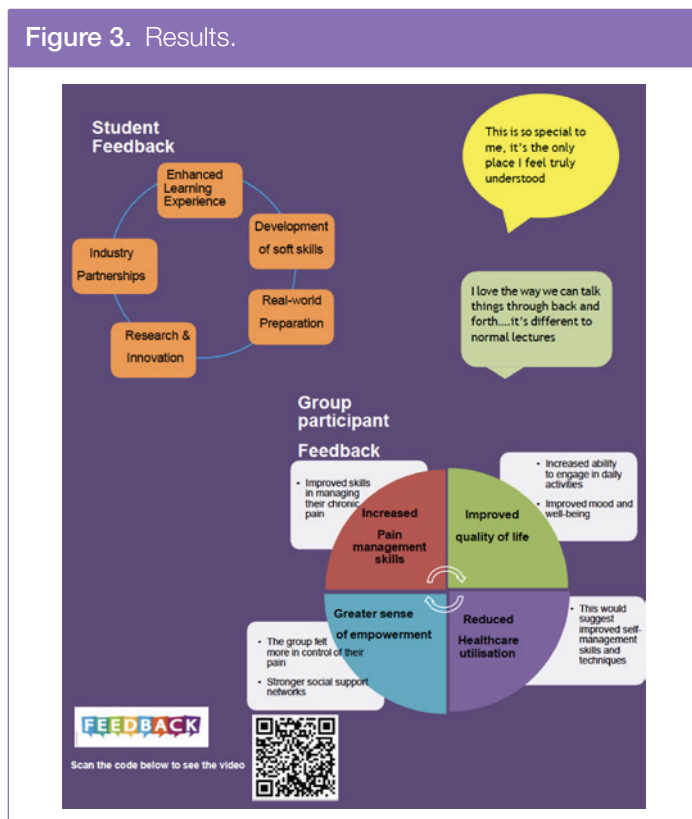
representative of the diverse ethnicity of the Bradford area. Attempts were made to link to existing National Health Service (NHS) and local community services. In the early stages, it became very clear that was better to have students take part in sessions rather than passively observe. This was a welcome development, and the group members were supportive of the students and pleased that they were interested.

The group quickly became self-supporting and engaged with the topics with enthusiasm. And good therapeutic relationship quickly developed between the group and the person leading it. Rather than rigidly follow a set topic, the group preferred to work flexibly and look at whatever came up, this kept everyone interested and sessions relevant to individual needs at the time.

It meant that several topics were often merged into each other and covered in ways that were relevant to peoples' issues at the time. Students attended in different ways. Some came for the 3 × 2-hour sessions required for their certification, whereas some others, especially MSc students, were especially interested and attended most sessions.

Results

Figure 3. Results.



Conclusion

The project was successful in delivering a community group allied to a powerful student experience.

Members from the community gained support and improved their health and well-being and benefitted from being able to highlight to future healthcare professionals the issues chronic pain patients live with on a daily basis.

Students gained valuable practice insights and understanding and were able to experience real-life scenarios. In addition to this, they were able to learn the practical elements of the theory.

The university benefitted by giving back to the community as well as providing students with the extra-curricular practical based learning and development.

In summary

The participants were able to manage their pain better.

There were better approaches and strategies to handling pain.

There was a sense of belonging in the group.

Reference

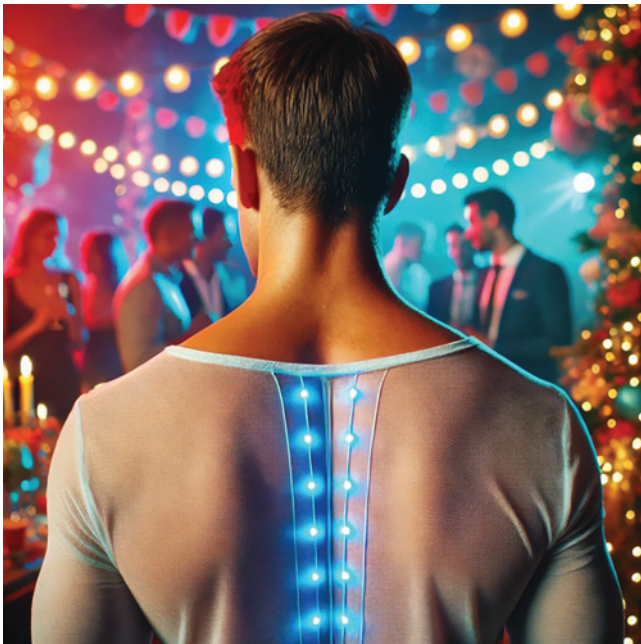
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This project was a collaboration between Pain Association Scotland and the University of Bradford.



David's story: the role of spinal cord stimulation

David Heap



On a Tuesday in June 2013, I was carrying a recycling box around the front of my car, and I twisted it around to get through the gap between the vehicle and the garage. This caused pain in my lower spine and down my right leg.

I had a very brief period of sciatica in about 1990, which was relieved by adjusting the seat in my new car.

The next day, the pain got much worse. I saw a general practitioner (GP) and was given analgesia. By the Friday of the same week, I had a loss of feeling in part of my right leg and had weakness in the same leg. I went to King's College Hospital Emergency Department on Saturday, as I was losing feeling and was experiencing a weakness in my right leg. The 4-hour wait was so excruciating and uncomfortable. I had lost half the feeling in my right foot.

The pain was a burning, tingling, shooting pain, which was like nothing I had ever experienced before. There was pain on the elevation of a straight right leg. I was diagnosed with

sciatica. The use of tramadol, non-steroidal medication and co-codamol did help, but it still left me in pain. I was taking so much analgesia that I had a spreadsheet, as being legal counsel, I had just advocated at an inquest for a tramadol-related death. My life at this point was punctuated by the time between doses of analgesia. I then had two steroid injections into my spine at L5:S1, which made no difference. The second steroid injection made the pain worse. The pain at this time was horrendous, consisting of burning, tingling, jolting and complete limb pain all the time. Sitting eased the pain a bit, and sleeping helped a bit more.

I was then seen in the Neurosurgery Unit at King's on 17 September 2013, where a brief time later (27 September 2013) I was admitted for surgery, undergoing a hemilaminectomy and microdiscectomy. The surgery took over 4 hours due to the highly calcified nature of the disc, requiring two Neurosurgeons, one to hold the spinal cord and the other to chip out and remove the herniated disc slowly.

This did ease the pain by about 50%, but it left me with a weak right leg and a sensory deficiency in my right leg and foot. Strangely, I was informed that the sensory deficit was due to diabetes, which confuses me to this day as I still have an average Hb1Ac level and take no diabetes medication. At this point, nobody told me if the nerve injury would be permanent. I would only be told that by Professor King in 2015. I was then referred to a Pain Specialist, where I was put on Pregabalin at 150mg daily. I continued taking tramadol. Strangely, the pain slowly got worse after the surgery on 27 September 2013, even though for the rest of 2013, the pain levels were relatively low.

In 2014, we moved to Lancashire and lived in the Preston area. I sought further help from my GP as the pain was getting worse. It was the same type of pain, with only the intensity changing depending on the activity I was undertaking. Mowing the lawn was a labour of Hercules. Driving was proving more difficult. Standing for more than 5 minutes was torture. I suppose the one thing that gets to you in the end is the energy needed to cope with the pain, both mentally and physically. Standing for extended periods was very painful. After a few

minutes of standing, my entire right leg would burn. I had my drugs increased. I was now on 400mg tramadol a day and 600mg of pregabalin per day. I tried duloxetine but could not tolerate it. I was eventually put on Oramorph. At this time, I was commuting to Leeds via Skipton station. I could not stand without considerable pain if the train was full, so I would leave early to go to Leeds and return from Leeds on a train where I could guarantee a seat.

From 2014 to 2016, I saw a Pain Specialist via my GP and had three spinal injections during that time. I also saw Professor King, a neurosurgeon, in Manchester in 2015. He informed me that he could do nothing for me in terms of additional spinal surgery intervention. At last, he told me that my nerves were damaged and my pain was neuropathic. I started using a walking stick, as walking had become so painful. I had an occupational health review, which commented on a drag and weakness in my right leg and a genuine trip hazard. The pain was terrible. It dominated my life and that of my wife as well. It was burning, jabbing and 'electric shock' pain down the right leg and tingling.

In July 2016, I underwent a Nevro Senza (a spinal cord stimulation device SCS-Ed) device trial implant. It was excruciating having it inserted; not the actual insertion, but when the electrode touched the spinal cord I would convulse in an uncontrolled manner. When the device was switched on I could walk out of the hospital for the first time in months without a walking stick and with much-reduced pain levels. Before the trial, it was painful to sit on non-padded chairs, but I can now sit on the same. I could stand still for minutes at a time, whereas before, standing caused incredible pain in my right leg.

The need to have to return to the hospital and have the trial implant removed was horrible. I was giving up the best pain relief I had been given and put on a waiting list for the properly implanted device sometime in the future. I continued pregabalin, tramadol, co-codamol and Oramorph.

In October 2016, I was diagnosed with gynecomastia and had a testosterone level of almost zero. The opiates that I was taking for pain relief were poisoning my hypothalamus and pituitary. I then had to take testosterone gel, which helped to relieve the hormone issue. Still, years later, I did notice that I was also suffering from undiagnosed secondary polycythemia at that time. Due to the above problems, I felt so tired, but as stated, pain makes you so tired.

Surgery for the implant was carried out just before Christmas 2016. I woke up from surgery and still needed all my pain relief

drugs. I remember this as my drugs had not been written up on my patient records, and I needed permission to take the prescribed Oramorph, pregabalin and tramadol that I had brought into the hospital with me. Therefore, the night postimplantation was challenging, giving a pleasing contrast when the device was switched on the following morning. It was terrific when the Nevro rep switched on my device in the morning. I know that it is said that the device needs to build its effect over time. It was not the case with me. All the pains listed above diminished to such a level that I was able to walk without a stick and reduce the levels of all the drugs that I was on.

Since the implant date in December 2016, the SCS device has worked very well. In 2019, I needed to increase pain relief measures as the pain was again getting worse, undoubtedly due to further trauma in 2019 when I slipped down the stairs. I suspect that the increase in pain was not purely neuropathic but was due to fresh dorsal nerve compression on the right side. The pain in May 2022 was so bad that I had to use the Sunflower badge scheme and ask for help as a disabled person when flying to Naples for a holiday on the Sorrentine peninsula. The pain was then so bad that I had to stop, sit and rest several times for just a walk of about 200 yards. It is recorded on my GP record, and I said that if I could not get relief from the level of pain I was in, I would gladly accept death. I was working as a management consultant at the Countess of Chester. I had to commute from Doncaster to Chester, so I went up on Sunday and stayed in a hotel locally. Walking from the car to the bedroom upstairs was so painful that I was in tears when I arrived at the room.

You may ask, what effect did the SCS device have on my pain? Occasionally, I would switch the device off. I can state absolutely that the device was working exceptionally well, but the surgery undergone in December 2022 successfully managed the additional pain. I saw the pre-surgical MRI scans in June 2023, which clearly showed that the fall in 2019 had caused a mess with a disc. I now must be incredibly careful lifting or twisting.

As stated, it was in December 2022 that I had further surgery on my spine due to further nerve compression on the right side at around the L5:S1 level. During the time awaiting surgery in December 2022, the Nevro implant was vital in easing the pain. I put the relief from the device at about 65% of my total neuropathic pain level, with pregabalin, duloxetine and oxycodone covering another 25%. Never at any time did I get complete pain relief, but I was thrilled to have the pain levels much attenuated by the SCS device and the drugs. Since the 7 hours of revision spinal surgery in December 2022, I have been able to come off tramadol, probably

David's story: the role of spinal cord stimulation

because it was no longer effective. I then came off the duloxetine and then the oxycodone. My pregabalin level has dropped from 300 to 75 mg bd. The combination of the Nevro Senza and the pregabalin does a beautiful job of controlling my pain. I cannot explain the terrible pain levels from 2019 to 2022. I believe that the SCS device did an excellent job in helping to manage the neuropathic pain element of the pain I had. The increase in pain, I feel, is due to somatic pain from the injury sustained in 2019.

The one issue that I have, and why I still have a Sunflower badge, is that pain is a hidden disability. The more you cope, the less people believe you are in pain. I have no doubt that had I not undergone the pain relief process I would be in a deplorable state currently. I am so privileged to have an SCS

implant, and I recently met a fellow implantee in Sheffield. The only drawback I can see is the need for careful MRI scans, as currently I am awaiting an Anterior Cervical Discectomy and fusion. I must travel from Doncaster to Sheffield for all my MRI scans due to the caution that needs to be taken when I undergo an MRI scan.

At one point, I had one programme on my device set to a low-/high-frequency programme, but I found the paresthesia unpleasant, so I am much happier with the 10k frequency of the Nevro Senza device.

In summary, SCS is a lifesaver. I was unfortunate to have additional trauma in 2019 after the spinal surgery in 2013 and 2016.

Martin's story: the role of spinal cord stimulation

Martin Dingemans



My name is Martin Dingemans and I am a 52-year-old farmer.

I have had chronic back pain for 15 years, and this has got progressively worse over the last 5 years.

My lower back was damaged by a trial I entered on a course of radiation to treat cancer, which resulted in the degradation of five discs in the area of my back, and from the physical nature of my work which caused aggravation and gave rise to symptoms of chronic pain.

I experienced constant pain 24 hours a day and a large reduction in my range of movement. There were jobs I was no longer physically able to do and jobs that would take me twice as long to achieve. I was unable to find a comfortable position and only managed a maximum of 4 hours of broken sleep a night. I could not stand up for more than 10 minutes and found sitting or lying down uncomfortable. My family described me as moody, and I was unable to take part in family activities such as walking due to sciatic pain. I was constantly battling pain, which was exhausting, and used to get frustrated at not achieving the things that my job required. I would be in pain 24/7 and so would rather be in the same amount of pain doing a job on the farm as I would sitting in a

chair; at least I felt that I had achieved something. I would have back spasms that would take me off my feet and suffered numerous tears to my hamstrings from them. This would give rise to urgency and incontinence, making it difficult to be in different environments. Being in constant pain is exhausting, especially if you cannot sleep and so contributing to a poor quality of life.

I had seen a range of medical professionals such as physiotherapists, strength and conditioning coaches, and acupuncturists; I purchased an inversion table and even enrolled in a 'yoga for lower backs course' to try and manage the pain. Collectively, these helped me identify exercises that would help pain spikes but meant that I would spend at least 2 hours every day either upside down and/or lying on the floor exercising/stretching. This proved challenging when in the middle of a ploughed field in a tractor! I had seen three surgeons and was finally directed to a pain specialist because they were all unable to offer a surgical solution to my problem. I then had five sets of diagnostic nerve blocks which were unable to identify the branch of nerves that could be disabled to help manage the pain. I had tried numerous prescribed drugs to help with neuropathic pain, but none of these were successful, or did not agree with me, or fit into operating heavy machinery on the farm.

I finally qualified for an SCS and started on the pathway to having it fitted. Various workshops and interviews to make sure you are a suitable candidate were attended and I had my surgery in June 2022.

Recovery from the operation was swift, and the 6 weeks post-surgery passed a lot quicker than I was prepared for as I am naturally a very busy person who is not known to be able to delegate!

The results of the SCS have been life changing to me. I didn't realise the amount of pain and the overall effect it was having on my life until I started my new journey out of pain. The pain no longer controls me and I now have the confidence of ranges

Martin's story: the role of spinal cord stimulation

of movement that would have brought me to tears before. I still struggle with my sleep but this is something that will improve over time. I can now walk longer distances and have more energy as I am not being drained by fighting high levels of chronic pain.

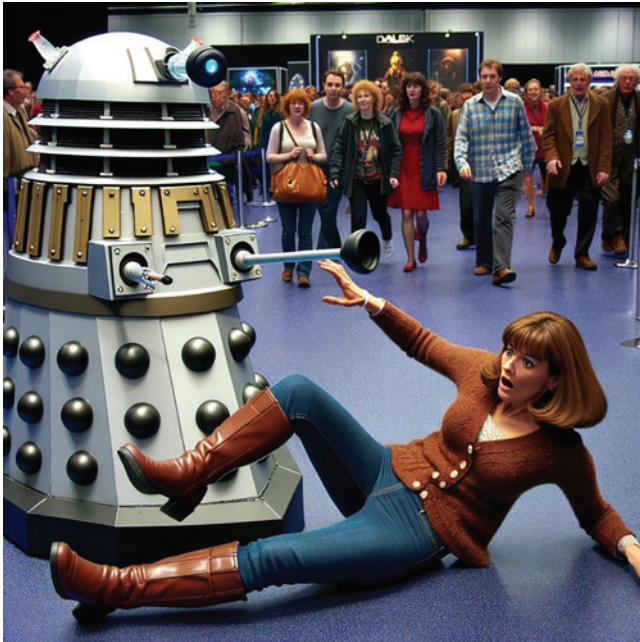
I am not completely pain free, but I knew it was not going to be a cure for my lower back pain and I know that my back is still mechanically restricted. To put some scores on the improvements, my overall background (constant) pain has reduced by 60%, my sciatic pain has gone totally, and my quality of life has improved by 80%.

I am still taking pain medication but the periods when the painkillers wear off are a lot shallower and my pain control is now more constant. We are working to reduce the painkillers with a view to not needing them in the future.

I was realistic about the level of pain reduction the SCS could offer me and I am now only 7 months post op, but the improvements I have seen are simply life changing to me. I am a stubborn individual and would always hate to be defeated by my back in not achieving a task on the farm. Now I tackle jobs and life with new confidence, knowing I am safe to do so without suffering the consequences.

Tales from general practice: Deirdre and the Dalek

Dr Steve Johnson



You know, sometimes I think Walter Mitty was onto something. Medicine is full of absurdities, and the only way to cope at times is to escape into a reverie.

You couldn't tell Deirdre anything she didn't already know. She had been my patient for 15 years or more. Now in her early 60s, she was a small, roundish lady who dressed in flowing black lacy skirts and tops. She would flounce into my consulting room like the hammiest of ham actors entering a stage. She didn't ask questions so much as make pronouncements. Also, she never let an opportunity pass to remind me that she had once nearly qualified as a nurse and that she was a renowned medium in her Spiritualist faith. As a result, she considered herself an expert on all things medical and all things pertaining to the wandering spirits of the dead. Her exaggerated movements seemed to be at odds with her stated ongoing complaint of terrible back pain. When she first registered with me, switching from another local surgery, she told me the back pain was so bad that she needed a hefty dose of morphine each night before

bed, along with an equally hefty dose of sleeping pills. Her previous general practitioner (GP) had prescribed these items reluctantly, nitpicking over the quantities she got through, and she was fed up with constantly having to explain why she was ordering her monthly prescriptions early. So she had switched to our surgery, confident that we would be more understanding. The thing was, she explained to me, she was in great demand as a medium, constantly being invited to appear at conferences and meetings around the country and internationally. Her globetrotting lifestyle meant that she was frequently crossing time zones and sleeping in different hotel beds of varying comfort. No wonder she struggled to get a restful and reasonably comfortable night's sleep.

While she was droning on my mind wandered and I imagined what life as a famous medium must be like? Did she have to sign autographs and pose for selfies? Did she do guest appearances on *Celebrity Seance*? . . .

One day Deirdre limped in on a pair of crutches. Her husband opened the door for her and was then irritably waved away when he tried to enter the room with her.

Deirdre checked that the door was closed. 'You will no doubt find this very amusing', she said primly, her lips tightly pursed. 'I was assaulted by a Dalek'. She peeled back the folds of her dress to reveal the cast covering her lower leg and watched intently for my reaction. When I failed to suppress the faintest glimmer of a smile she jumped in. 'There! I knew it. No-one has taken this seriously. My husband, the casualty staff at the hospital, and now you'.

Deirdre huffily refused to supply any details about how the injury came about. She stood over me and insisted I detail and record the extent of her injuries and then write to her solicitor so that she could pursue a claim for damages against the Dalek operator. She had been forced to cancel a big event in the United States, and the resultant 'lost opportunities' were the nub of her grievance. Once or twice over the next few days I started to compose the report for her solicitor, but after the first few lines, I was overtaken by a profound weariness and

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couldn't think what to say next. So I shelved it, awaiting inspiration.

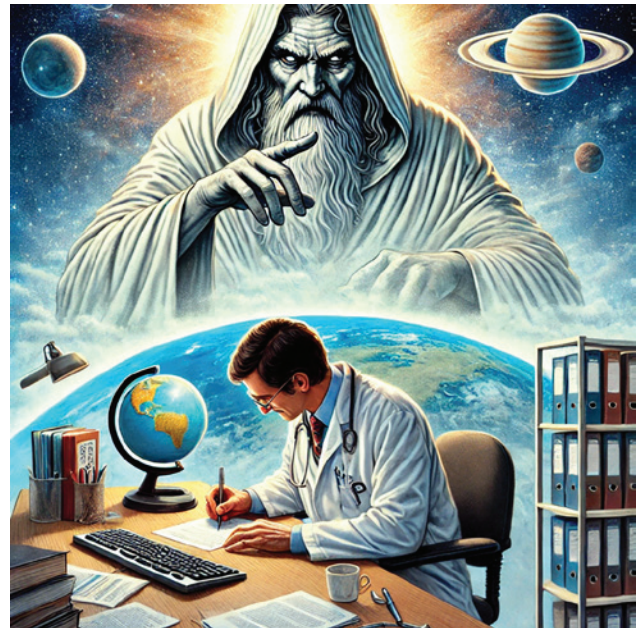
I happened to see her husband a week later for a diabetes check-up, and he cheerfully provided me the details of the Dalek accident. Deirdre had been invited to be a medium at a 'charity event' in a large conference centre. There was a full-sized battery-powered Dalek moving about the hall, threatening to exterminate the attendees unless they threw a few coins into a small basket slung under his cannon. Small children were shrieking in mock fright and running away when the Dalek approached. The Dalek cornered a young girl and then realised his turning circle was not sufficiently good to turn around. After a few attempts the top of the Dalek flipped open and a man's head appeared and looked about for help. 'There's no bloody reverse on this thing. Could someone just give me a push?' Two bystanders cheerfully helped. Unfortunately, they backed the Dalek into Deirdre, who was deep in conversation with a potential client, knocking her off balance and spilling her drink. The Dalek operator was full of apology and offered to get her another drink.

Her husband paused, rooted around in his jacket pocket and produced a scrap of paper. 'Now, about my prescription, Doctor . . .'

'Hang on'. I said. 'Why the cast and crutches . . . and legal proceedings?'

'The next morning her ankle was really stiff and painful so I took her to A&E. She wouldn't let me in to the cubicle so I don't know what was said exactly, but she was with the doctor a long time . . . there were raised voices and the doctor looked pretty cheesed off when he came out the cubicle. Deirdre came home with the cast and crutches. She said she had been told her tendons were badly bruised'.

Later, composing myself once more to write the report, Walter Mitty came to my rescue. I imagined penning the



following report on the basis that a direct approach to the Dalek operator's employer might be the best way forward.

*Dear Davros, creator and supreme leader of the Daleks,
I am writing to you asking that, in the interests of expediency, you be merciful to your new enemy, Deirdre. She is not aware of the awesome destructive power of your wrath. She injured her ankle after a technical hitch with one of your Dalek crew. She seeks a few earth pounds in compensation – a mere trifle for your vast wealth. Far better to pay than have the immensely inconvenient bother of a UK court appearance . . . there are bound to be stairs involved, for a start . . .*

*Your faithful servant
Dr Johnson (earthling GP)*

Of course, what I actually wrote for her solicitor was something far more boring and non-committal.

