Abstract Book

1st New Caledonia and Pacific Pain Forum

22th April 2022 — SPC Anse Vata

DOULEUR NC
ASSOCIATION DES PROFESSIONNELS DE SANTÉ

Pacific Community
Communauté du Pacifique

Message from the President

Since the DOULEUR NC Association's creation in 2014, its aims have been to ensure better attention is paid to pain during health care in New Caledonia and to hold evening events on medical topics. This year, for the first time, we are holding a meeting on the theme of pain, open to all health professionals.

The pandemic has caused us a considerable delay in care, which we need to catch up on during the current pause in the health crisis.

It is with great pleasure that the Organising and Scientific Committees have prepared this First New Caledonia and Pacific Pain Forum. We will be hosted in this magnificent venue at the SPC in this mythic part of Noumea: Anse Vata.

To open the forum, we will focus on the how pain and suffering are perceived in the Kanak world with Mr. Wapone Cawidrone and Ms. A-tena Pidjo.

For this first forum, Prof. Eric Viel, an anaesthesiologist and pain specialist at the Nimes University Hospital, will be our guest of honour and will shed some light on the topic of persistent post-surgical pain. He will also talk about topical medications, which are a subject of current interest for localised neuropathic pain.

We will also have with us Dr Dexter via a live broadcast from Sydney as well as Dr Bruno Leroy who has come from Liege to show us an original approach to educational therapy for chronic lower back pain with his associate, the cartoonist Pierre Kroll, who is very well-known in Belgium.

Finally, our New Caledonian colleagues will provide us with overviews on various aspects of pain and how they are managed.

The speeches will be broadcast live throughout the Pacific Community network with interpretation for English-speaking listeners.

Bonne conférence à tous.

Dr Luc Brun

DOULEUR NC
ASSOCIATION DES PROFESSIONNELS DE SANTÉ

Organising Committee

Dr Luc Brun
Dr Thierry De Greslan
Mme Marie Claire Kabar
Mme Anne Le Du
Mr Michel Bœuf
Mme Stéphanie Roujas
Mme Claire Line Biavat
Mme Karine Lantéri
Mme Isabelle Dumont

Scientific Committee

Dr Luc Brun
Dr Thierry De Greslan
Dr Gael Guyon
Dr Jean Luc Isambert
Dr Gian Maria Drovetti
Dr Lorenço Xavier
Dr Frederic Rigault
Mme Maelle Deniaud

Forum Programme

Plenary sessions: Jacques Iékawé Conference Room	Short papers: Library Room
7.45 - 8.00 am | Welcome	
8.00 - 8.15 am | Opening Adress (Dr Thierry De Greslan)	
8.15 - 09.00 am | "Kuni": Pain tolerance in Kanak and Pacific Island cultural representations and in the clinical approach (Wapone Cawidrone, instructor in Kanak languages and culture; Caroline Graille, PhD in social and cultural anthropology)	
9.00 - 9.45 am | Pain in cancerology and palliative care (Dr Gianmaria Drovetti, oncologist, Kuindo Magnin Clinic; Dr Angélique Ayon, soins palliatifs, CHT)	**9.00 - 9.45 am | Topical treatment: a revolution in the treatment of peripheral neuropathic pain (Capsaicin, botulinum toxin, etc.) – new recommendations** (Professor Eric Viel, CHU Nîmes, France)

9.45 - 10.15 a.m (30 min) Break and visit to displays

10.15 - 11.00 am | Chronic post-operative pain: epidemiology, mechanisms and contributory factors, medical/economic consequences (Professor Eric Viel, CHU Nîmes, France)	**10.15 - 10.45 am | Treatment of lower back pain: the point of view of the rehabilitator and the rheumatologist** (Dr Jean-Luc Isambert, Physical Medicine and Rehabilitation, CSSR ; Dr Bénédicte Champs, rheumatologist, Nouméa)
	10.45 - 11.30 am | Acute medical and post-operative pain in children (Dr Gael Guyon, pediatrician, CHT)
11.15-12.00 pm | Presentation of the SFETD 2021 white paper: La douleur post-chirurgicale et sa chronicisation (Professor Eric Viel, CHU Nîmes, France)	**11.30 - 12.00 pm | Psychology of pain** (Maelle Deniaud)

12.00 pm - 1.30 pm : Lunch on the deck (e-ticket registration required)

Plenary sessions: Jacques Iékawé Conference Room	Workshops: Library Room
1.30 - 2.15 pm (45 min) | How neurosurgeons can ease chronic pain (Dr Mark Dexter, neurosurgeon, Sydney, Australia)	**1.30 -2.15 pm** 1 - MEOPA (Dr Oliver Kesteman, CHN; Ms Myriam Balme, GAZPAC) 2 - TENS (Mme Laurence Gracia, Mme Sandra Monnier, CHT) 3 - Music therapy, virtual reality helmets, acupressure mats (Ms Maelle Deniaud, CHT ; Ms Béatrix Boutin, Ms Suti Sudjasmin, CHS ; Mr Stéphane Guétin, Music-Care, Paris)
2.15 - 3.00 pm (45 min) | No worries: I can handle headaches (Dr Anae Monta, neurologist, Noumea)	**2.30 - 3.15 pm** 4 - Ostéopathy (Mr Michel Bœuf, Nouméa) 5 - Hypnosis (Dr Jessyca Samin, anesthesiologist, CHT ; Mme Claire-Line Biavat, Nouméa) 6 - Anti-inflammatory diet (Ms Alexandra Souprayen, Noumea)

3.00 - 3.30 : Break and visit to displays

3.30 - 4.15 pm (45 min) | Pain and sleep: sleep difficulties (Dr Thierry De Greslan, neurologist, CHT)	**3.30 - 4.15 pm** 7 - Acupuncture (Dr Drovetti Gian Maria) 8 - Pilates (Ms Aissatou Badji) 9 - Treating chronic lower back pain: via the back or the mind Benefit of cartoons (Dr Bruno Leroy and Pierre Kroll CHR La citadelle Liège, France)

4.30 - 5 pm: Visit to displays, tombola prize draw and prize-giving

5 - 6 pm: Closing coktail with music by the Quatuor à Cordes

6.00 - 7.00 pm | Public lecture

In the beginning was the music: intersecting perspectives across cultures, sound universes and health care (Stephane Guétin, Music Cara HDR in linguistics; Ms Stephanie Geneix Rabault, MCF)

7.00 pm: End of the Forum

DOULEUR NC

ASSOCIATION DE PROFESSIONNELS DE LA SANTÉ

Plenary sessions

Jacques Iékawé Conference Room

'*Kuni*': resistance to pain in Kanak and Pacific Island cultural representations and in the clinical approach

Authors

Wapone Cawidrone, Kanak culture and language instructor

Caroline Graille, PhD in social and cultural anthropology

Abstract

"What have you eaten? What did you say? What have you done?"

It is generally acknowledged, in the Kanak world, that illness never arrives by chance and that a form of social imbalance, whether visible or invisible, is necessarily the cause of sickness, especially if it becomes persistent and shows symptoms of aggravation or intensification. The accompanying pain then takes on a symbolic dimension which, although crucial for the patient and for everything connected with Melanesian traditional therapeutics, generally escapes clinical examination and the biomedical diagnosis done by the doctor.

This "two-voice" communication dynamic draws firstly on the mythical history of the *Maître de Koné* (Master of Koné): this is one of the most ancient oral legends on the Lizard, a primordial totem animal in the Kanak world, recorded in Houaïlou by Pastor Maurice Leenhardt (and published in 1932 in *Documents Néo-Calédoniens*). The physical and psychological pain engendered by the lizard's stunning attack is a way of metaphorically describing suffering and the acceptance thereof, but also the resilience of the sick person and the successive modes of remediation that are brought forward in order to offset and then fight the cause of the illness.

Digression in some vernacular Kanak languages (there are about 30 of these) also then makes it possible to show the representation and expression mechanisms for pain, especially depending on the external or internal parts of the body concerned, and their analogy with the plant world (bark, trunk, sap, etc.), but also the sacred as well as the warrior dimensions which may come with the traditional therapeutic arsenal: clairvoyant, diviner, healer, pharmacopoeia, magic basket, *jinu* (the power of the ancestors), etc., forming a range of traditional resources and skills that make it possible to detect the origin of the disease, counter its effects and relieve its symptoms.

Finally, the notion of "medical pluralism" reflects the healthcare experience of a majority of Kanak and New Caledonian patients, who generally reconcile the successive or simultaneous use of traditional medicine and biomedicine: it then becomes appropriate to examine the expectations of these same patients as regards "white man's medicine" in terms of specific treatments for pain, according to scales of tolerance and interpretation which need to be looked at objectively and reassessed with regards to the country's specific cultural context.

Pain in oncology

Author

Dr. Gianmaria Drovetti

Abstract

Pain is a complex, multifactorial concept, particularly in oncology. It is first a question of the patient's experience of it, but also involves how the "health professional" perceives it. The anthropological, historical and psychological representation of pain may be considered next. Pain may also be approached in terms of its scientific aspect, particularly since the development of the neurosciences. Last, the epistemological concept and the concept of cognitive and moral philosophy cannot be dismissed.

"You cannot insult a man more atrociously than by refusing to believe he is suffering." (Cesare Pavese, *This Business of Living*)

Pain in palliative care

Author

Dr. Angélique Ayon

Abstract

Palliative care involves treating patients with an incurable illness from the initial palliative phase to the terminal phase.

Intractable pain that cannot be addressed using standard treatments is one of the criteria for admission to the 10-bed palliative care unit at New Caledonia's Territorial Hospital Centre (CHT). Most often, patients are receiving advanced palliative or terminal care.

This pain is associated with cancer, as well as vascular pathologies such as artery disease.

Several techniques and alternatives are possible: nonpharmacological and pharmacological (specifically, perimedullary analgesia, including epidural, intrathecal and perineural).

In brief, the CHT anaesthetists approach this treatment in the unit as follows: The medical teams prepare a treatment plan which they present to and discuss with the patient and, possibly, the family. This kind of care typically concerns a group of approximately 10 patients between the ages of 18 and 99.

This technique must be subject to a protocol and triggered more quickly. It should involve the use of a technology that allows the patient to return home with greater security.

Chronic post-surgical pain: Epidemiology, public health consequences and medical-economic impact

Author
Prof. E. Viel, Centre for Pain Evaluation and Treatment of the Nîmes University Hospital and the Montpellier-Nîmes School of Medicine — eric.viel@chu-nimes.fr

Abstract

Chronic post-surgical pain (CPSP) is both a scourge that has long been misunderstood or underestimated and a significant public health problem. In addition to its impacts on patient health outcomes, quality of life and potential need for functional rehabilitation, it has significant medical-economic consequences. More than 300 million surgical procedures are performed annually throughout the world; approximately 10 million of those are in France.[1] Nearly 60% of those patients experience moderate to severe post-operative pain. The more intense the post-operative pain and the longer it lasts, the higher the incidence of persistent post-operative pain (defined as longer than three months). Based on the location and nature of the surgery, 10-56% of patients will develop chronic pain.[2-7] CPSP may occur after all kinds of surgeries and affects people of all ages. However, older patients represent a rapidly-growing segment of the population and the rate of surgery within that group rises every year. Thus, CPSP is of particular concern among older people because it has a significant impact on both somatic and cognitive recovery, quality of life and morbidity/mortality[8]: suffering, social isolation and increased consumption of treatment and medication. The latter can worsen the situation based on the significance and incidence of their adverse effects, including cognitive, digestive and urinary problems.

Incidence of CPSP, according to Glare et.al[(7)] (2019)

Nature of the procedure	Incidence of CPSP	Incidence of severe pain	*Number of procedures*
Limb amputation	30-85%	5-10%	-
Total knee replacement	13-44%	15%	723,086
Caesarean section	6-55%	5-10%	1,142,680
Cholecystectomy	3-50%	-	300,245
Craniotomy	0-65%	25%	-
Total hip replacement	27%	6%	487,625
Groin hernia repair	5-63%	2-4%	-
Laminectomy + spinal fusion	10-40%	4-6%	564,911
Mastectomy	11-57%	5-10%	-
Aorto-coronary bypass	30-50%	5-10%	160,240
Thoracotomy	5-65%	10%	-

Chronic post-surgical pain:Epidemiology, public health consequences and medical-economic impact

CPSP risk factors arise from the patient, whether the factors are genetic or epigenetic (pre-operative drug consumption, perioperative inflammatory state, preoperative pain, whether or not related to the disease leading to the surgery), or the surgical technique (surgical approach, coelioscopy or laparoscopy vs. open surgery, suture mode, etc.). Pharmacological factors may also promote CPSP, particularly preoperative morphine consumption or improperly extended postoperative morphine consumption; one promotes morphine sensitivity and the other, morphine hyperalgesia. Awareness of the scope of the CPSP phenomenon calls for a review of our practices, from the use of less invasive and damaging surgical approaches, the careful use of analgesic agents, and increased use of non-drug therapies, including restoring movement and psycho-social approaches.

Selected bibliographic references

Weiser TG, Haynes AB, Molina G Lipsitz SR, Esquivel MM, Uribe-Leitz T et al. Estimate of the global volume of surgery in 2012: an assessment supporting improved health outcomes. Lancet 2015; 385 (Suppl 2):S11

Kehlet H, Jensen TS, Woolf CJ. Persistent postsurgical pain: Risk factors and prevention. Lancet 2006; 367:1618–25

Wylde V, Hewlett S, Learmonth ID, Dieppe P. Persistent pain after joint replacement: prevalence, sensory qualities, and postoperative determinants. Pain 2011;15:566-72

Gilron I, Vandenkerkhof E, Katz J, Kehlet H, Carley M: Evaluating the association between acute and chronic pain after surgery: Impact of pain measurement methods. Clin J Pain 2017; 33:588–9

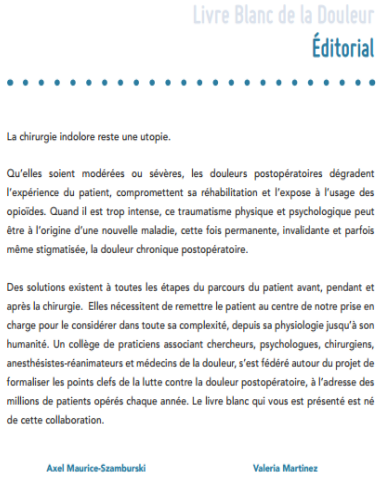
Schug SA, Bruce J. Risk stratification for the development of chronic postsurgical pain. Pain Reports 2017;2:e627

Glare P, Aubrey KR, Myles PS. Transition from acute to chronic pain after surgery. Lancet 2019;393: 1537-46

2021 White Paper of the French Society for the Study and Treatment of Pain (SFETD): When post-surgical pain becomes chronic

Author

Prof. E. Viel, Centre for Pain Evaluation and Treatment of the Nîmes University Hospital and the Montpellier-Nîmes School of Medicine eric.viel@chu-nimes.fr



The summary of this 216-page collaborative publication, coordinated by V. Martinez (for the SFETD) and A. Maurice-Szamburski (for the Pain Committee of the French Society of Anesthesia and Intensive Care (SFAR)), includes five sections:

Section 1: *The medical approach (three chapters): Chronic post-surgical pain (E. Viel); Pathophysiology of chronic postoperative pain: From the experimental to the clinical. C. Rivat & A. Tassou); Preventing chronic postoperative pain. (V. Martinez & F. Aubrun).*

Section 2: *The psychological approach (two chapters): The general psychological framework of chronic postoperative pain (S. Conradi & R. Minjard); Psychological risk factors associated with chronic postoperative pain and their treatment approach (A. Masselin-Dubois & S. Baudic).*

Section 3: *The surgical approach (two chapters): Preventing chronic postoperative pain in orthopedic surgery (L. El Sayed & A. Sautet); Preventing chronic postoperative pain in thoracic surgery (J. Assouad & H. Etienne).*

Section 4: *22 one-page fact sheets on key decision-making criteria and practices in responding to diverse situations of chronic post-surgical pain.*

Section 5: *this tool box includes 11 sheets with scales and questionnaires that can be used in specific situations.*

This publication will be available on the websites of both organizations.

How neurosurgeons can ease chronic pain

Author

Dr Mark Dexter, neurosurgeon, Westmead Private Hospital, Sydney, Australia

Abstract

Neurosurgeons can offer a variety of procedures to assist in the management of chronic pain. They also have a crucial role to play in the diagnosis and investigation of a variety of chronic pain syndromes. These roles are often of most benefit in the setting of a specialised multidisciplinary pain management team.

The neurosurgical procedures may include:

- Ablative Neurosurgical procedures (Peripheral, Spinal and Central)
- Neurolysis and Neurectomy in the Peripheral Nervous System
- Peripheral Nerve Stimulation
- Spinal Cord Stimulation
- Motor Cortex Stimulation
- Deep Brain Stimulation
- Microvascular Decompression
- Stereotactic Radiosurgery (Gamma knife)
- Intrathecal Drug Delivery

Trigeminal neuralgia is the most recognised and best studied of the facial neuralgias but it is by no means the only cause of facial pain. It is unique in that it is one of the relatively few forms of chronic neuropathic pain that is not only treatable but often curable. It will be used as an example of the ways in which neurosurgeons play a role in the diagnosis, investigation and management of chronic pain. As there are a variety of treatment options such as medical therapy, peripheral neurectomy, gasserian rhizolysis, microvascular decompression, stereotactic radiosurgery, motor cortex stimulation and deep brain stimulation, it is an interesting condition in which the spectrum of neurosurgical procedures that can be used in the management of chronic pain can be explored.

No worries: I can handle headaches

Author

Dr Anae Monta, neurologue, Nouméa

Abstract

1) Secondary Headaches

Unusual headaches / *de novo* (new) < 6 months / neurological signs – visual or general / post traumatic
Questioning: usual / unusual; sudden / gradual; long-standing / recent; paroxysmal / continuous; spasmodic / chronic; clinical examination; monitoring vital constants

1 Gradual-onset headaches: clinical – 'IH4' and meningeal syndrome:
cerebral thrombophlebitis, brain tumour, idiopathic 'IH', 'HSD', eclampsia, acute hydrocephaly, PRES, hypertensive encephalopathy, meningitis…

2 The slightly more sudden: pituitary necrosis, intracranial bleeding, stroke…
3 Thunderclap headaches: HSA -SVCR
4 Vascular dissections
5 Hypotension of the CSF and its complications (thrombophlebitis / SDH)
6 Intoxications (CO…)
7 Local causes: glaucoma / sinusitis / stomato / cervical …
8 Horton's Headaches

Etiological summary +++ EMERGENCY
Brain scan with INJECTION +/- ASD
+/- lumbar puncture
Blood test +/- Haemoculture -proteinuria -toxic…
Brain MRI

Focus on angiostrongylosis

2) Primary Headaches OSAS *well-known:*

15% Migraines: Diagnostic criteria, occasional form / chronic form, auras, when to take imagery
Treatments: one-off and long-term – Information on the well-known anti-CGRP ABs
Vascular risk and 'POP'

Tension headaches; Diagnostic criteria, When to take imagery, Treatments: one-off and long-term

Focus on: headaches due to abuse of medicines

Neuralgia:

Facial Neuralgia: Diagnostic criteria, Imagery, treatments
Neuralgia in the large occipital nerve (Arnold) Diagnostic criteria, Imagery and treatments

Trigemino-autonomic headaches

VFA: Diagnostic criteria, Imagery, one-off and long-term treatments, update on smoking
Hemicrania continua and paroxysmal hemicrania

Mixed neuralgia + activation Trigemino - autonomic: SUNCT and SUNA: introduction

3) Other entities: hypnic headaches; OSAS, AHT, on request …

4) Questions - answers

Pain and sleep: restless slumber

Author

Dr Thierry De Greslan, neurologue, CHT

Abstract

The connections between acute pain and sleep would seem obvious: how can someone sleep well when in pain and how can pain be tolerated when even sleep offers no relief. But what happens when the pain or insomnia become chronic? Many studies explore this dyad and the subject finally appears to be gaining some attention. Pain and sleep are a dreadful pair of lovers. They never leave the other's side, day or night, and their passionate relationship is fascinating. Our patients are locked into a particularly vicious cycle: The lack of sleep worsens the sensation of pain which, itself, intensifies their insomnia.

The perspectives that medicine offers – from epidemiology to anatomy, from neurophysiology to neuro-imaging, from clinical experience to treatment effects – help us to better understand this inseparable relationship. This presentation will focus on unlocking the secret of this tumultuous liaison by including another actor – memory. This new key may allow us to consider possible treatments, improving sleep and easing pain. Can we even achieve one without the other?

Short Papers

Library room

Topical treatments: a revolution in treating peripheral neuropathic pain with high-concentration capsaicin and botulinum toxin: new recommendations

Author

Prof. E. Viel, Centre for Pain Evaluation and Treatment of the Nîmes University Hospital and the Montpellier-Nîmes School of Medicine - eric.viel@chu-nimes.fr

Abstract

Peripheral neuropathic pain is encountered frequently and may be due to multiple aetiologies: scarring from surgery or trauma; chemotherapy (anti-cancer or anti-HIV drugs); metabolic or toxic (associated, respectively, with diabetes and alcohol; infection (post-herpetic); deficiencies; or genetic (various channelopathies or small-fibre neuropathies). The "typical" recommendations (French and European) primarily involve drugs administered systemically: anti-seizure drugs (gabapentinoids), tricyclic antidepressants, weak opioids and, ultimately, oxycodone. Topical medications appeared only belatedly and, for lack of sufficient evidence in the literature, were used only as a last resort in the event that the options listed above failed. After controlled studies were published, the French recommendations were revised in November 2020, establishing topical therapies as second-line treatments. These include the high-concentration capsaicin (8%) patch and intradermal injection of botulinum toxin A. The lidocaine 5% patch is also a first-line treatment, together with electrical nerve stimulation (TENS).

In France and Europe, the capsaicin patch may be marketed for any kind of peripheral neuropathic pain. It came on the French market in April 2011 and has been the subject of many controlled studies, which report that it is tolerated well, based on the near-absence of systemic side effects and greater efficacy than that of drugs administered systemically. It was recently authorized on the North American market for both post-herpetic and diabetic neuropathy, pending extension of approval to post-surgical neuropathic pain. Botulinum toxin A has been used for many years in physical medicine and rehabilitation (including for limb spasticity and cervical dystonia), neurology, ophthalmology (blepharospasm) and aesthetic medicine. It lacks marketing authorization for treatment of peripheral neuropathic pain. The toxin's mechanisms of action in neuropathic pain – particularly peripheral (reducing the release of neurotransmitters in the synaptic cleft, acetylcholine and reducing the release of CGRP, substance P and glutamate) - are complex. They are also central (axonal transport of TRPV1 receptors and retrograde intraneuronal distribution of the toxin). Many randomized controlled trials have confirmed the safety and efficacy of the botulinum toxin when indicated for use in treating peripheral neuropathy. However, the heterogeneity of the protocols studied preclude the use of this toxin as a first-line treatment. Based on the published studies, we may conclude that botulinic toxin is safe, long-acting and without major side effects.

Selected bibliographic references

Gilron I *et al*. Evaluating the association between acute and chronic pain after surgery: Impact of pain measurement methods. *Clin J Pain* 2017; 33:588–9

Glare P *et al*. Transition from acute to chronic pain after surgery. *Lancet* 2019;393: 1537-46

Smith BH *et al*. Neuropathic pain in the community: Prevalence, impact, and risk factors. *Pain* 2020, 161: S127–S137

Moisset X *et al*. Pharmacological and non-pharmacological treatments for neuropathic pain: Systematic review and French recommendations. *Rev Neurol (Paris)* 2020;176:325-52

Topical treatments: a revolution in treating peripheral neuropathic pain with high-concentration capsaicin and botulinum toxin: new recommendations

Selected bibliographic references

Hampää M *et a*l. Capsaicin 8% patch vs. oral pregabalin in patients with peripheral neuropathic pain. *Eur J Pain* 2016;20:316-28

Simpson D *et al*. Capsaicin 8% patch in painful diabetic neuropathy: a randomized, double-blind, placebo-controlled study. *J Pain* 2017;18:42-53

van Nooten F *et al*. Capsaicin 8% patch versus oral neuropathic pain medications for the treatment of painful diabetic

peripheral neuropathy: A systematic literature review and network meta-analysis. *Clin Ther* 2017;39;210-4

Viel E *et al*. Treatment impact on patient-reported outcomes in peripheral neuropathic pain: comparing single intervention with topical high-concentration capsaicin to daily oral pregabalin. *Pain Phys* 2021;24:453-63

Datta Gupta A *et al*. A systematic review and meta-analysis of efficacy of botulinum toxin A for neuropathic pain. *Toxins* (Basel). 2022;14:36-45

Pirazzini M *et al*. Botulinum neurotoxins: Biology, pharmacology and toxicology. *Pharmacol Rev* 2017;69: 200-35

Ranoux D *et al*. Botulinum toxin type A induces direct analgesic effects in chronic neuropathic pain. *Ann Neurol* 2008;64: 274-83

Attal N *et al*. Safety and efficacy of repeated injections of botulinum toxin A in peripheral neuropathic pain (BOTNEP): A randomised, double-blind, placebo-controlled trial. *Lancet Neurol* 2016, 15, 555–65

Salehi H *et al*. The effects of botulinum toxin type A injection on pain symptoms, quality of life, and sleep quality of patients with diabetic neuropathy: A randomized double-blind clinical trial. *Iran J Neurol* 2019;18:99-107

Taheri M *et al*. The effect of intradermal botulinum toxin A injections on painful diabetic polyneuropathy. *Diabetes Metab Syndr* 2020;14: 1823-8

Moisset X *et al*. French guidelines for neuropathic pain: An update and commentary. Rev Neurol (Paris) 2021;177:834-7

Management of spinal disorders at the CSSR

Author

Dr Jean-Luc Lambert, médecine Physique et readaptation, CSSR

Abstract

The management of chronic painful spinal disorders or those at risk of becoming chronic dates back to the creation of the post-operative care and rehabilitation centre (CSSR) in 2015.

Initially, the GLC (chronic back pain group) program lasted four weeks in an outpatient setting with, of course, multidisciplinary practitioners, e.g., physical and rehabilitation medical services, physical therapy and massage, adaptive physical activity instructors and occupational therapists.

With the purchase of iso-kinetic equipment including a spinal module for instrumental evaluation, the program was modified in 2017 and strengthened by the systematic involvement of a registered nurse (patient education), dietitians, psychologists and social workers, as needed.

The program is called RFR (functional spinal rehabilitation), lasts six weeks and is only covered by CAFAT (New Caledonia's social and medical security program) a single time per patient.

The program's components and the type of patients treated meet the 2000 French Higher Health Authority (HAS) standards and the 2019 fact sheet.

Patients are referred either by general practitioners or rheumatologists and orthopaedic surgeons and, most particularly, by the Territorial Hospital's pain assessment and treatment unit (UETD - Dr Luc Brun), which the CSSR has a monthly agreement with.

The patients' medical histories vary but the prerequisite for participating in an RFR program is that the medical and surgical approach has been fully explored, and the common point for all our patients is the existence of negative biological, psychological or social risk factors.

Finally, it should be noted that as part of follow-up by the Occupational Medicine Department, most patients who engage in a professional activity have already benefited from either work adaptation or reclassification, provided that the companies are able to offer suitable positions/ workstations and no longstanding underlying conflicts exist.

A major issue for this program is, then, its economic objective of consolidating treatment approaches and reducing the health-care use.

Treating chronic lower back pain

Author

Dr Bénédicte Champs, rhumatologue, Nouméa

Abstract

Lower back pain is one of the most common reasons that people visit the doctor. This pain can have many causes.

Appropriate treatment requires determining the aetiology of the pain precisely: damage to a facet joint or disc, spondylolisthesis, referred pain or other cause. Clinical examination complements imaging (dorso-lumbar spine X-rays or lumbar spine CT scan +/- lumbar spine MRI).

Multiple therapies are available and should focus on rehabilitation: from physiotherapy to a prescription for appropriate physical activities or sessions at a physiotherapy centre.

The treatment should be multi-disciplinary and may involve a physiotherapist, rheumatologist, physical medicine and rehabilitation physician, pain treatment centre or sports coach.

The patient has a central part to play in their treatment.

A physical therapy prescription to treat "disabling chronic lower back pain" qualifies the treatment for coverage under the Social Protection Fund (CAFAT), without having to request coverage for a long and costly illness. In addition to physical therapy for pain management, patients also need rehabilitation. This may include exercises for the back and abdominal muscles, muscle strengthening, stretching and spinal relaxation.

The medical treatment is tailored to the individual. Long-term use of pain medication is not recommended. Occasionally, during periods of acute pain, a short-term course of analgesics (level 1 or 2) or NSAIDS may be prescribed. Targeted spinal corticosteroid injections may be proposed (epidural, facet joints or iliolumbar).

Spinal surgery is useful in some cases. A spine specialist – orthopaedic surgeon or neurosurgeon - must assess this. Every treatment is unique to the patient and must be discussed on the basis of the situation: laminectomy, treatment for a herniated disk or fusion (arthrodesis).

Regular clinical follow-up – six-monthly or annually - is necessary. The imaging is updated on a case -by-case basis in response to changes in the clinical situation and aetiology.

Acute pain in children: From approach to treatment

Author

Dr Gaël Guyon, pediatrician, CHT

Abstract

The management of pain in children has been changing constantly for some 30 years, through the steady development of knowledge (physiopathological, pharmacological, etc.), the gradual evolution of medical practices and medical professionals' attitudes, the development of multi-function medical units dedicated to this issue, and the energy of associations working in this field. Learned societies and health authorities in multiple countries have issued good practice recommendations. In addition, in 2020, the International Association for the Study of Pain proposed a new definition of pain that better reflects the progress made in understanding pain: "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." This definition is particularly appropriate for children (non-verbal expression, personalisation, etc.) and introduces the various pathways for managing pain.
The sensation of pain is present from birth, including among premature infants. Its cognitive representation varies and changes as we grow, suggesting that a range of behavioural approaches to treatment is needed.

Managing a child's pain effectively first requires the ability to recognize it, particularly in the absence of verbal expression. This calls for clinical judgment because pain is subjective and cannot be measured by tests or imaging. We must believe a child when they express their pain, either in words or through their body – and be able to take the time needed. Clinicians now have a range of specific tools to guide them: pain assessment scales (based on sensitivity and specificity) that have been adapted and approved for each age bracket and type of pain.

This step – locating the pain – is essential. It must be done in a comprehensive way, incorporating memory and psychological aspects, the family and cultural environment, and the child's higher level of vulnerability. In addition, it must also involve an exchange of information both matching the child's age and suiting the parents, who are partners in treatment and whose abilities must be valued.

While the pharmacological response to nociceptive pain is now incorporated in medical practice, this treatment should be supplemented by and/or linked to alternative treatment methods, whether or not drug-based. In paediatrics as in adult medicine, the drugs are categorized according to the WHO's three-step analgesic ladder. Many of them can be used from birth; specifically, morphine, which is largely underused in daily practice because of long-standing biases. Analgesics administered internally, in the traditional way (orally, intravenously, rectally, etc.), may be combined with or substituted by topical treatments (blocks, adhesive bandages, patches), sugar solutions (for new-borns), gas via inhalation or nasal administration, physical techniques (physical therapy or neurostimulation), and cognitive methods (distraction or attention). Each therapeutic method acts on one of the four components of pain, each of which is intertwined with the others.

Today, no one can say any longer that children do not suffer. Failure to provide personalized pain relief to ease their pain is no longer acceptable.

Psychological aspects of chronic pain

Author

Mrs Maëlle Deniaud, clinical psychologist, New Caledonia's Territorial Hospital Centre (CHT)

Abstract

Pain is a universal and unavoidable phenomenon. It is inherent to the human condition and has been part of human history since the beginning of time. The situations that provoke pain are as diverse and varied as are the stories and individuals who recount them.

It was only when the Law of 4 March 2002, with its Article L110-5, was passed that pain treatment was determined to be a "fundamental right of every person," paving the way to establish treatment as a public health priority.

The chronic pain facilities developed since the 1990s are dedicated to complex situations, in which pain is considered to be chronic (HAS, 2008). They provide a framework for intervention and insight into the complexities of a pain clinic.

In these facilities, patients with chronic pain may, with a referral from a health professional, meet with a team composed of, at a minimum, a doctor, nurse and psychologist. Each member brings a way of seeing, a building block that helps to lay the foundation for understanding the problem in all its dimensions.

"The psychological evaluation of chronic pain is an essential element of the overall assessment, with a three-part focus:

- Psychological evaluation of the pain;
- Psychopathological evaluation of the patient; and,
- Evaluation of the psychological consequences of the pain, the ability to adapt to pain, or the possibilities of the patient's acceptance of a specific analgesic." (SFETD, 2013)

"Thus, in a context where pain, complaints and subconscious experience intersect, the psychologist will base the clinical encounter with the subject in pain on the account of a suffering and bruised body" in the transference experience and its reverberations.

The WHO defines pain as: ***"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage."***

Given the variable nature of the pain and its experience, as recounted by the patient, no boundaries exist any longer between the psychological and the physiological. In the field of psychology, the boundaries between mind and body came down long ago.

This is what we will explore together, focusing on three dimensions:

- <u>Sensory impact:</u> pain is an impact that the organism perceives as a threat. It is immediately experienced as anguish.
- <u>Psychological impact</u>: pain is a strange, disorienting feeling; it threatens the subject's equilibrium, particularly when it becomes chronic.
- <u>Cognitive and behavioural impact</u> of chronic pain: patients create a set of strategies, thoughts or images in order to confront this disorganization.

"When we are in pain, we no longer hear, we no longer speak, we no longer think." (CAVRO, 2007. Douleurs et intersubjectivité. Le journal des psychologues, 3 (246), 30-34.)

Workshops

Workshop 1: MEOPA

Dr Oliver Kesteman, CHN

DEFINITION OF THE ACTIVITY

Meopa is a **medicinal anxiolytic and analgesic gas**. Meopa is a mixture of 50 % oxygen and 50 % nitrogen protoxide. It is a colourless and almost odourless gas, available in 2-to-20 litre capacity bottles and distributed under various brand names.

INDICATIONS

Meopa is mostly used in hospital settings to relieve pain or help patients manage their anxiety during painful short forms of treatment: puncture, bandaging, fracture reduction, sedation during dental care (in particular with anxious patients or those suffering from a handicap), obstetrical analgesia, pending peridural analgesia or when such is refused or impossible.

CONTRA-INDICATIONS

The contra-indications are: patients needing pure oxygen ventilation, patients presenting an undrained effusion (especially intracranial, pneumothorax or bullous emphysema), patients having recently received an ophthalmic gas.

DESCRIPTION OF THE TECHNIQUE

It is administered to patients through an inhalation mask (nasal or facial) or a mouthpiece.

UNDESIRABLE EFFECTS

Undesirable effects: nausea, vomiting, temporary pressure and/or volume increase in air-filled cavities of the body (normal or pathological), euphoria, psychodysleptic disturbances with no association with another anaesthetic agent.

STUDIES AND RECOMMENDATIONS

Leger F. Kuhn E. *Évaluation des pratiques et risques professionnels liés à l'utilisation du MEOPA au CHU de Nantes*. Archives des maladies professionnelles et de l'environnement Vol 81. 2020

Victorri-Vigneau C. Paille C. *Pratiques d'utilisation du MEOPA dans un CHU : quelle conformité ? Therapie Vol 72 issue 6. 2017.*

Workshop 2: TENS

Laurence Gracia, Nurse, Noumea

DEFINITION

TENS (**T**ranscutaneous **E**lectrical **Ne**rve **S**timulation) is a non-drug therapy used to ease chronic pain in patients. It uses the properties of an electrical current transmitted through electrodes placed on the skin.

The treatment is prescribed in pain facilities and the technical placement of the electrodes is done by specially trained care personnel whose knowledge is regularly re-assessed. It is a delegated act.

INDICATIONS

Severe neuropathic pain (involving peripheral nerves or nerve roots): Amputation (phantom limb, stump), Peripheral nerve damage, Shingles, Causalgia ,Mono and polyneuritis, Radiculalgia

Chronic non-neurological pain: Rheumatic pain (lumbago, lumbosciatic pain, arthrosis, tendinitis), Myofascial pain.

CONTRAINDICATIONS

Absolute : Pacemaker/defibrillator, Pregnancy, Area facing the carotid sinus, Use while driving, Total anaesthesia of an area (a motor deficit without anaesthesia does not preclude neurostimulation), Allergy to electrodes.

Relative : Multifocal pain topography, Severe allodynia, hyperesthesia, Patient difficulty in understanding or accepting the use of neurostimulation

DESCRIPTION OF THE TECHNIQUE

The technique invloves placing electrodes on the skin. The electrodes are connected to a portable device that generates the programme and intensity needed to ease the patient's pain.
During a test session, the nurse and the patient determine where to place the electrodes; the nurse instructs the patient how to set the device and how to conduct sessions.

BIBLIOGRAPHY

Bjordal JM, et al. *Transcutaneous electrical nerve stimulation (TENS) can reduce postoperative analgesic consumption.* A meta-analysis with assessment of optimal treatment parameters for postoperative pain. Eur J Pain. 2003;7(2):181-8.

Johnson MI. Transcutaneous electrical nerve stimulation (TENS) as an adjunct for pain management in perioperative settings: a critical review. Expert Rev Neurother. 2017 Oct;17(10):1013-1027.

Dailey DL, et al. Transcutaneous Electrical Nerve Stimulation Reduces Movement-Evoked Pain and Fatigue: A Randomized, Controlled Trial. Arthritis Rheumatol. 2020 May;72(5):824-836.

Richard E. Liebano et al. An Investigation of the Development of Analgesic Tolerance to Transcutaneous Electrical Nerve Stimulation (TENS) in Humans. Pain. 2011 February ; 152(2): 335–342

Workshop 3A : The acupressure mat

Maëlle DENIAUD Psychologist, Noumea

DEFINITION OF THE ACTIVITY

The 'champ de fleurs' acupressure mat is a certified medical instrument, designed to produce a specific form of **nerve stimulation**. Pain relief is effected by a combination of the secretion of endorphin in the nervous system, relief from inflammation, an increase in blood circulation, and muscle, nerve and joint relaxation

INDICATIONS

Relief from lumbar and neuralgic conditions, stress reduction and sleep improvement.

DESCRIPTION OF THE TECHNIQUE

When the user lies down on the mat, a total of 5525 pressure points are simultaneously applied to the back. This method stimulates the moderate release of endorphins without over-stimulating the nerve endings. In this way, during the recommended 15-to-45-minute application period, the analgesic hormone is gradually released.

The 'lotus flower' tips stimulate the nerve endings, which transmit the signals to the central nervous system, thus triggering the secretion of endorphins and other neurotransmitters (dopamine, serotonin, oxytocin). The endorphins inhibit the transmission of the stimuli, thus producing the analgesic effect. Result: the intensity of the pain is reduced. In addition, these neurotransmitters also have a calming effect and help enjoy deep sleep.

BIBLIOGRAPHY

C Hohmann et al. The Benefit of a Mechanical Needle Stimulation Pad in Patients with Chronic Neck and Lower Back Pain: Two Randomized Controlled Pilot Studies. Evidence-Based Complementary and Alternative Medicine Volume 2012, Article ID 753583.

Workshop 3B : Music Therapy, Virtual Reality Helmet

Maelle Deniaud, Psychologist, Noumea

DEFINITION OF THE ACTIVITY

'MUSIC CARE' is a personalised and standardised form of therapy, derived from musical therapy techniques and based on the principles of hypnotic analgesia. It involves listening to **musical sequences specifically composed to induce a state of psychomotor relaxation**. Each musical sequence is composed in accordance with the 'U' standardised sequence protocol.

INDICATIONS

MUSIC CARE is a supplementary and broad-use non-drug treatment. It can be used in many indications: chronic pain, anxiety issues, depression events and sleep disorders and by any type of health professional. It can be offered to any kind of patient (newborn, children/adolescents, adults up to elderly people), with or without cognitive disorders.

DESCRIPTION OF THE TECHNIQUE

Listening to music leads to a modification in the nervous and haemodynamic system. Music is a multidimensional and stimulating sensorial message. It stimulates cognition (memory, focus). It has antalgic virtues, through an attenuation of the conduction through afferent pain fibres. And anxiolytic virtues by stimulating the production of endorphin and dopamine. It facilitates emotional regulation. It acts actively on psychomotricity. And it is conducive to and strengthens interpersonal ties.

<u>The standardised 'U' sequence model comprises 3 phases:</u>

Phase 1: INDUCTION - stimulating rhythm, representing the emotional state. Gradual variation in the musical parameters (slowing tempo, simplification of rhythm and orchestral formation, lower volume).

Phase 2: RELAXATION - slow rhythm, reduction of all musical parameters.

Phase 3: AWAKENING - awakening rhythm, gradual reintroduction of the musical parameters

STUDIES AND RECOMMENDATIONS

Effect of music intervention in the management of chronic pain: a single blind randomized, controlled trial. Clinical Journal of Pain 2012 ; 28: 329 - 37.)

Effects of music therapy in intensive care unit without sedation in weaning patients versus non ventilated patients. Annales Françaises Anesthésie Reanimation 2007 ; 26 :30 - 8.)

Workshop 4: Osteopathy PO2

Michel Bœuf, ostéopathe, Nouméa

DEFINITION OF THE ACTIVITY

The 2-session osteopathy protocol is part of an approach to further develop osteopathy strategies and the quality of osteopathic care.

It represents an original guideline for osteopathic treatment and is a proposed protocolisation of osteopathy in accordance with the principles of Evidence Based Medecine (EBM) to better treat pain.

INDICATIONS

Adults: common spinal pain, with or without radiculopathy, tension headaches, tendinitis, sprains, coccygodynia, chest pain, temporomandibular joint dysfunction

Children aged 10 to 18: 'postural' pain in the lower limbs and the spine

CONTRA-INDICATIONS

Absolute: bone tumour, fracture or advanced osteoporosis

Relative: infectious, inflammatory or psychiatric illness

DESCRIPTION OF THE TECHNIQUE

Conventional investigation: type of pain: location, triggering factors, operation, chronicity, paraclinical exploration, imagery, listening to the patient's complaints

Original clinical examination: battery of 13 provocation pain tests and Pre-existing Torsion Situation.

Conventional treatment: vertebral (structural), visceral (smooth muscles), muscular (trigger points and facial stretching) and cranial (relaxation, intention).

Pain assessment: simple numerical evaluation (numerical scale) throughout treatment

STUDIES AND RECOMMENDATIONS

Rubinstein SM et al. Benefits and harms of spinal manipulative therapy for the treatment of chronic low back pain: systematic review and meta-analysis of randomised controlled trials. BMJ. 2019 Mar 13;364:l689

HAS : **r***ecommandation des mobilisations pour les lombalgies communes*. 2019

Bœuf M, Brun L :

PO2 et sciatique L5, PO2 et thoracotomie, PO2 et tendinopathie, et PO2 et coccygodynie. Posters au congrès de la SFETD. 2021 et 2022.

Effet du Protocole Ostéopathique en 2 séances (PO2) chez les patients souffrant de rachialgies non spécifiques. Un essai clinique croisé randomisé (en cours…)

Le Schéma de Torsion Préexistant (STP) : un nouveau modèle de schéma d'adaptation musculo-squelettique du rachis. (en cours…)

Workshop 5: Hypnosis

Claire-Line Biavat, Hypnothérapeute — Dr Jessyca Samin, Anesthésiste, CHT, Nouméa

DEFINITION OF THE ACTIVITY

Hypnosis is a **natural conscious cerebral state**. As part of pain management, the hypnotherapist uses this state as a tool, in order to modify the perception of pain.

We perceive pain to varying degrees of intensity and unpleasantness, depending on a number of factors: culture, education, context, beliefs, emotions (stress, fear, anxiety).
The process is cerebral modulation of the painful stimulus.

By working on perceptions, hypnosis makes it possible to manage pain thresholds and intensity. It also assists with the managing of emotions and the beliefs that go with them.

INDICATIONS

Any type of pain
Acute pain: surgery, emergencies, painful care practices.
Chronic pain: migraine, backache, irritable colon, post-operation pain, muscular pain, pain related to cancers.

CONTRA-INDICATIONS

Schizophrenia / Unexplored pain

THE MAIN TECHNIQUES USED IN HYPNOSIS

Transfer of analgesia or desensitisation
Regression to a non-painful state (for chronic pain)
Hypnotic relaxation
Dissociation
Metaphors

STUDIES AND RECOMMENDATIONS

http://www.laryngo.com/tip/hypnoseHypnosedation.pdf
http://sofia.medicalistes.org/spip/IMG/pdf/Hypnose_en_anesthesie.pdf
https://www.google.com/url?q=https://vi-meo.com/256484425&sa=U&ved=2ahUKEwjExMXwpoj2AhWWQvEDHRxVBNoQtwJ6BAgEEAE&usg=AOvVaw09bnfAGCF_wD2bw_5RZVRd
https://vimeo.com/186251686

Workshop 6: Anti-inflammatory dietary regimes

Alexandra Souprayen, Charlène Guignet, Heiti Mata

Diététiciennes Nutritionnistes, Nouméa

DEFINITION OF THE ACTIVITY

The purpose of dietetics is to **design a personalised varied and balanced daily meal content programme**, in order to prevent or take into account: the consequences of particular ailments, metabolism disorders, infections, allergies, or inflammatory events that may cause pain.

INDICATIONS

For any person from birth to the later life stages: during each specific stage in life (growth, pregnancy, sport…), in good health, or suffering from chronic diseases (obesity, diabetes, cardio-vascular, renal diseases, food intolerances, allergies, inflammatory rheumatism …)

CONTRA-INDICATIONS

No contra-indication, which does not mean you should not consult your doctor for a blood test in addition to the nutritional advice.

DESCRIPTION OF THE TECHNIQUE

- Initial consultation: anamnesis, meal content enquiry, dietary assessment
- Follow-up consultations: re-evaluation of objectives depending on patient feedback

<u>The specifics of the 'anti-inflammatory' dietary regime are based on</u>:

- A balanced weight (prevention of overweight status and obesity)
- Oméga 3 supplementation (scientific demonstrations)
- Mediterranean diet: (cardio-metabolic and joint benefits)
- ! Antioxidants: vitamins ACE, polyphenols, lycopene, probiotics, cinnamon, saffron, curcuma… (lack of scientific data, so no need for systematic supplementation, a healthy and balanced diet makes it possible to cover antioxidant needs.)
- ! No unjustified diet content eliminations (dairy products or drastic vegetalian diet, or gluten-free, or lactose-free)

STUDIES AND RECOMMENDATIONS

HAS-sante.fr : consultation diététique recos – 01/2006

SFR : *Recommandations de la Société française de rhumatologie sur l'alimentation des patients ayant un rhumatisme inflammatoire chronique* – Claire DAIEN– méta- analyses 29/09/2021

Workshop 7: Auricular Acupuncture

Vanessa Top, nurse, Nouméa

DEFINITION OF THE ACTIVITY

In Traditional Chinese Medicine (TCM), **pain is due to a blockage.** Treatment using needles, acupressure points, magnets, moxibustion, suction pads on specific points help the body to restore its new balance and ease circulation, whether the obstruction is associated with Qi (energy), blood, external causes (heat, cold, wind, damp, etc.), or causes linked to lifestyle factors (food, emotion management, physical activities, etc.).

INDICATIONS

It is preventive: preventing imbalances and pain (physical or psychological pain), the person is seen 3 to 4 times a year; and curative. It is used in a manner **complementary to Western medicine**, through joint attention from the doctor and the traditional practitioner for chronic pain, such as lumbago, fibromyalgia, headaches but also anxiety/depression disorders, insomnia, PTSD… It also acts on the side effects of invasive treatments such as chemotherapy, hormone therapy.

CONTRA-INDICATIONS AND SIDE EFFECTS

A doctor's opinion should be sought, especially for fragile subjects (the elderly, those with a weakened immune system or with many comorbidities, etc.).

Side effects are infrequent: temporary rash, heat sensation, local pain, bruise, fatigue, feeling of malaise.

EXPERIENCE OF THE NADA PROTOCOL in the 'Ligue contre le cancer', Nouméa:

NADA is an auricular acupuncture protocol, stemming from research in the 1970s by Dr M. O. Smith, and also especially from work by Dr P. Nogier, an acupuncturist from Lyon, France. It involves the introduction of 5 needles in the two outer ears. It is a simple, non-verbal method, that supports people holistically to find a new balance. Used as supporting care within the 'Ligue contre le cancer'.

STUDIES AND RECOMMENDATIONS

Moisset X et al. *Traitements pharmacologiques et non pharmacologiques de la douleur neuropathique : une synthèse des recommandations françaises*. Douleur analg. 33:101-112. 2020

De Valois BA et al. NADA ear acupuncture for breast cancer treatment-related hot flashes and night sweats: an observational. *Medical Acupuncture* 24(4). DOI:10.1089/acu.2012.0897. 2012

Bruce, L. Ear acupuncture: A tool for recovery. Yale School of Medicine Department of Psychiatry Website. Contributed by Connecticut Mental Health Center. Retrieved from http://medicine.yale.edu/psychiatry/newsandevents/cmhcacupuncture.aspx. 2011

Hollifield M et al. Acupuncture for posttraumatic stress disorder: A randomized controlled pilot trial. The Journal of Nervous and Mental Disease, 195(6), 504-513. 2007

Workshop 8: Pilates

Aïssatou Badji, Nouméa

DEFINITION OF THE ACTIVITY

The Pilates method is a form of **gentle gymnastics** that associates deep breathing with physical exercises, derived from yoga, dance and gymnastics.

INDICATIONS

The Pilates method is mainly used as an approach to training to improve strength, flexibility, coordination and good posture. When practised regularly over quite a long period, it is said to have an impact on peoples' general state of health.

The principal indications are:

Chronic lumbago, drop in functional capacity, fatigue, depression and loss of quality of life.

CONTRA-INDICATIONS

In the event of pain that can be attributed to serious problems, a doctor must be consulted because, as the trademark is not a registered one, the method does not come under the supervision of a governing body.

DESCRIPTION OF THE TECHNIQUE

It can be used on the ground, on a mat or on equipment. 'Proprioceptive toys' can also be used (balls, springs, elastic cords) inducing a loss of balance, which prompts the body to trigger a reaction from a specific set of stabilising muscles.

The Pilates method is grounded in on 8 basic principles that should be ever present in the mind of its practitioners: concentration, control, centre of gravity, breathing, fluidity, precision, order of movements and isolation.

STUDIES AND RECOMMENDATIONS

A Patti et All. *Effects of Pilates Exercise Programs in People With Chronic Low Back Pain, Systematic Review.* 2015

M Lastennet. *La place du Pilates en prévention de la récidive de la lombalgie. Science du vivant HAL. 2019.*

Workshop 9: Treating chronic lower back pain: via the back or through the brain? The benefit of cartoons

Dr Bruno Leroy, anesthésiste, Liège, Belgique — Pierre Kroll, dessinateur, Liège, Belgique

DEFINITION OF THE ACTIVITY

Benign non-specific chronic lumbago is the chronic disease with the biggest impact on patients' quality of life (1).

PHYSIOPATHOLOGY

The source of pain, according to the bio-medical model, is not easy to identify because it is difficult to accurately determine a nociceptive source. **The bio-psycho-social model** takes a more holistic approach to the condition, including beliefs and makes better treatment possible.

TREATMENT

Various treatments have been proposed on the basis of the bio-medical model. The results are quite disappointing. The interdisciplinary approach yields better results. (2)

DESCRIPTION OF THE TECHNIQUE

Among the techniques available through the interdisciplinary approach, the modification of patient beliefs seems to play an important part.

It makes it possible to avoid avoidance and strengthens patients' motivation. (3,4)

In addition to this form of management, we have drawn cartoons to try and change patients' harmful beliefs.

STUDIES AND RECOMMENDATIONS

Lancet 2012 Dec 15;380(9859):2163-96. doi: 10.1016/S0140-6736(12)61729-2.

Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. Vos T and all.

Réadaptation du handicap douloureux chronique , Michel Morel Fatio, Bruno Leroy, Elsevier Masson 2019

Vlaeyen JW Kole-Schnijders AM Boeren RG van Ecek H Fear of movements/(re)injury in chronic low back pain and its relation to behavioral performance Pain 1995 ;62 :363-72

Vlaeyen JW Morley S, Linton S, Boeresma K, de Jong j pain-related fear : exposure-based treatment of chronic pain. Seattle : IASP press 2012

Acknowledgments

The Organising and Scientific Committees for the First New Caledonian and Pacific Pain Forum would like to extend their warmest acknowledgments to the Pacific Community for hosting us at their site and providing such top-notch logistical and organizational assistance. We also want to acknowledge the institutions, the Territory's health and medical authorities, the health facilities, and our partners from the private-sector industry and individual medical care services.

Our deep thanks to all the speakers who volunteered to make oral presentations and write the meeting's abstract booklet, which will make a good keepsake for all those attending this first forum. A special thought for those who have travelled long distances to be here (Prof. Eric Viel, Mr. Stéphane Guétin, Dr Bruno Leroy, Mr. Pierre Kroll) and for Dr Mark Dexter who was not able to leave Sydney due to the health crisis.

Thank you to all the volunteers who assisted with the organisation and logistics for this meeting.

Special thanks go to Beryl Fulilagi and Christelle Lepers of SPC and Dr Berlin Kafoa, without whom this forum would not have been possible. Finally, thanks to Camille Menaouer for her help with communication.

The Organising and Scientific Committees

Partners


GAZPAC
CALÉDONIE


sanofi


Eden-Pharma
Nouvelle Calédonie


PACIFIC CARE
LE BIEN-ÊTRE À DOMICILE


Médical Partner


SMP
La santé, notre priorité !


INTERMED


THUASNE


UniPharma
NOUVELLE-CALEDONIE


MUSIC CARE


GRÜNENTHAL

Notes

Notes

1st New Caledonia and Pacific Pain Forum, 22 April 2022

SPC, Anse Vata

http://douleur.nc/