

# 'Global Year Against Acute Pain'

IASP has launched the Global Year Against Acute Pain, a yearlong initiative designed to raise awareness of the different aspects of acute pain worldwide. The European Federation of IASP Chapters (EFIC) first launched the Global Day Against Pain when David Niv, IASP member and EFIC president (now deceased), conceived the idea in 2001. Following the success of this initiative, the IASP Council recognized the need to develop an even more powerful statement to raise the profile of pain worldwide. In 2004, supported by various IASP chapters and federations holding their own local events and activities across the globe, IASP launched its first Global Year Against Pain. The official launch day takes place on the third Monday of every October. 'Global Year Against Acute Pain' has followed 'Global Year Against Cancer Pain', 'Global Year Against Pain in Women' and 'Global Year Against Musculoskeletal Pain', which was observed throughout the world by engaging in pain related activities, organizing conferences, symposia and workshops on cancer pain. Hand bills were distributed and advertisements were placed in the newspapers. Many training activities for healthcare professionals were carried out throughout the world. It collectively created an atmosphere in which pain was talked about more often than ever. The pain management started to be regarded as a major discipline in the medical fraternity. The activities were not restricted to the various chapters of IASP, but many non-affiliated organizations were also actively engaged in the activities.

Despite tremendous research being undertaken to understand the pathophysiology of pain, and despite recent advances in therapeutic as well as interventional techniques, pain remains a serious health problem that affects people's quality of life worldwide, and the issues surrounding pain will continue to grow as the average lifespan increases. Yet, many a pain sufferers continue to be under-treated. In developing countries in particular, where there are a number of serious diseases that can cause severe pain, there is often little or no pain relief available for those afflicted with such diseases. Abundant evidence indicates widespread underassessment and undertreatment of acute pain, and failure to provide proactive pain plans<sup>1</sup>. In the United States alone, more than 46 million inpatient and 53 million outpatient surgeries take place annually. Over 80% of patients who undergo surgery in the United States report postoperative pain<sup>2</sup>.

Of these patients, 86% state that the pain is moderate, severe, or extreme. Most of these patients report worse

pain control after discharge from hospital. Barriers of particular relevance to optimal acute pain management reflect failure to address long-standing, prevalent myths about acute pain and the importance of its control<sup>1,3</sup>.

Problems related to health care professionals include: out-of-date or inadequate attitudes and knowledge, e.g., mistaken ideas that postoperative pain control interferes with prompt recognition of surgical complications;

inadequate staffing of an acute pain service, resulting in ad hoc efforts oriented toward treating pain rather than preventing it systematically<sup>4,5</sup> and incomplete, sporadic, or nonstandard pain assessment etc.

There are problems related to patients including belief that "nice" patients do not complain about pain or do not show suffering (including cultural factors); a tendency to be satisfied with inadequate pain control, particularly when health care providers are perceived as supportive and caring<sup>6</sup>; reluctance to take pain medications because of side effects (e.g., nausea, vomiting) and other consequences (e.g., addiction, tolerance) etc.

Problems related to the health care system include: low priority given to pain control education for health professionals; regulatory impediments to controlled substance use; cost-shifting to patients (e.g., refusal by health institutions to provide epidural or nerve block disposable sets, being costly); inadequate infrastructure, including knowledgeable personnel to deliver medications and other interventions (e.g., patient-controlled analgesia, cognitive-behavioral techniques) and relative to the burden of acute pain, a disproportionately low clinical research funding<sup>7,8</sup>.

The control of pain has been a relatively neglected area of governmental concern in the past, despite the fact that cost-effective methods of pain control are available.

During the last decade or two, knowledge of the physiology and psychology of acute pain has progressed substantially. Methods for acute pain measurement have improved, new drugs and techniques for acute pain have emerged, and acute pain relief has advanced in numerous clinical situations including postoperative pain, trauma, burn pain, spinal cord injury, back pain, and acute medical conditions. In addition, the need for acute pain management has gained recognition in a variety of clinical settings, especially postoperative care, intensive care units, emergency departments, and prehospital care. Practice in acute pain medicine now extends well beyond the management of postoperative pain. In addition, emphasis

has shifted to outcomes that go beyond good pain relief, such as decreases in postoperative morbidity and reductions in the risk of developing chronic pain after surgery, injury, or an acute medical condition. Yet, despite substantial advances in pain research in recent decades, inadequate acute pain control is still more the rule than the exception. Numerous studies show that fewer than half of postoperative patients receive adequate pain relief<sup>9</sup>. Patients presenting to the ED with significantly painful conditions fare no better.

Acute pain has many negative consequences for the patient, for the clinicians managing the patient, and for those who manage the hospital or clinic that deals with acute pain. Poor pain management puts patients at risk, creates needless suffering, and increases costs of care.

Millions of parturients, worldwide, give birth to babies in pain. This is not only the case with rural women delivering in their home environment, but most of the hospitals of undeveloped countries do not offer facilities of painless labour. Even where it does exist, the service is not offered to all. Deficiency of trained staff and required funds raise major obstacles in provision of painless labour service to all. Better staffed and well-equipped hospitals offer it to paying parturients, but a lot many entitled ones are left without. Governments need to address this issue on priority.

Trauma is another major issue linked to the production of acute pain. In many trauma victims endogenous opioids remain the only therapy for often excruciating pain associated with it. Healthcare professionals often feel hesitant to offer potent analgesics to the victims due to their unfounded beliefs and myths.

No wonder we need a major breakthrough to shatter the myths and leap forward towards an understanding that pain management must be offered not as a privilege, but a basic human right of every person who has pain, whether it is a crying surgical patient lying in postoperative ward, a screaming parturient or a victim of trauma. The barriers have to be crossed. Rules and regulations have to be written and guidelines have to be adhered to. It must be an all out war against ineffective pain management.

'Global Year Against Acute Pain' is set to focus the world attention towards this important aspect. Let us be

optimistic that this year will bring good news to pain sufferers.

## REFERENCES

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## EDITOR'S NOTE

In an effort to keep pace with the rapid progress in scientific research in the fields of anaesthesiology, pain management, intensive care as well as resuscitation, periodic changes in the editorial board, responsible for maintaining quality of the content and bringing out the print and online versions of the journal become utmost necessary. Hence, we have decided to dispense with the editorial review committee. Articles received for publication in the journal have already been scrutinised by one of the editors and/or sub editors, and sent to two separate peer reviewers, preferably from the developed countries, for reviewing.

We intend to involve separate sub-editors for different sections, anaesthesiology, pain management, intensive care, resuscitation, Trends & Technology, Clinipics, Cliniquiz, Academic Activities and for our website [www.apicare.net.pk](http://www.apicare.net.pk). Suitable candidates will be appointed after careful selection by the editorial board.

★ **Dr. Samina Ismail** graduated from Dow Medical College Karachi (Pakistan), and qualified FCPS (Anesthesiology) in 1998 and fellowship in Clinical Anaesthesia from University of Toronto in 2005. She has been Residency Director of anaesthesia residency programme at Aga Khan University Karachi (Pakistan), and thus involved in postgraduate education, administrative and academic activities at University level and developed the anaesthesia curriculum for the university. She delivered a number of lectures and presentations as invited speaker and conducted various workshops.

Dr. Ismail is currently heading the Obstetric Anaesthesia Services at AKUH as an Associate Professor and has special interest in Obstetric anaesthesia. She has published a number of research articles in national and international journals and received University research grant for a research project, published in the 'International Journal of Anaesthesia'.

We welcome her on the editorial board as assistant editor with the optimism that her new appointment will help transform 'Anaesthesia, Pain & Intensive Care' into a leading journal in the region.

★ **Dr. Rashed A. Hasan, MD, FAAP** is a highly acclaimed academician in pediatric intensive care. He is American Board of Pediatrics certified. He secured sixth highest national score in the USA in the final in 1992, and was recertified in 2006. He was certified by American Board of Pediatric Critical Care in 1996, recertified in 2002 and 2009. He has special interest in pediatric ventilatory care, pediatric intensive care, respiratory infections and comorbid factors in pediatric population. He has a large number of research papers to his credit on diverse topics related to pediatric intensive care. He is currently serving as Chief, Pediatric Critical Care Medicine at St Vincent Mercy Children's Hospital, and as Associate Professor of Clinical Pediatrics at University of Toledo Health Sciences Center, 2121 Cherry Street, Toledo, Ohio (USA).

We warmly welcome him as a member of Editorial Advisory Board of the journal and feel that his addition to the board will help raise the high standards of the journal even further.

★ **Dr. Rana Altaf Ahmad** has joined Editorial Advisory Board of the journal as a member. He graduated from Nishtar Medical College, Multan-Pakistan in 1986, qualified DA from Bahauddin Zakariya University, Multan in 1989 and FCPS in 1998. He was awarded Noor Begum Gold Medal and College Silver Medal for securing first position in Gynae & Obstetrics. He has been a member of Pakistan Intensive Care Society, Pakistan Society for Study of Pain, Saudi Anaesthetic Association Riyadh; Gen. Secretary of Pakistan Society of Anaesthesia. Multan and Senior Vice-President, Pakistan Medical Association, Multan. He has a number of research papers to his credit.

Dr. Rana Altaf Ahmad is currently serving at CPE Institute of Cardiology Multan as Head of Cardiac Anaesthesia & Critical Care Department.

## REVIEWERS

Apicare thankfully acknowledges the very positive contribution by the following scholars, who very kindly reviewed the articles received for publishing in the journal.

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