Editorial

Persistent pain is a remarkably common and remarkably expensive healthcare problem. In the developed world, approximately one in three people reports a persistent pain condition; in South Africa, this number is probably closer to one in two people.[1-3] The economic cost of pain to South Africa has not been formally calculated, but in Australia and the United States, the cost-to-country of persistent pain exceeds the combined costs of cancer and diabetes.[4,5] Persistent pain is not a problem to be taken lightly.

Between 10 and 50% of patients undergoing surgery will develop persistent postoperative pain.[6] The causes and risk factors are varied, and many are not clearly understood. Iatrogenic nerve damage is one obvious cause, and, indeed, postoperative pain is often neuropathic in nature. Neuropathic pain carries a very high burden of disability and mental illness: in a multicentre cohort survey, two in three people with neuropathic pain had suboptimal sleep, one in three had a current mood disorder, over 90% reported feeling 'sadness most of the time' and 'tired most of the time', and 18% had a current risk of suicide.[7] Neuropathic pain is also particularly difficult to treat, with the best pharmacotherapy available (tricyclic antidepressants) showing a number-needed-to-treat (NNT) of 3.6.[8] In this issue of SAJAA, Moabelo & Parker report their medicines usage evaluation of pregabalin, an alpha-2-subunit binding agent that is one of the first-line medications for neuropathic pain.[8] Incidentally, pregabalin has a rather unimpressive NNT of 7.7 for a 50% reduction in neuropathic pain despite enthusiastic marketing from its producing company, Pfizer. The authors found acceptable adherence to good prescribing practice at the Groote Schuur Hospital Chronic Pain Management Clinic, but they raise the importance of using validated tools to support diagnostic clarity and point out that the dosage recommendations in local South African guides and the pregabalin package insert conflict with international dosage guidelines. Such inconsistency must surely foster confusion.

One risk factor that has repeatedly been found to be associated with persistent post-surgical pain is poorly controlled acute pain after surgery.[6,9-11] In the current issue of SAJAA, van den Bosch et al report their study of the prescription and dispensing of analgesic medication in a Durban-based paediatric setting. That study sheds light on the use of different classes of drugs, and on a particularly concerning mismatch between what was prescribed and what patients actually received. That only 15% of prescribed opioids were actually given to the children suggests that hospital staff are more worried about the risks linked to opioids than about the risk of persistent pain (and its lifelong sequelae) conferred by inadequate postoperative pain control. There is an obvious need for better education of hospital staff, as is pointed out by the authors themselves. In another paper in this issue, Grace reports on the use of analgesia to address pain after Caesarean section in Timor-Leste, in Southeast Asia. This piece makes for interesting reading because of the distinct context, where patients are traditionally prevented from eating for six hours after surgery, and analgesic options are comparatively limited. A relevant, incidental observation is that the study itself seemed to have benefits for patient care in that appropriate use and delivery of analgesics improved during the course of the study, providing motivation for the use of observational clinical research to address deficits in care. One surprising aspect of these two studies is that neither commented on the effects of analgesia: there was no study outcome that clearly reflected change in pain due to therapy. This is an important outcome that would lend value to future research on prescribing and dispensing behaviour.

Together, these three papers reflect a wide variation in analgesic prescribing and dispensing practices. As all three sets of authors suggest, there remains a crucial need for education of healthcare staff about pain. Some of this education is already under way in South Africa: the free-to-attend, brief Essential Pain Management programme* is gradually being rolled out around the country, thanks to the commitment of PainSA and a small group of trainers. That programme includes a 'train the trainers' component in which course attendees are offered the chance to become trainers themselves, thus accelerating the wider delivery of this education. Some clinicians are seeking further training in pain, through the Train Pain Academy non-profit organisation, PainSA's 'Pain Academy' events that are held around the country, the University of Cape Town's Postgraduate Diploma in Interdisciplinary Pain Management, or their own professional organisations. As local research sheds light on the inadequacy of our current approach to clinical pain, workshops on the science and treatment of pain are gradually inching their way into our undergraduate training programmes. The evidence is clear that the best way for complex pain conditions to be managed is by an interdisciplinary team, and so it would be self-defeating for this training to happen with each profession in its own silo; it is interdisciplinary training that is required. A widespread, interdisciplinary educational drive focused on understanding pain and training clinicians to systematically apply evidence-based treatments could go a long way towards changing situations such as those reported in this issue by van den Bosch et al and Grace and improve the prevention (as well as the treatment) of persistent postoperative pain.

Disclosures: VJM receives speakers' fees from the Train Pain Academy non-profit organisation for teaching courses on pain and rehabilitation, and teaches for the University of Cape Town's Postgraduate Diploma in Interdisciplinary Pain Management.

* Information on the Essential Pain Management programme is available at http://fpm.anzca.edu.au/fellows/essential-pain-management

Victoria J Madden

Pain research team, Department of Anaesthesia and Perioperative Research, Neuroscience Institute, University of Cape Town

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