



International Association for the Study of Pain

# IASP

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## S I G > N E W S L E T T E R

### PAIN OF UROGENITAL ORIGIN

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### Message from the Chair

Dear friends and colleagues,

*'The physician must generalize the disease, and individualize the patient.'*

-- Oliver Wendell Holmes

I remember this quote as I have just attended the excellent meeting of the European Federation of IASP Chapters (EFIC) meeting in Lisbon. Maria-Adele Giamberardino and Michal Granot spoke at a fascinating Topical Seminar entitled "Pelvic and Urogenital Pain Mechanisms—from Bench to Bedside." I was delighted at the large number of audience participants.

Urogenital pain is beginning to be appreciated not only as a specific organ problem, but also as a significant multisystem pain condition. Too often in the past, pain in the urogenital region has not been understood by those physicians looking after these patients. Pain in this location has been managed by gynecologists, gastroenterologists, and urologists who have focused for too long on a single organ as the cause of the pain. Pain management services have often not been fully involved in the management of patients with abdominal and pelvic pain, and our knowledge regarding peripheral and central pain mechanisms have not been used. While there is still much that we do not know or understand, we do continue to learn from our basic science colleagues who are continually updating knowledge and understanding. The central sensitization that accompanies urogenital pain does influence symptom presentation, diagnosis, and management. The crux of management for many patients is recognition of these and then an explanation that enables them to understand their condition.

How fruitful it would be if we could encourage our colleagues from gynecology, urology, and gastroenterology to join IASP and PUGO and contribute their knowledge and understanding to our organization and vice versa. To date, PUGO has 122 members, of which seven are gynecologists/obstetricians, three are gastroenterologists, and six are urologists. Perhaps it could be a goal for all of us to add one colleague from a specialty group to IASP and PUGO over the next year! *(Continued on page 2)*

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### Message from the Chair *(Continued from page 1)*

In the UK, and in many other countries, care pathways for patients in pain are being developed to improve the patient experience and to enable the patient to see a specialty that can assess, advise, and treat at an appropriate time. Musculoskeletal pain and neuropathic pain have a head start as there has been much investment in these conditions over the past few years. It is important that we ensure that chronic visceral and urogenital pain is recognized in these pathways and that access is available for patients to multidisciplinary services. It is vital that pain medicine, physiotherapy, and psychology are included in pathways for urogenital pain, as there is always a fear that if these professions are omitted, they will not be funded.

The PUGO Taxonomy Task Force, chaired by Andrew Baranowski, is in the final stage of its work. Very soon this will be completed, and the draft taxonomy will be available to all PUGO members on the listserv for comment. Comments should be sent expeditiously once the document is available for view, as the taxonomy needs to be submitted to John Loeser by the end of the year. This will be a consensus working document as the field is ever-changing, and as such, so will the taxonomy change as our understanding increases. We thank Andrew wholeheartedly for his generous commitment to this process, which has been very time-consuming over the past year.

I am delighted to let you know that plans for PUGO's annual meeting, "Convergences in pelviperineal pain," are going well with our French and Canadian colleagues. Visit the website to see the provisional program. The dates are December 16–18, 2009, and this important meeting will give all of you the opportunity not only to visit the picturesque town of Nantes before the holidays and visit the famous Christmas market, but also to listen to excellent basic science, translational, and clinical research. I do hope many of you will be able to attend this meeting, and I look forward to seeing you there.

I am also delighted to tell you that PUGO will hold a satellite meeting on Sunday, August 29, 2010, just prior to the start of IASP's 13th World Congress on Pain at the Palais des congrès in Montréal. PUGO also submitted a successful bid for a

workshop as part of the congress program entitled "Pain and the woman." Many thanks to John Hughes, who has worked tirelessly on getting both of these approved by the Scientific Program Committee. PUGO will also be holding an extra separate meeting during the Congress for members to discuss and debate the proposed taxonomy.

I also wish to thank Alain and Thibault for compiling this newsletter, as communication between members is vital to our continuing success. Please forward any views or comments that you have to me, as dialogue is a two-way process. If you have suggestions, I would be delighted to hear them.

Kindest regards,  
Beverly Collett, SIG Chair



### Editorial

Welcome to the second edition in 2009 of the PUGO Newsletter. In her message from the chair, our president reflects the importance for us to integrate our knowledge with colleagues from other specialties interested in pelvic pain. Unfortunately, these colleagues are too few...

The meeting "Convergences in pelvi-perineal pain" in Nantes next December will certainly give PUGO members the opportunity to share a multidisciplinary approach of pelvi-perineal pain. For more information, you can visit the website at: [www.convergencespp.org](http://www.convergencespp.org)

Dr. Collett's comments emphasize the importance of sharing knowledge with pelvic floor physiotherapists and psychologists. In this issue, Stephanie A. Prendergast and Elizabeth H. Rummer, two pelvic-floor physiotherapists from San Francisco, will overview the role of physical therapy in myofascial pain syndromes. Furthermore, Stephanie will participate in the meeting in Nantes.

Our first "Personal and Faculty profile" will feature Dr. Andrew Baranowski.

Finally, we would appreciate receiving interesting publications

from PUGO's members. We would also like to have a colleague from a developing country to share with us his or her experience and approach in pelviperineal pain.

If you have any comments or suggestions, please contact us.

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## The Role of Physical Therapy in Myofascial Pelvic Pain Syndromes

Current research is showing that many chronic pelvic pain syndromes have multiple etiologies spanning several disciplines. Patients with complex syndromes such as vulvodynia, interstitial cystitis/ painful bladder syndrome, nonbacterial chronic prostatitis/chronic pelvic pain syndrome, and pudendal neuralgia present with myofascial impairments upon physical examination, making physical therapy a necessary component of an interdisciplinary treatment plan.

A physical therapist specializing in pelvic floor dysfunction can help identify and treat pelvic abnormalities in men and women with hypertonic pelvic floor disorders. Literature has described physical therapy treatment of the pelvic floor using biofeedback, real-time ultrasound, electrical stimulation, stretching and strengthening, neural mobilization, and structural and biomechanical correction.

As the field of pelvic medicine has advanced, findings from animal and clinical research have shown that chronic pelvic pain syndromes involve musculoskeletal structures that extend beyond the pelvic floor muscles and surrounding joints. Consequently, the medical profession has incorporated manual examination of the pelvic floor muscles, internal and external connective tissue, and myofascial trigger points into the evaluation of a patient with pelvic pain. It is our position that incorporating manual physical therapy techniques will improve patient outcomes. This article presents the rationale behind the use of manual techniques and how to use them in evaluation and treatment.

### Physical Therapy Evaluation and Treatment

Evaluation and treatment of patients with pelvic pain involve several components. A comprehensive evaluation and treatment address the connective tissue from the ribs to the knees, myofascial trigger points and hypertonus of the entire pelvic floor musculature and external pelvic girdle muscles, peripheral nerves of the pelvis and lower extremity, and the patient's structure, joint mechanics, neuromuscular recruitment, and strength.

### Connective Tissue

Healthy connective tissue is not thickened or painful and moves freely. To both evaluate and treat connective tissue dysfunction, a physical therapist must employ a technique known as skin rolling. This manual technique manipulates connective tissue to normalize its mobility, improve circulation, reduce hypersensitivity, and minimize the negative reflexive effects on surrounding muscle, nerve, and viscera. Since patients with pelvic pain typically have connective tissue restrictions in the thighs, along the bony pelvis, in the gluteals and in the abdomen, all areas must be evaluated and treated. External connective tissue manipulation involves the therapist 'pinch-rolling' the affected tissue (below the skin and above the muscle) between his/her thumb and other four fingers, with both hands.

### Pelvic Floor Muscles

The internal pelvic floor muscle exam begins with the therapist inserting one finger into the vagina or rectum, noting if there is pain or excessive tension upon entry. Motor control should be manually assessed prior to specific muscle examinations. Motor control is assessed by asking the patient to concentrically contract (squeeze) and eccentrically contract (push out) the levator ani muscles and voluntarily relax or "drop" the pelvic floor muscles. By palpating the pelvic floor muscles, the concentric strength of these muscles is scored using Laycock's modified Oxford Grading System. The physical therapist should also note the rate at which the levator ani muscles relax after a concentric contraction. Muscles that are hypertonic, or tight, have difficulty relaxing or returning to a normal length after a single concentric contraction. After noting the motor control of the levator ani muscles, each muscle of the pelvic floor—including the obturator internus, ischiocavernosus, bulbospongiosus, transverse perineal, coccygeus, and anal sphincter—must be assessed for tone, presence of myofascial trigger points, and areas of muscle spasm and/or tenderness.

Traditionally, strength and motor control of the pelvic floor muscles have been assessed using biofeedback. Unlike biofeedback, a manual exam enables the therapist to assess the strength and quality of the contraction, as well as the tone of the musculature. Sometimes a therapist finds it beneficial to use both biofeedback and a manual assessment. The last component of the internal examination is palpation of the pudendal nerve for tenderness and/or a positive Tinel's sign, otherwise known as the Valleix phenomenon. Upon palpation, if a patient experiences sharp, shooting pain in the sensory distribution of the pudendal nerve, the test is positive. The nerve can be palpated for tenderness in four locations: at the ischial spine, at Alcock's canal, at the terminus of the inferior rectal branch, and along the dorsal branch.

To treat the pelvic floor musculature, the physical therapist

inserts one finger in the vagina or rectum to access the pelvic floor muscles. Manual techniques are employed to normalize muscle tone and motor control, and to eliminate myofascial trigger points. The techniques are performed by directly stretching the muscle, compressing the muscle, and/or using movement to achieve a muscle release. The most desirable technique should decrease muscle tone while causing only minimal discomfort for the patient. After a successful series of pelvic floor treatments, the muscles should have improved tone and motor control, and the patient should report less tenderness upon palpation of the muscles.

### **Myofascial Trigger Points**

Another common finding with patients who suffer from pelvic pain is the presence of myofascial trigger points in the pelvic floor and the muscles attaching to the pelvis. Myofascial trigger points (MTrPs) are hyperirritable spots, usually within a taut band of skeletal muscle or the muscle's fascia, that are painful upon compression. They cause referred pain, local tenderness, and autonomic phenomena such as abnormal sweating, persistent and profuse nasal discharge and tear secretion, and excessive lubrication. Trigger points also cause proprioceptive disturbances, such as dizziness, tinnitus, and distorted weight perception of lifted objects. Untreated trigger points can lead to motor dysfunction and muscle weakness of involved and surrounding muscles, and can interfere with adequate muscle lengthening. In the evaluation of a patient, the physical therapist should examine multiple muscles for MTrPs that could be contributing the patient's symptoms. The extrapelvic muscles that must be evaluated include the abdominal muscles, the iliopsoas, the adductors, and the gluteals.

After identifying the MTrPs, there are two manual techniques the physical therapist can use to eliminate them. In the first technique, the therapist manually compresses the trigger point for 60 to 90 seconds or until he/she can feel the trigger point "release." The second technique requires the therapist to compress the trigger point and instruct the patient to very gently contract the involved muscle 10 to 15 times, or until the therapist feels the trigger point release. The choice of technique depends on the preference of the individual therapist and the tolerance of the patient.

### **Adverse Neural Tension**

David Butler defines adverse neural tension as an abnormal physiological and mechanical response produced from nervous system structures when their normal ranges of movement and stretch capabilities are tested.

Manual therapy techniques are used to test for and treat adverse neural tension. To evaluate a nerve, a physical therapist needs to palpate all relevant nerve fibers along the length of the nerve, assessing for tenderness, swelling, and Tinel's Sign, and perform nerve mobility testing. If nerve

palpation causes shooting pain, Tinel's Sign is considered positive. If nerve palpation simply produces pain, this should be noted. Mobility testing involves lengthening the nerve via extremity movement (if the nerve crosses a joint) or by distracting nerve fibers within normal limits. The tests by themselves are limited and need to be paired with other physical findings and a thorough assessment to determine all factors contributing to the patient's symptoms. It is also important to remember concepts of referred pain and consider the tests may also place force or tension on mechanical interfaces that may be symptomatic themselves.

If a nerve is found to be under adverse neural tension, manual treatment can be approached three ways. The first approach is via direct nerve mobilizations (not stretches). This approach involves creating movement of the nerve, either passively by the physical therapist or actively by the patient. It is not therapeutic to stretch an inflamed nerve. The next technique is to treat problematic interfaces in order to take excessive tension or compression off of the nerve. Finally, indirect therapies, such as education and positional modifications, can help reduce symptoms while a patient is in treatment.

Prior to initiating treatment, a PT must consider the severity, irritability, and nature of the nerve-related symptoms and tailor the techniques to create a reduction, rather than an increase, in the patient's symptoms. The patient's presentation will guide the therapist to determine if the techniques will push the patient into the symptomatic zone during the treatment. The end result should always be a decrease in symptoms as the therapist repeats the treatment technique during the session. When the treatment is successful, the patient should report a decrease in intensity or elimination of their symptoms immediately after the treatment. However, it is normal for a patient to feel soreness, but it should be noted that soft-tissue soreness is different than their symptoms. As a general rule, a patient may report pain or discomfort during the technique; however, if the pain increases (versus decreases or remains the same) during the technique, the therapist should stop.

### **Structure**

The pudendal nerve can be significantly affected by abnormalities of the sacroiliac joint because it exits the sacrum and travels between the sacrotuberous and sacrospinous ligaments. Any deviation of the joint that can result in tension at the sacrum or that narrows the space between the two ligaments must be addressed. As multiple strategies exist to treat sacroiliac joint dysfunction, the therapist should determine which is best for their patient and the techniques should be incorporated into the treatment session.

### **Treatment Plan**

A typical physical therapy treatment program consists of one to four hours of physical therapy per week until the symptoms begin to decrease. As a patient's symptoms decrease, less

frequent physical therapy is required. The therapist will also make appropriate suggestions for lifestyle modifications and prescribe a home exercise program based on the clinical findings. The frequency, duration, and expected goals of physical therapy are dependent on the severity and longevity of the problem and the mechanism of injury. When creating functional goals for a patient, it is important for both the therapist and the patient to have realistic expectations.

### Interdisciplinary Treatment Approach

Because the symptoms of pelvic pain span several disciplines, an interdisciplinary approach is often the most successful. After other pathologies have been ruled out, it is reasonable to begin treatment with the most conservative approach (physical therapy). Additional medical treatments may be necessary or beneficial depending on the patient's presentation.

### Conclusion

The musculoskeletal component of chronic pelvic pain is significant, and if left untreated, can prevent a patient's condition from improving. An interdisciplinary approach, including manual techniques, can help a patient eliminate or manage his/her condition and restore their quality of life. Stephanie A. Prendergast, MPT, and Elizabeth H. Rummer, MSP



## Personal and Faculty Profile



Dr. Andrew Baranowski

I think that undergraduate medical education is formative for the future. I made a decision to study at Guy's Hospital Medical School because it offered not only a good scientific background to the understanding of medicine but also an early introduction to the clinical aspects.

Right from the start, the importance of a good history and clinical examination was emphasized. Those skills I still use on a daily basis, 25 years on! In many cases, diagnosis can be made from the history, the clinical examination, and any further investigations that primarily serve to either confirm one's initial thoughts or lend one to ask further questions.

When I was at medical school, it was unusual for students to take on an in-depth study to Bachelor of Science (BSc) level separate from the main medical degree. However, I was fortunate to be able to study to honors the subjects of Pathology and Basic Medical Science. I did not know at that time that this was going to be so important in my future career. However, it was partly because of that specialist

training that I was eventually to be in a position to study and undergo research with Patrick Wall and his colleagues.

Having qualified from medical school with both the standard medical degrees Bachelor of Medicine, Bachelor of Surgery, or in Latin *Medicinae Baccalaureus, Baccalaureus Chirurgiae* (MB BS) and my BSc Hons, I undertook my first "house job," or internship, on a general medical ward specializing in chest medicine and respiratory cancer. That was in 1984, about the time that the first preparations of slow-release morphine were being made available clinically. The nature of our unit was that we had many patients with complex cancer-related pain who required opioids. However, the skill in using the slow-release opioids was limited, and it struck me that this was an area where there was room for further learning and development. This idea and my thoughts on pursuing a career in pain medicine were something that I took with me to my next house job working on the professorial surgical unit at Guy's Hospital. My enquiries led me to understand that the best way to take forward a career in pain medicine would be via the anesthetic route.

Hospice care was still in its early days. It was in 1967 that the first purpose-built hospice, St. Christopher's Hospice, had been built by Dame Cicely Mary Saunders, but not until the 1980s that palliative care programs were beginning to develop. In those days, palliative care was very much associated with care of the dying. Both at Guy's Hospital and St. Thomas's Hospital, just down the road from Guy's, they had anesthetic lead units that worked with pain patients, whatever the nature of the pain. These units had been among some of the earliest in the United Kingdom.

Having completed my house jobs, and on the advice of the anesthetists, I proceeded to broaden my education in preparation for a career in anesthetics with an interest in pain medicine. I had always felt a degree of insecurity in the management of children and so started a six-month senior house officer training in pediatrics, which included work on the special care baby unit. I then went on to spend six months working in the St. Bartholomew's Hospital oncology unit based at Hackney. In those days, the hospital was not a purpose-built center for the management of cancer patients but an old Victorian building with a very traditional atmosphere. However, the oncology wards were a community in their own right, and the care the patients received was among the best available. The oncologists

were enthusiastically involved, not only in the clinical management of their patients, but also research. As junior doctors, we were expected to provide practical support for the research. One of the projects whom I was involved with at that time related to the use and pharmacodynamics of slow-release morphine. This experience cemented my career aims and led me to appreciate the importance of clinical research in pain medicine.

Following this, I spent the next six years training in anesthetics. I think we can always question whether or not this is relevant training for a consultant in pain medicine. However, there is no doubt that anesthetic training does include many components that are invaluable. My first anesthetic position was at a General Anaesthetics and Burns Unit, Queen Victoria Hospital, East Grinstead. The skills I learned during this time are always in the background, should I have a complicated case. It was also at that time that I first met Beverly Collett. She was my senior and responsible for my anesthetic training at that time. It's interesting how the two of us have proceeded along our own separate ways and ended up having so much in common. Despite Beverly not being involved in my pain training, something obviously rubbed off! I don't know if Beverly remembers giving me acupuncture for neck pain that was caused by my bad habit of cradling the telephone between my shoulder and neck. We still provide acupuncture in our center today.

Other formative memories that are a part of the anesthetic training include working with Professor Felicity Reynolds, who was the first female Professor of Obstetric Anaesthesia in the UK. I still lay out my interventional trolleys in the same obsessive way that she did. Indeed, one reason for continuing my anesthetic training at St Thomas's Hospital was because I knew that Felicity would not be able to examine me for my higher exams. She was precise in everything!

At St Thomas's Hospital, I also had the opportunity to train with Douglas Justins, who is now Dean of the Faculty of Pain Medicine, the Royal College of Anaesthetists, and Charles Pither. The first concept of a cognitive behavioral pain management unit was based at the Whittington Hospital. It was run by Shirley Pearce, a professor at UCL, and Peter Skinner. Charles Pither visited the center and several abroad, and this resulted in him setting up INPUT

at St Thomas's Hospital. It was my exposure to INPUT that taught me the fundamentals of pain management programs.

At the National Hospital for Neurology and Neurosurgery, Queen Square, there were also many formative experiences! Frank Kurer was the pain consultant at the time, and he encouraged me and was very supportive. Unfortunately, Frank became terminally ill at an early age. However, he will not be forgotten, and he was remembered by Anita Holdcroft and Sian Jaggar in their book, *Core Topics in Pain*, published in 2005 and in which I had the pleasure of being an author. Paul Nandi took over for Frank and today remains a very dear colleague—someone who is reliable and who will always give great thought and consideration to any clinical problem. In the pain department, I also had the opportunity to meet and work with Peter Nathan, one of Patrick Wall's contemporaries and one of the first pain medicine consultants in the UK. The influences of Peter and Patrick have also rubbed off on John Scadding and Geoffrey Schott, and as a result, Queen Square probably has more neurologists with an interest in pain medicine than any other center.

Most of my clinical pain medicine training took place at St. Thomas's Hospital, The National Hospital, Queen Square, and the Medway Hospital with Bob Buist. Paul Nandi and I inserted one of the first spinal-cord stimulators at Queen Square in a patient in 1993, and we continue to provide a service to this day. Before I leave this part of my training, I need to acknowledge that there are many other individuals who have influenced me, who I continue to mention and to think about on a regular basis.

While at St Thomas's Hospital, I was introduced to Patrick Wall and had the honor of being able to listen to him lecture on a number of occasions. He expressed an interest in my background, and with his support I went on to study for my Doctorate of Medicine (MD), a higher research degree for medically qualified doctors in the UK that requires a number of years of pure research. My research supervisor was Steve McMahon, and (as well as having a great opportunity of working with Steve) I was introduced to many other eminent scientists such as John Priestley, Praveen Anand, Clifford Woolf, and Tony Dickinson to name but a few. I also had the opportunity to work with Patrick Wall in his laboratory. My work was primarily aimed at the neurochemical changes that occur with nerve damage. However, we were also

interested in the changes associated with reinnervation. Some of this research involved the urogenital system, and it was as a consequence that I developed an interest in urogenital pain.

I spent two years in the laboratory learning about pain mechanisms and learning research techniques. The time was invaluable to enable me to broaden my reading. However, I had to go back into anesthetics to complete my training. Following that, I had to make one of the most difficult decisions of my career. Was I going to be primarily a clinician or a research scientist? I've always felt that those two years of laboratory have been two of the most important years of my career. However, my primary ambition was to be a clinician, and so when the opportunity to become the first consultant in pain medicine (that is the first with a formal contract) arose at The Middlesex Hospital—a major teaching hospital in London and a part of UCLH—I had to apply. I remain convinced the years in the laboratory where formative, and it was because of the understanding that I gained there and the opportunity that it gave me for learning that I was in a position to develop the service we now provide, which is among one of best in the UK. My only regret is that it is still very difficult to combine clinical practice, to develop a center (we now have a staff of around 50), and to combine that with clinical research. I have come to the conclusion that a team effort is necessary with separate individuals undertaking these activities.

When I started at what was the Middlesex Hospital, the urologists soon found out that, as a result of my previous research, I had an interest in urogenital pain. Therefore, at a very early stage in my consultant career, I started to run a specific urogenital clinic. At the very start, we integrated physical interventions with psychological and physiotherapy interventions. It has taken 15 years to formulate that process. As well as me, we now have another consultant, and the input of several physiotherapists and psychologists. The team is supported by administrative staff and management. Specialist nurses also run their own clinics. Along with urogenital pain patients, I continue to see complex neuropathic pain and spinal patients within the National Health Service. I also provide a spinal cord stimulator service and a sacral root stimulator service for pelvic pain patients. We are able to offer biofeedback and a range of physiotherapy and psychology interventions (both for individual as well as for groups) aimed at this

difficult cluster of problems. This year saw our first patients progressing through LINK, our cognitive behavioral program for specifically for urogenital pain patients.

Over the years, I have continued with basic clinical research, but more recently, I have become more involved in the application of translational research into guidelines. This has been particularly so in the field of urogenital pain, and I have contributed to guidelines and discussions within the UK, the rest of Europe, and the USA. This work is ongoing as we look to writing a classification system on urogenital/pelvic pain for IASP.

Teaching has been an important part of my consultant career. I'm currently a Regional Adviser for Pain Medicine for the Royal College of Anaesthetists, and as such I am working closely with the London Deanery for the provision of a Pan London Advanced Pain Training Programme. Progressively, we will see a greater integration of pain medicine training into the Deanery for all grades. In the UK, the current system is one of the Royal Colleges setting the standards for training, and the local Deanery ensures the training is implemented to that standard.

Over the past 14 years or so, I have organized meetings at the Royal Society of Medicine (RSM), looking at those areas of pain medicine that are not routinely covered by the other educational systems. The RSM is one of the oldest institutions in the UK providing continued medical education, and is currently one of the largest providers of accredited education in the UK. Pain medicine meetings have been held regularly at the RSM with the Anaesthetic Section often taking the lead. Over the past few years, we have been consolidating that effort, and last year at my instigation, the Council of the RSM approved the setting up of a Pain Medicine Subsection with the President of the Anaesthetic Section as President of the Pain Sub-section, and I was appointed as Vice President to the lead the sub-section through its formative years. Recently we had a meeting on "Ethics and Pain Medicine" where one of the problems discussed was the management of pain in the patient who was a drug addict but also dying with cancer. How do you manage their illegal drug-seeking behavior in the hospice setting?

During my training at St Thomas's, their Clinical Scientific Meetings that they organized jointly between the clinicians

and basic scientists made an impression on me. These meetings were free and accessible to anyone with an interest. When I was appointed as a consultant, right from the start I set up similar meetings within our department. Despite the fact that I no longer run these meetings, I am pleased to note that they are still ongoing, and all professionals with an interest can attend.

Over the years, I have been involved in numerous publications, and I have written many chapters. I've always considered the dissemination of learning to be important and was very pleased when my proposal for a book on urogenital pain was accepted with the first edition being published in December 2007. I believe this still remains the most definitive book on the topic available. I'm very grateful to all the authors who contributed to the 48 chapters within the book. Most of us write these chapters with little recognition and often no financial recompense.

PUGO was set up in 1998 at a meeting in Eilat, Israel. On the evening I was due to fly out to attend the meeting, there were government warnings of a possible missile strike from Iraq. As I was sitting in the airport listening to these warnings, I decided to go to the meeting, as I hoped that I would be sent back if there was any real threat! A small group of like-minded individuals attended the meeting, and I was elected as the Chairman-Elect. For a number of reasons, I was invited to take on the chairmanship earlier than expected and so became Chairman of PUGO in 2001 and served until 2005. During that time, my main aim was to raise the profile of urogenital pain, and to achieve this I started to work with a number of agencies. The most hospitable of these was the European Association of Urology, and they invited me to join them in writing their first chronic pelvic pain guidelines published in 2004. As chairman of PUGO, I also organized with my colleagues several meetings to raise the profile of the subspecialty. I have remained on the council of PUGO and continue to be involved in organizing meetings such as the collaborative meeting—"Update on Urogenital Pain: Current Issues and Controversies"—held in Glasgow in 2008 to coincide with the 12th World Congress on Pain.

Over the past year, it has become very difficult within the National Health Service in the UK as we strive towards a service that will see the patient and provide the initial treatment within an 18-week waiting time. For chronic

illness, these targets are difficult to meet. Prior to this initiative, my waiting time had progressively crept up to some 18 months. We either had to comply or risk being closed down. The management was very supportive, and as a result of a significant investment of staff, we had met the 18-week target. However, it resulted in a reduction of the priority for other activities, which at times can even be difficult to consider. Over the past few years, my main academic aim has been to consider the classification of urogenital pain and to work with my colleagues on a possible classification to be accepted by the IASP Taxonomy Committee. Every time I feel that we are near to completing that, new developments and new understanding occur. Although this can be frustrating, as we feel that we are never reaching our goal, it also makes the subject more fascinating.

I think the future for pain medicine in the UK is good. Recently the Chief Medical Officer for England and Wales published his annual report, and pain medicine was one of the five key points. Training in Pain Medicine is now established with the formation of The Faculty of Pain Medicine and their standards being accepted by many Deaneries. Urogenital pain medicine is being accepted by the various colleges of medicine, and specialists outside of the field are being educated in the subject. Over the past 10 years, I have chaired a group (now a charity) that aims to engage in a dialogue across cultures with other pain specialists and promote good standards of pain management. We achieve this through education by interactive discourse and lectures covering both the clinical management and the basic science of pain. There are many countries that still struggle for pain to be recognized as a separate condition and where appropriate management is denied. I hope that PUGO, through its international links, will be an instrument for change in the field of urogenital pain management across the world.

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