The Stanford Chronic Pain Self-Management Program

By: Glen Hutzul

Living with chronic pain equates to having a disability. Having a disability means living a life at less than full strength, but I believe that life can still be rich. Many of us need help to learn how to successfully manage our pain. One program that gives pain patients the tools to lead a rich, satisfying and fulfilling life is the Stanford Chronic Pain Self-Management Program.

This program is led by two co-leaders, one of whom must have chronic pain so that that facilitator can understand the participants’ pain. I have taken this program myself and found it to be very helpful.

There are four components to the program, as outlined below:

1. Each person with chronic pain is different
2. There are things you can do to feel better; one’s pain is not eliminated but these actions will help you to become more active and more involved in your life.
3. With knowledge and experience, each person will become the best judge of what works best for them.
4. The responsibility for managing your chronic pain day to day rests with each individual

This last statement is especially important as not all individuals are ready to accept this responsibility! Some look to professionals such as doctors and therapists to alleviate their pain. When the pain does not disappear completely, they begin to lose control over their lives and they lose hope. Learning to manage pain more effectively, a person regains control in his/her life and also gains hope that life can be better. In short, the program helps passive individuals become active.

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Building a Resource for Pain Patients

The journey for a patient learning to live with chronic pain is a difficult one. It’s challenging to navigate the system to find out what services and treatments available to help you manage your pain. Traditionally, we’ve relied on the family practitioner to provide this information, but that’s not always possible today.

The members of ACTION Ontario are advocating for the creation of a central resource that will answer the questions that are most common for patients with chronic pain. Questions like:

- Are there doctors who specialize in treating pain patients? How do I find one?
- If a specialist at a Pain Clinic prescribes medication for me but my family physician will not renew it, what are my options?
- Is there a central listing of out-patient hospital rehabilitation programs covered by OHIP?

• How do pain patients locate non-traditional therapies for pain management, such as acupuncture?
• Why is some pain classified as ‘chronic’?

ACTION Ontario feels there is need for a central index and a listing of currently available resources, created and updated by the Ontario Ministry of Health and Long-Term Care, that doctors, healthcare professionals and patients can use to locate the resources that are needed by those living with chronic pain. There are currently many, many resources available, provided by a myriad of organizations, but unfortunately, it is often very difficult to learn what they are and who provides them.

If you have questions or ideas about the resources available for pain patients that you would like addressed, please submit them to email@actionontario.ca.

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Project ECHO Ontario — Chronic Pain

Project ECHO Ontario was funded by the MOHLTC in Ontario in April 2014 to assist primary care physicians in remote, rural and underserved urban areas to manage their patients with chronic pain and learn best-practice for opioid stewardship. ECHO Ontario is modeled after the original project that launched in New Mexico in 2003 and follows the same fundamental principles for success:

- The use of videoconferencing technology (Ontario Telemedicine Network) to connect specialist/expert hub sites with community physicians and health care centres.
- Sharing of best practices to reduce variation in patient care.
- Supporting healthcare providers’ management of their patients through case based learning.
- Compliance with privacy legislation and monitoring outcomes of the project.

Primary care physicians and other healthcare providers who participate in ECHO Ontario become part of a larger knowledge network. These providers meet weekly through videoconferencing sessions with an inter-professional ‘hub’ of pain and addiction experts located at the Toronto Rehabilitation Institute and at Queen’s University. The two-hour weekly sessions include a didactic (instructive) presentation by a hub member or guest speaker followed by cases presented by the community ‘spokes’ from all over Ontario. All case presentations are de-identified and feedback and suggestions are provided first by the spokes in the community and then by the inter-professional team at the hub sites. Healthcare providers who participate in ECHO gain professional interaction with colleagues, access to specialists, and no-cost continuing medical education (CME). There is also tremendous benefit to patients living in remote areas who can now receive best practice care without long waits or having to travel long distances for consultations with distant pain specialists. ECHO moves knowledge, not people.

ECHO Ontario completed the first cycle of the project, including 32 weekly sessions, in February 2015. During this first phase ECHO linked with over 25 primary care sites across Ontario, mentored over 100 healthcare providers, and issued over 1000 CME hours. ECHO participants reported improved pain assessment skills, less professional isolation, better understanding of safe opioid prescribing, and more confidence treating chronic pain patients within their local communities.

ECHO Ontario has launched a second cycle with a new curriculum for 20 weeks and plans to host hands-on pain management workshops in Thunder Bay and Kingston. As Project ECHO Ontario supports increasing numbers of healthcare providers through this model there will be an expanded capacity for best care practices in some of the more underserved areas of the province.

ECHO continues to recruit primary care providers to join the ECHO program and invites interested community healthcare providers to visit www.echoontario.ca for more information and how to register for the ECHO program.

THE ECHO HUB & SPOKE MODEL: Connecting inter-professional expert HUBS with a network of community based healthcare provider (PCP) SPOKE sites

www.actionontario.ca
ACTION Ontario – Moving the needle on chronic pain in Ontario

By Dr. Angela Mailis-Gagnon

In March 2005, myself and other colleagues came to the table to form ACTION Ontario with a goal of improving the diagnosis and care of Ontarians living with neuropathic and other forms of chronic pain. In 2007 People with Neuropathic Pain, the patient group of ACTION Ontario, was born.

ACTION Ontario hosted three symposia during National Pain Awareness Week to bring light on the need to address pain. In November 2008, the first symposium was titled Neuropathic Pain: One Face, Many Causes. The second, in November 2009, was Towards an Ontario Pain Strategy. In November 2010, ACTION Ontario hosted its third symposium titled Patient Input for System Change, and held its first Chronic Pain Awareness Day at the Ontario legislature.

In March 2009, the issue of abuse of opioids was brought to the forefront and the Ontario Ministry of Health and Long-Term Care (MOHLTC) sought a number of pain experts to assist in addressing the problem. I was one of those experts and the then Assistant Deputy Minister of the Ontario Public Drug Programs promised us that this was only the start of changes in the provincial scene of pain management. The Narcotics Advisory Panel led to the creation of the Narcotics Safety and Awareness Act.

At public hearings on the Narcotics Safety and Awareness Act at the Standing Committee on Social Policy, health care professionals and patients told the members of the Committee that chronic pain was a huge problem and needed a comprehensive approach. Days later I received a call from MOHLTC and I participated wholeheartedly in the birth of a precious document, the Blue Print for a Comprehensive Pain Strategy in Ontario.

A pediatric network has been created and is been supported between four major cities; The adult academic pain centres in the province are currently collaborating to create a similar network for clinical care, education and research; Additionally, the Ministry is facilitating the development of a strategy for all adults in chronic pain across the province.

Things gradually changed. By now:
Pain services have been enhanced within the Family Health Teams;
The ECHO project spearheaded by a member of the ACTION board together with a group of academic leaders, became the first telemedicine educational program to reach remote communities and train health providers across the province and was funded for a three-year project at the UHN by 1.33 $M in June of 2014;
ACTION Ontario, the PNP Steering Committee (patient group), myself and members of the Board have been there in each of these steps, actively participating in the process.

What does the future hold?
The Ontario Ministry of Health and Long-Term Care is looking to address a series of initiatives within the Comprehensive Pain Strategy. The realization that chronic pain is a huge problem for our society has come to policymakers some time ago. Doing nothing to address it, particularly as chronic pain prevalence increases rapidly as we grow older, is not an option. ACTION Ontario (our patient group and our board) continues to be in the forefront of these initiatives, fulfilling our vision and mission to facilitate changes, educate and advocate on behalf of the sufferers. Managing pain properly should not be a privilege, but our right.

Preventing chronic pain

The importance of vaccination has been in news recently due to measles outbreaks. You may wonder, however, what vaccination has to do with chronic pain.

An important aspect of chronic pain management that is often overlooked is the opportunity for chronic pain prevention. Although neuropathic pain often does not always have an obvious detectable cause, there are some definite, known common causes. By proactively addressing these causes, some incidences of chronic pain can be avoided. One such cause is shingles, whose incidence can be reduced by around 50% through vaccination.

Given the opportunity to greatly reduce the incidence of shingles through immunization, ACTION Ontario would like to urge the Government of Ontario to move forward on one of the prevention elements of a comprehensive pain strategy by initiating a publicly-funded shingles vaccination program, which would help reduce the incidence of shingles and neuropathic pain, and consequently, the associated costs of healthcare.

Mira Steranka, a Mississauga resident in her 60s, has been living with postherpetic neuralgia, or nerve pain that lasts after the rash and blisters from shingles has disappeared, in her eye for 10 years. “From my experience, it would be more cost effective to prevent shingles than to treat it when it happens. When you have shingles or postherpetic neuralgia, you can’t work and the cost to the healthcare system in time and resources is more than the cost of prevention,” said Mrs. Steranka.
Medical Marijuana, another tool in our tool box to face Neuropathic Pain

By Dr. Kevin Rod

Neuropathic pain is not a rare condition. Approximately 2-3 percent of people who live in developed world suffer from this condition. This means that around one million Canadians are dealing with this problem right now. When it comes to problems, the only good thing about the word MILLION is that it grabs our attention.

I have the privilege of being a pain physician and a neuropathic pain patient at the same time. This gives me a better perspective of the view from both sides of the physician’s desk. Above all, I have felt and understood the frustrations of a neuropathic pain patient. For many other medical conditions there are tests that can exactly show a structural problem that is causing the condition. Once the test results come back, there is usually a surgeon who can fix it with a knife or a doctor that can help it with a pill. But when it comes to neuropathic pain, it becomes different story. To begin with, Neuropathic pain is an umbrella term for a wide selection of different diseases that can cause it. Each of these hormonal, traumatic, viral, ischemic or other causes have a different natural history, course of behavior and as such respond differently to treatments. Their level of progression or severity can affect the presentation of neuropathic pain in different shapes and forms.

Neuropathic pain once established is a very uncomfortable condition. When we have a condition like that, we like to have a test to get to the bottom of the problem and a quick solution for it, so we can get on with our lives. Unfortunately, most of the times we can’t have that with neuropathic pain. That is when frustration builds up for both patients and pain practitioners. As patients we are looking for answers and can’t care less for the evidence and guidelines that doctors are looking for. As doctors, we have the goal of making patients better without ever harming them.

In order to help them and not harm them, we have to look for evidences and follow the guidelines. Dr. Angela Mailis, Dr. DE Moulin and other colleagues have published a descriptive consensus statement and guidelines from Canadian Pain Society on Pharmacological management of chronic neuropathic pain in 2007. This guideline put Cannabinoids as the Fourth line of treatment. It means that there are other classic and accepted groups of medications that should be tried first before resorting to cannabis or products from this family.

Currently the courts have allowed patients to have access to dried marijuana if a doctor would recommend it through a medical document. It is something like a prescription but because Health Canada does not recognize Cannabis as medication yet, we don’t call it prescription. However, the College of Physicians and Surgeons of Ontario has decided to consider it as a prescription to make it simple for everyone involved. This document should have the patients name and address, the amount of marijuana allowed per day and the duration of validity of the medical document in order to be accepted by one of Health Canada’s approved licensed producers. The patient will send it to the producer and they would sell it to the patient by sending it to the patient’s home address.

So what is the problem?
The problem is that patients can get all the lung hazard of smoking with smoking marijuana. Young patients of less than 25 years old may have long lasting cognitive impairments with regular use of marijuana. Patients may have a higher risk of car accidents if drive after smoking. Mixing marijuana and alcohol can majorly increase the cognitive impairment. Mixing it with tobacco would increase the risk to patient’s lungs and there is some reports of increased risk of lung cancer with smoking marijuana. It is not a cure for all as some may believe. Patients with history of mental disorders may do poorly on marijuana and it may aggravate schizophrenia presentations. Despite the common belief of many users, there are some people who do get addicted to marijuana. Increasing urge to use more in daily use, spending a lot of time and money on acquiring marijuana, decline in social and professional performance and continuation of use despite the knowledge of harm are among the signs of addiction to marijuana.

Doctors do not have enough information about when and how to use it as there is no national guidelines there yet. There is not enough information and experience available for the doses of cannabis for different medical conditions.

On the side of evidence, there is some evidence of effect for medical marijuana in Multiple Sclerosis muscle spasms, and in Neuropathic pain as a fourth line agent to be tried. The suggested doses are different by different sources and everyone is going through a learning curve at this point. However, none of the sources supports a daily high dose of cannabis for neuropathic pain. The Health Canada literature on Medical Marijuana suggests that most patients would benefit from a dose of 0.5 grams to 1.5 grams of marijuana a day. A recent article from Dr. M. Kahan in Canadian Medical Association Journal suggests a dose of 0.4 gram and using harm reduction strategies for high dose and frequent users. The message is, if it is going to work, it can work at lower doses and there should not be a need for high doses. Lower doses would be associated with less risks.

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Doctors and patients need to be a lot more educated about this. At our Toronto Poly Clinic Medical Marijuana Program, we have a patient educational program that patients agree to follow once they are approved to be on this program. We are also gathering the baseline information before use about state of pain, sleep, mood and function followed by their re-evaluations after use in different intervals based on the level of risk for each patient. We hope that we would all learn more about effects and side effects of these treatments by close observation and unbiased research.

We all hope for the final silver bullet treatment that would solve all our problems in one shot. At this stage, Medical Marijuana cannot be that for us. It is just another tool in our tool box for facing Neuropathic Pain.

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Some of the issues that the group discusses in class are:

- Understanding pain’s components
- Hurt vs. Harm
- How to become an active Self-Manager
- Learning how to pace activities
- Solving everyday problems
- How to improve communication [i.e. with health professionals, family]
- The Moving Easy Program [combining flexibility exercise with strength training]

The segment that I personally found most useful was “Solving everyday problems”. I’ve participated in other pain management programs but the emphasis seemed to be on the individual solving his/her problems. The Stanford Program asks the group to ‘brainstorm’ and come up with as many alternative solutions to his/her particular problem as possible. After 6 weeks, we’ve learned to ‘stretch our brains’ a little and think a little more creatively. Problem solving becomes a little easier; we tend to become a little less self-critical and finally, after sharing for 6 weeks, we don’t feel quite as self-conscious about having chronic pain. This makes the problem-solving process (and the resulting solution) broader and more accessible.

Results? Research shows that those who take the program experience more vitality; less pain; less dependence on others; improved mental health; more confidence and become more involved in everyday activities.

In addition to the chronic pain program, there are also self-management programs for Chronic Disease; Diabetes; Arthritis and HIV. The cost of materials for each course (for workbooks which each participant keeps) is $25 for each participant. A list of organizations that offer the Stanford programs can be found at: patienteducation.stanford.edu/organ/.

For more information on Action Ontario, please go to our website www.actionontario.ca
Pain is a fact of life. Everyone experiences it sometime, with back pain being the most common. Often, the pain signal results from a vicious cycle of structural damage, tissue breakdown and inflammation, leading to chronic, long-term pain that drastically impacts every aspect of a person’s life. Effective treatments are limited in providing lasting relief. Often, frustrated people turn to natural and complementary approaches when they no longer get adequate results from medications. There are many different natural options making it very confusing in determining what approach would be most beneficial for your specific condition.

Are you deficient in the sunshine vitamin and magnesium?

Deficient levels of both vitamin D and the mineral magnesium play such an essential role in nerve function and pain signalling for chronic pain patients. A study published in November 2012 found that certain types of pain are related to vitamin D deficiency. Results indicated that 95.4 percent of the subjects were vitamin D deficient, and 85.5 percent of the subjects had improvement in pain with vitamin D supplementation. Multiple studies found that vitamin D deficiency may be responsible for generalized, non-specific pain especially if it is resistant to manual and conventional treatments. Vitamin D can be a simple yet very effective therapy for chronic, non-specific pain if you are deficient. To determine if it may be contributing to your pain, have a qualified healthcare practitioner assess your serum levels and supplement appropriately (with high enough doses) to restore your optimal levels. The biggest mistake people make is that they don’t take high enough doses and then fail to monitor levels to see if the vitamin D levels are increasing.

Magnesium is a mineral that is involved in over 300 biochemical processes in the body. One of its most important functions is that it plays a key role in producing energy and maintaining muscle and nerve function. Specifically in chronic pain, magnesium can be helpful for offsetting the effects of too much calcium which causes muscle spasms and tightness. Magnesium acts like a plug in nerve receptors that are over-stimulated. The problem is that most people do not have sufficient levels of magnesium for optimal health. People with chronic pain are especially deficient. A gradual depletion of nutrients from our soils has left many foods with lower levels of magnesium. Another factor that contributes to magnesium deficiency is that is often is depleted by various common conditions (i.e. IBS, Crohn’s disease) and medications (i.e. proton pump inhibitors, diuretics). Various forms of magnesium are available. For example, magnesium oxide is not well absorbed and can have a laxative effect while magnesium glycinate is much better tolerated and absorbed. Ask your integrative healthcare practitioner which form and dose is best for you.

Stop feeding your inflammation

All chronic conditions such as cardiovascular disease, cancer and chronic pain have a strong and persistent link with chronic inflammation. Eating a diet high in refined fats and sugars encourages inflammation while eating a balanced diet with unrefined good fats (like omega 3s), low amounts of refined sugar, and high in nutrient rich, plant based foods reduces inflammation. Sugar is one of the biggest drivers of inflammation with a key source being refined carbs like bread, pastries and pasta. These are rapidly converted to sugar. Sugar also promotes weight gain and is linked to diabetes. Emerging research is showing that refined foods such as a breakfast sandwich can rapidly increase inflammation right after consumption. To break the cycle of inflammation and pain it is paramount to limit foods that promote damage. On the flip side, culinary spices such as ginger and turmeric are now being intensely studied on their ability to quench inflammation right at the cellular level. Speak to a nutrition expert to help you identify which foods to stop and which ones to start eating.

Cut out food sensitivities and allergies

Knowledge of food allergies, food intolerances and food sensitivities has been growing rapidly over the past few years. People are discovering that certain foods have the power to negatively impact their health. Unlike typical allergies (like peanuts or a bee sting), food sensitivities and intolerances do not cause acute and severe reactions but rather cause a low grade, chronic effect that can be responsible for a wide range of symptoms. These effects happen slowly over a period of hours or even days. This makes it much more difficult to identify a food sensitivity, or intolerance. A key concept to understanding why food intolerance has such a powerful and wide ranging effect is the connection of our digestive tract and immune system.
Natural Evidence continued from page 7

Food sensitivities cause chronic irritation and inflammation of our digestive tracts, which results in our immune systems being over stimulated and becoming sensitized to normally harmless food particles. To identify what specific food intolerances you can either stop eating the most common food allergens and then reintroduce them or get a food allergy blood test, which assesses your immune response to the most commonly allergic foods (dairy, wheat, eggs, soy). For people with chronic pain, migraines, skin conditions, digestive upset, autoimmune disease and IBS assessing food sensitivities is a key step to break the viscous cycle of inflammation.

Get the Help of Naturopathic doctor

Which remedy will work for you? One way to take the guessing out of your decision is to work with a board certified naturopathic doctor (ND). They are trained in the art and science of both conventional and alternative medicines. ND’s integrate standard medical diagnostics and utilize a broad range of natural, evidence based therapies (such as herbal medicines, vitamins and nutrition) as opposed to just pharmaceutical drugs. Additionally, naturopathic medicine believes that each individual is unique and, therefore, each treatment plan should be tailored to that patient and their unique health concerns. ND’s are often the “Sherlock Holmes” among healthcare practitioners since they use a very unique approach to assessing patients. Many chronic pain patients visit an ND after no other doctor or healthcare practitioner is able to help them or get to the bottom of their symptoms. It’s important to work with a healthcare practitioner and inform him/her of all your medications and supplements that you are taking since there can be interactions with some medications you are currently using.

Profile: Joe Italiano

For Joe Italiano, “the pain is still here and will always be.” Joe is not able to function in everyday living like he used to. Joe is off morphine now and is on hydromorphone instead, which has the same type of effect, but helps him stay more alert.

Unfortunately, Joe’s story is one of “falling through the cracks.” It took five years post-surgery for Joe to get into the pain clinic. Why did it take so long to get there? To get the answer to this and to make sure his healthcare was being handled appropriately, Joe and his wife, Michelina, hired a case management firm that lead them on a trail of issues. Joe understood his case was complex but no one was ever changing strategies to find what will work for you. The decision to hire a case management firm was based on a myriad of issues. Joe understood his case was complex but no one was explaining the “why” of his pain or open to providing him with the opportunity to discuss Dorsal Column Spinal cord stimulation (DSC) therapy. The tipping point came when a doctor wouldn’t allow Joe to get an MRI done in the U.S. as he had done previously (due to his severe claustrophobia Joe must use an open MRI).

When someone recommended to Joe that he hire a case management firm, Joe and Michelina were hesitant due to the cost – they had depleted most of their savings at this point. However, they were at the end of the line with the current management of Joe’s care.

The case management firm went through all of Joe’s medical reports and put together a clinical summary to send to U.S. doctors. Two specialists in the U.S. responded and both indicated that Joe could be a candidate for DSC; however, Joe would have to find a Canadian surgeon who would agree with the need for surgery.

Today, Joe regularly sees the inter-disciplinary team at Dr. Angela Mailis’ Pain & Wellness Centre. However, recently, every 7-10 days, Joe experiences a 24-hour coma and he sleeps all day because his body seems to be storing hydromorphone and releasing it all at once. The next morning, Joe doesn’t remember the day before at all.

“Living with pain is constant journey that requires everchanging strategies to find what will work for you to be able to manage, and live with, your pain,” said Joe.

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“Living with pain is constant journey that requires everchanging strategies to find what will work for you to be able to manage, and live with, your pain,” said Joe.

After 10 months of family doctor visits and countless specialists’ appointments, Joe heard about Dr. Fred Gentili, Deputy Chief of the Division of Neurosurgery at Toronto Western Hospital. Joe asked for a referral and was seen almost immediately.

Dr. Gentili successfully isolated the issue by looking at the thoracic spine, which no one had looked at yet. Joe went for another MRI, this one specifically for his thoracic spine.

The MRI images showed calcification around vertebrae T9 and T11 that caused compression on the spinal cord and not allowing nerve flow and blood flow back up to the brain. Joe had emergency surgery to remove the two calcified fragments and immediately Joe was able to move his toes.

Waiting with pain

After surgery, it took four weeks of rehab for Joe to learn to walk again. He was told that it would be a six-month wait to get into the pain clinic. After a few referrals that went nowhere, and no answers as to why, Joe and his wife Michelina hired a case management company to look into his case.

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“Living with pain is constant journey that requires everchanging strategies to find what will work for you to be able to manage, and live with, your pain,” said Joe.
When I opened up my new pain clinic in Vaughan in September 2014, I did not know what to expect. The clinic is located in the heart of Vaughan/Woodbridge, away from downtown Toronto. My ambition and goal was to create a truly interdisciplinary team offering pain services under one roof in York region, the first of its kind, bringing truly best practices and science to the community. I put together a team of several professionals, many of whom come from my own Toronto Western Hospital program (pain physicians, an electrophysiologist, a psychologist, a neuropsychologist, a naturopathic doctor, a Mindfulness trained facilitator and manual therapists such as chiropractors, an osteopath and massage therapists). I wanted to offer all the things under one roof, things that my patients have been asking. This means, I wanted to create the impossible: a centre that would be able to offer all kinds of services, such as traditional western style medicine with diagnostic tests, medication, injections and surgery if needed (of course, some of these would be referral based and not done at my centre); psychological services (one-to-one, all the way to group therapy); manual therapies (including multiple modalities and active exercise therapies); nutrition and lifestyle counselling; mindfulness based chronic pain management; and self-management approaches for preservation of wellness and control of chronic pain.

A medical referral is needed by patients in order to see our medical doctors. However, such referral is not needed to see our manual therapists, psychologists or naturopathic doctor, with most non-medical treatments not funded by OHIP. While some patients may have extended health benefits, many don’t or if they do, they are not sufficient.

In the first 3 ½ months of the clinic’s operations, I have come to some astounding realizations:

- 30% of all the patients referred are between the ages of 65 and 97 years! The need for pain management in the older population of this community is heart breaking (if one considers that seniors are no more than 15% in the Comprehensive Pain Program downtown). More than half of the seniors have serious and multiple medical problems.

- While downtown I see almost equal numbers of females and males, in my Vaughan clinic I see three times more women than men. This puzzles me as I never expected to see such a gender difference.

- One in two patients 18-65 years of age (this means working age group) despite chronic pain, are at work, as compared with only 20% of patients who attend my downtown program.

- While 65% of patients are on opioids when referred to the downtown program, in my Vaughan clinic I can count in one hand the patients on strong analgesics, as this population seems to have a strong aversion for drugs. However, I am making some headways convincing my elderly patients that small doses of proper painkillers can make a dramatic difference in the quality of their lives.

To top this up, within 3 ½ months, I am now as busy as I am in the downtown hospital. The need for pain management in the community is truly immense, something that caught me off guard.

So here are some examples of what I see:

A 48-year-old businessman was referred to us from Orangeville three weeks after a considerable car accident that left him with concussion symptoms and cervicogenic headaches. Three weeks of intense therapy by our manual therapists has made a huge difference and the man is getting ready to return to work.

A 68-year-old retired real estate broker had three serious neck surgeries that left him with severe nerve damage and intractable neuropathic pain. He was sent to me after he attempted suicide with and extremely painful chronic joint scarring. Within a week we had arranged for an urgent appointment with one of the expert orthopaedic surgeons at the Toronto Western Hospital while combination of low dose opioids and antidepressants/neuropathic drugs helped with her pain until she had her surgery a month later.

A 51-year-old bank manager with a weak left leg from old polio broke her thigh bone slipping on her staircase at home 1 ½ years ago. By the time I saw her, she had three consecutive knee surgeries and was left with a permanently straight and fixed knee, which was hot, swollen and extremely painful due to nerve damage and extensive joint scar tissue. Within a week we had arranged for an urgent appointment with one of the expert orthopaedic surgeons at the Toronto Western Hospital while combination of low dose opioids and antidepressants/neuropathic drugs helped with her pain until she had her surgery a month later.

A 68-year-old retired real estate broker had three serious neck surgeries that left him with severe nerve damage and intractable neuropathic pain. He was sent to me after he attempted suicide with alcohol and overdosing on his medications. Concerted investigations and care made a huge difference. He has pulled out of his serious depression, his pain is manageable (he refuses medications anyway), and he came to see me last week to announce that he is doing much better, he thanked me repeatedly for the care we gave him, and told me he is returning to part time real estate work.

An 86-year-old woman came accompanied by her daughter (a picture I see all the time in my Vaughan clinic). She spoke little English. She barely took a few steps on a roller walker as her knees were both literally shot, but she would never consider surgery. I prescribed pediatric doses of liquid morphine (actually we have a paper submitted for publication with my downtown team on the great effects of liquid morphine on the elderly). Two weeks later, she came to hug me as “she is 90% better”.

To make the long story short, the immense need that exists in the community truly took me by surprise.

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