

*The American Association of Neurological Surgeons and
the Congress of Neurological Surgeons Joint Section on*



Pain



n e w s l e t t e r

Message from the Chairman

Perhaps few persons who are not physicians can realize the influence which long continued and unendurable pain may have upon both body and mind.

This quote from Weir Mitchell begins White and Sweet's 1955 classical book, "Pain: Its Mechanisms and Neurosurgical Control". Mitchell wrote in 1872. Sweet wrote in 1955. Today, when so much can be done to alleviate chronic pain, the majority of physicians either fail to appreciate the wisdom of this statement or are unaware of what neurosurgery has to offer when all other methods of treatment save narcotic drugs have failed. Have we advanced beyond this concern or have we actually retreated? Sweet continues in his introduction, "As far as pain is concerned there is no justification for release from life by euthanasia".

Modern surgery for pain control began with attempted peripheral neurectomy for tic douloureux. Marechal tried sectioning branches of the infraorbital nerve for several patients of Nicolaus Andre as he reported in 1756. He failed. Horsley, however, succeeded in excising the Gasserian ganglion for tic pain in 1891, more than one-hundred years later. Letievant published an early text on the surgery of pain, perhaps the first, in 1873, focusing on neurectomies for facial and extremity pain.

Where do we stand today in the treatment of pain? The Joint Section on Pain has completed a sequence of symposia on neurosurgical intervention in chronic pain and published the last on a CD-ROM. Computers have transformed our educational technology, yet the unsolved problems Sweet proposed in 1955 remain unsolved. Frequent failure to benefit herpetic and other neuralgias of the face other than classical tic douloureux, certain painful phantoms following amputation, and



Jeffrey Brown, M.D.

the intensely disagreeable sensations which sometimes follow injury of the spinal cord and peripheral nerves serves to remind us that we still have much to learn.

At upcoming meetings of the AANS and CNS our scientific presentations still focus on these issues. We will present "mini-symposium" at the Pain Section afternoons in Seattle at the CNS. The first day will focus on pain management in a clinical practice. Robert Levy will speak on "Building a Pain Practice". Kim Burchiel will discuss "Understanding Pain Management: A Core Curriculum".

Richard North will follow with a review of "O u t c o m e s Assessment" in pain neurosurgery. The second afternoon symposium is titled, "Neurosurgical Management of Chronic Pain". Ken Follet will review "Pain Types and Basic Treatment Considerations". Joel Seres has the task of analyzing "Rational Long-term Use of

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Opioids". Finally, the technical aspects of neurosurgical pain control will be reviewed by Jamie Henderson, "Applications of Augmentative Techniques" and Nick Barbaro, "Applications of Ablative Techniques".

This year, the honored guest of the CNS, is John M. Tew, Jr. who has expanded on the work of William Sweet, further developing the technique of radiofrequency thermal rhizotomy for treating trigeminal neuralgia during the course of his career. On the final day of the meeting, there will be a symposium on the neurosurgical treatment of trigeminal neuralgia. Ron Apfelbaum will review microvascular decompression. I will look at percutaneous treatment and John Tew will provide an overview based on his more than two decades of experience.

Our Satellite Symposia have been quite successful, well attended and well reviewed. We will present another during the upcoming AANS Annual Meeting in New Orleans in 1999. All the didactic presentations of the Philadelphia symposium, "Interventional Therapies in the Neurosurgical Treatment of Pain," are available on a CD-ROM offered for sale by the Joint Section on Pain. Each lecturer's slides have been digitized and synchronized to the speaker's audio presentation. The slides can be reviewed individually, separate from the audio if one wishes. In some cases, especially tables and graphs, the slides can be enlarged to more clearly review them. There is a film presentation on the surgical techniques for spinal infusion pump implantation. The CD-ROM is suitable for Macintosh or IBM computers. The cost is \$250. It is considerably less than the registration costs of the symposium. The CD is consistent with modern concepts of "asynchronous learning", learning at one's own pace in one's own environment that is the cornerstone of advanced academic teaching methods.

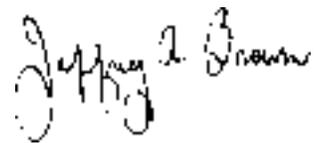
Too often we as neurosurgeons who treat pain focus on quantifiable data, techniques and technology in our formal presentations and miss a sensitivity to our patients' expression of inner pain and suffering. We should take one moment to reflect on the meaning of our work.

Colleagues:

Enclosed in this issue of the Pain Newsletter is an application for membership in the Joint Section on Pain (see page 11.) We encourage you to forward this application to colleagues with interests in pain management.

The goals of the Section are to assure the highest quality of medical care for the management of patients with pain problems and to assure an appropriate socioeconomic and political climate conducive to the effective and efficient delivery of medical care to patients with pain problems.

This summer I had the opportunity to visit Rome and to review how classical Roman artists depicted the anguish and joy of man in marble stone and layered oil paintings. They could not treat, but they could indeed understand how man's endurance of pain affects the soul and they expressed this as clearly as it has ever been stated. Grand issues were depicted as Olympian struggles with gods and giants. "The Laocoon" and the "Dying Galation Soldier" are representative Pergamon sculptures, art that was commissioned from the wealth of Alexander's conquests. "The Laocoon", a statue of a priest who defied Apollo's wishes for a gift horse to lead to Trojan victory, is depicted in the acute anguish of pain with his gaze toward heaven, his face animated, open-mouthed and challenging. This is acute pain. Chronic pain and suffering is viewed differently. "The Dying Galation Soldier" has his face dropped downward toward earth, eyelids hanging, half-closed, mouth partially open, jaw sagging, as if the energy to demonstrate expression is now depleted. "For there is nothing that abateth so much the strength as pain". Ambrose Pare is said to have written, as quoted by Sweet. The treatment of chronic pain is the re-infusion of that energy into the soul. It is a worthwhile undertaking. I am pleased to have led this Section for the last year towards that goal.



*Jeffrey Brown, M.D.
Medical College of Ohio*



Drs. Jeffrey Brown and Sean Mullan

Dr. Jeffrey Brown (right), Chairman of the Joint Section on Pain with Dr. Sean Mullan, innovator and pioneer in the area of surgical treatment of pain and application of stereotactic principles to cerebrovascular and other disorders.

Message from the Editor

I was privileged to be a guest at the 19th Annual Scientific Meeting of the Australian Pain Society in Tasmania, in March 1998. The official opening of the Annual Scientific Meeting was made by the Honourable, Sir Guy Green, A.C., K.B.E., Governor of Tasmania at the meeting in Hobart, Monday, 30 March 1998. I was very impressed by the Governor's opening remarks as they seemed to distill much of what we feel our current mission and opportunities are in pain medicine. I met the Governor and he was obviously an erudite and congenial gentleman. I should add that he composed these opening comments based entirely upon his own research, going over the proceedings of the ISAP Meeting in Vancouver. It is remarkable that a politician would take the time to do this research and develop such a worthy product. I thought you would enjoy reading this.



*Kim Burchiel M.D., F.A.C.S.
Oregon Health Sciences University*

**OPENING REMARKS
19TH ANNUAL SCIENTIFIC MEETING AUSTRALIAN PAIN SOCIETY BY THE
HONOURABLE SIR GUY GREEN A.C., K.B.E, GOVERNOR OF TASMANIA
HOBART-MONDAY, 30 MARCH 1998**

I would like to add my welcome to you all to this conference. I would like to extend a special welcome to Tasmania to all our visitors from interstate and overseas. We are delighted to see you here and I do hope you find the time to enjoy some of the many attractions Tasmania has to offer.

The work of the Australian Pain Society and the holding of scientific meetings of this kind fulfil an increasingly important function.

As you know, in recent years significant developments have taken place in the way in which pain is perceived and how it is managed and treated.

The concept of pain as a distinct disease entity is becoming more widely accepted with the result that pain management is being seen not as merely ancillary to some other branch of medicine but as a speciality in its own right.

At the same time, recent advances in a number of areas including neurophysiology, neuropharmacology and the psychological aspects of pain such as its relationship with post traumatic stress disorder and compensation neurosis have led to greater recognition of the multidimensional nature of pain and the need for a multidisciplinary approach to its management. That is well illustrated by the syllabus materials for refresher courses published by the International Association for the study of pain in 1996 in which it was recognised that in order to adequately cover the field no fewer than 19 distinct courses had to be provided.

Your society and meetings of this kind perform an important function by encouraging the perception of pain as a distinct disease entity and by encouraging a multidisciplinary approach to its management and treatment.

Your society also makes a valuable contribution to improving the management and treatment of pain by promoting research and facilitating the dissemination of new information. Your work also has significant economic implications. Federal health authorities classify pain along with diabetes and asthma as one of the major components of the cost of health care in Australia, it is being estimated that pain costs the system something like \$14 billion (Australian) per annum.

An innovative feature of your meeting is the holding of an all day symposium on opioids and non-cancer chronic pain. As many of you would be aware that is an area of special interest in Tasmania. The Tasmanian opium poppy industry is the only



*Kim Burchiel M.D. and The
Honourable Sir Guy Green A.C., K.B.E.*

lawful producer of opiates in the Southern hemisphere and supplies about 40% of the world's needs. The industry's heavy investment in research and its development of new poppy varieties, new sowing techniques, a highly mechanised harvesting process and advanced technology have made it the most efficient poppy industry with the highest opiate alkaloid yields in the world. And could I say that whilst no one in Tasmania would ever want commercial considerations to influence clinical judgement, I suppose that if it turns out that your considered view were that the greater use ought to be made of morphine based opioids, we would not be altogether unhappy.

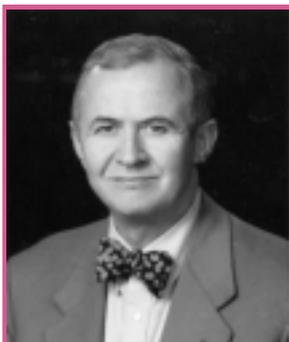
Although I appreciate that you are primarily concerned with the practical aspects of your field I must say that I think that it also raises some most interesting philosophical issues.

The idea that there is a relationship between the intractability of pain and its survival value is of real interest for the philosophy of biology: the concept of the relief of pain as a basic human right which has been advanced by Professor Cousins of the University of Sydney raises important questions for moral philosophy, whilst the association between the psychology of pain and its physiological consequences, such as changes in neurons and neurotransmitters, throw light on the mind-body problem. I know that you would not have much time for indulging in idle speculation about questions of that kind but I think that those aspects of your field do raise really fascinating questions.

You are engaged in an important, intellectually demanding, rapidly developing field which is of great significance for the quality of life of an enormous number of patients and for the economy of our country. I extend my best wishes to you all in your endeavours and hope you have a most enjoyable and rewarding meeting.

I have pleasure in declaring the 19th Annual Scientific Meeting of the Australian Pain Society open.

OREGON HEALTH SCIENCES UNIVERSITY BEGINS COLLABORATION WITH UNIVERSITY OF ANKARA

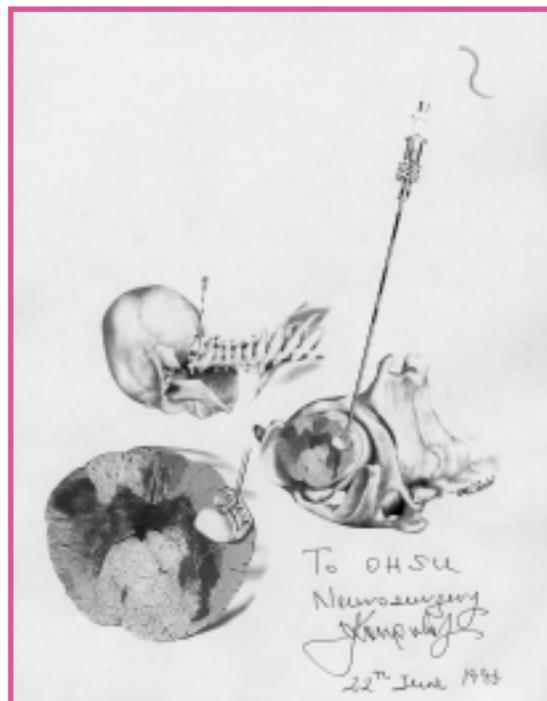


Professor Yucel Kanpolat

The Oregon Health Sciences University's Department of Neurological Surgery, has initiated a formal collaboration with the Department of Neurosurgery at the University of Ankara, Turkey to promote and to further develop the surgical management of pain. Dr. Kim Burchiel kicked off the collaborative effort with a visit to the University of Ankara, February 28-March 3, 1998. During that time, he observed several procedures performed by Professor Yucel Kanpolat, using CT-guided techniques for both cordotomy and trigeminal tractotomy (see Illustration). Dr. Kanpolat reciprocated with a visit to OHSU, June 21-23, 1998. At that time, a CT-guided cordotomy and tractotomy were performed on two patients.

The plan for collaboration will include frequent exchange of faculty, fellows and residents, as well as joint research projects and participation in AANS/ CNS practical courses on pain management.

The mission of this collaboration will be to promote the international development of surgical pain management, relevant teaching and research activity.



SPINAL CORD STIMULATION ELECTRODE DESIGN: A PROSPECTIVE, RANDOMIZED COMPARISON OF PERCUTANEOUS AND LAMINECTOMY ELECTRODES

Richard B. North, M.D, David H. Kidd, M.S., John C. Olin, P.A., Jeffrey M. Sieracki, M.S.

Department of Neurosurgery, School of Medicine, John Hopkins University, Baltimore, Maryland

AANSPHILADELPHIA 1998

Spinal cord stimulation for chronic, intractable pain has been increasingly successful in clinical practice because of recent technical improvements, in particular the development of electrodes with multiple contacts, supported by programmable implanted pulse generators. Contemporary electrodes may in some cases be placed percutaneously, and in other cases require a limited laminectomy.

We have performed a prospective, randomized comparison between different electrode designs, using a computerized system which allows direct patient interaction and quantitative measures. A series of 24 patients with chronic lumbosacral pain syndromes, in whom percutaneous four-contact electrodes were tested first, then underwent implantation at the same spinal level of two different electrode configurations: 12 received a new percutaneous four-contact electrode of the same design, and 12 received an insulated four-contact array, implanted via laminectomy.

The insulated array performed significantly ($p = 0.0006 - 0.0039$) better than the percutaneous electrode in the same patients by all 3 measures tested (overlap rating, overlap calculation, amplitude), for "usage" amplitude at the 3 standard bipoles examined. By comparison with the percutaneous temporary electrode, at subjectively identical stimulation intensities, the permanent insulated array required significantly lower amplitude. Overlap of pain by paresthesias, calculated from patients' drawings on a graphic input device, was significantly better for the permanent electrode, whether percutaneous or insulated array. Patient ratings of overlap were significantly better for both permanent electrodes, as well; each design was superior by one of two measures.

Some of the technical advantages we have observed may be associated with improved clinical outcome; extended follow up is planned to address this.

CONTEMPARY PERCUTANEOUS TECHNIQUES FOR TRIGEMINAL NEURALGIA

G. Robert Nugent, M.D.,

Robert C. Byrd Health Sciences Center Morgantown, WV

AANSPHILADELPHIA 1998

At the Breakfast Seminar on the percutaneous treatment of trigeminal neuralgia held at the AANS meeting in Philadelphia, I discussed the radiofrequency technique as I use it emphasizing that this is an excellent method of treating tic douloureux provided that it is performed properly. This means that it must be appreciated that most patients with true tic do not require dense numbness in the trigger areas to be rid of the pain. It is amazing how little numbness is adequate to treat most patients. The surgeon must contain his/her enthusiasm for going for a sure cure by making the face too numb. This will only lead to unhappiness because of annoying dyesthesias in the face and perhaps loss of the corneal reflex. In this case less is far better than more. That does not ignore the fact that in the spectrum of trigeminal neuralgia patients there is a small percentage (perhaps 5%) who are most difficult to cure despite having had various treatments, microvascular decompressions, glycerol or what have you.

It was pointed out that it is a myth that the most difficult part of the technique is penetration of the foramen ovale. With the various techniques available and a little experience this is readily accomplished. More important, and more difficult, is the creation of an adequate and proper lesion once the electrode is within the retrogasserian rootlets.

The only time we put the patient to sleep is just prior to penetrating the foramen ovale and we always use mexthoexital (Brevital) 35 to 40 mg usually. Propofol has consistently proved to be a poor second best in our experience. It is also a myth that Brevital leaves the patient too obtunded for proper sensory testing during or after the procedure.

It is important to treat the patient with radiofrequency while he/she is awake during the lesioning, to prevent too much numbness or unwanted numbness. This can be accomplished by using a small cordotomy-type electrode that allows the lesion to be made in the retrogasserian rootlets where the discomfort is easily tolerated. This allows constant on-line monitoring of the location and extent of the numbness being created in the awake patient. This minimal numbness accepts a long-term recurrence rate of about 27% but with recurrence this out-patient procedure can easily be repeated and patients readily return for retreatment when necessary. This small electrode does not permit temperature monitoring but the value of temperature monitoring is something of a myth in that the final lesion does not depend upon the ultimate temperature but the relationship of the electrode tip to the retrogasserian rootlets. When directly in the rootlets the lesion will come on at a lower temperature than if it is away from the ideal location. Dr. Sweet noted that his final temperatures varied from 47 to 108 degrees. The making of multiple small but incremental lesions is the safest technique to avoid too much numbness in the face.

Long-term results (>9years), as reported by the patient, in over 1600 patients treated for trigeminal neuralgia with these techniques yields an Excellent to Good result in 88%, a Fair result in 8% and Poor result in 4.5%. Dysesthesias were described as Mild to Moderate in 36% (82% of these also graded the overall result as Good to Excellent), Severe in 3% and Intolerable (anesthesia dolorosa) in 0.4%. There was a 3.5% incidence of loss of the corneal reflex and a 0.3% incidence of neurolytic keratitis.

It is possible to safely treat first division tic with this electrode provided the patient is awake to permit constant monitoring of the eyelid blink reflex during the lesion making. We have been able to treat 91% of patients with first division triggering cure the pain and only slightly diminish the corneal reflex.

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Selected Abstracts from the 66th Annual Meeting of the American Association of Neurological Surgeons

April 25-30, 1998

NGF and Anti-NGF Treatment of Chronic Pain Following Spinal Cord Injury

Marc D. Christensen
Claire Hulsbosch

Syracuse, NY

Spinal cord injury (SCI) frequently results in chronic pain and dysesthesias. We have developed a model of chronic pain following traumatic SCI. Furthermore, the mechanisms responsible for the induction and maintenance of chronic pain have been investigated and treatment modalities tested. Male Sprague-Dawley rats were hemisected at T-12 and were tested pre-operatively and post-operatively in response to mechanical

and thermal stimuli using paw withdrawal and supraspinal responses to von Frey hair (vFh) and a radiant heat source. Prior to spinal hemisection in controls (n=10), the rats did not withdraw their paws or vocalize to vFh bending force of 4.41 mN. Following SCI (n=10), an increased frequency of paw withdrawal to 4.41 mN by 70% and decreased latency of withdrawal in response to radiant heat source occurred (p<0.05). Mechanisms responsible for the development of these dysesthesias after SCI include anatomical and molecular plasticity of pain fibers in response to endogenous neurotrophins such as nerve growth factor (NGF). Spinal cords and dorsal root ganglia (DRG) or intrathecal NGF (35ng/hr)-treated animals (n=5) had increased levels of nociceptive peptide calcitonin gene-related (CGRP) protein and mRNA when compared to controls (p<0.05). The NGF-treated rats also displayed marked exacerbation of mechanical and thermal allodynia as assayed by vFH testing, thermal withdrawal latencies, and supraspinal nociceptive behavior such as vocalization (p<0.05). Finally, animals treated (n=10) with intrathecal antibodies to NGF (anti-NGF) had attenuated quantities of CGRP protein and mRNA in the spinal cord and DRG (p<0.05). Also, intrathecal anti-NGF prevented the development of mechanical and thermal allodynia and supraspinal nociceptive behaviors following SCI (p<0.05).

Microendoscopic Discectomy : Surgical Techniques and Initial Clinical Results

Kevin Foley
Maurice Smith

Memphis, TN

Percutaneous endoscopic approaches to lumbar discectomy remain controversial. In general, they have not proven to be as efficacious as conventional open surgery. We have developed a new endoscopic technique which allows the surgeon to address free fragment disc and bone pathology while providing easy access to the entire lumbar spine. The purpose of this study was to determine the feasibility and efficacy of this novel endoscopic approach to lumbar disc disease.

Forty-one patients with single level radiculopathy secondary to lumbar disc herniation were treated with microendoscopic discectomy (MED). The patient population consisted of 28 males and 13 females with ages ranging from 23 to 67 years. Disc levels included L2-3 (2 patients), L3-4 (3 patients), L4-5 (11 patients), and L5-S1 (25 patients). Five patients had far-lateral discs; the remaining disc herniations were within the spinal canal. Twenty-five (61%) of 41 cases had free fragment pathology. The surgery was performed under epidural anesthesia on an outpatient basis. A 16-mm tubular retractor was inserted via a small paramedian stab wound. An adjustable endoscope was attached to the refractor. Under direct endoscopic vision, a hemilaminotomy, medial facetectomy, resection of ligamentum flavum, retraction of nerve root, and removal of disc were performed as necessary. Concomitant lateral recess stenosis (12% of cases) was addressed with a specially modified high-speed drill. Follow up ranged from 8 to 18 months, with a mean of 13 months.

All patients had substantial relief of their radiculopathy. Under modified Macnab criteria, all patients had good to excellent results. All patients were discharged home within hours of surgery except our first patient, who sustained a dural tear and was admitted for 48 hours. There were no other complications. Return to work ranged from 2 to 40 days in the non-workers' compensation population (mean 14 days) and 14 to 107 days in the workers' compensation population (15% of cases, mean 58 days).

The MED procedure combines standard lumbar microsurgical technique with endoscopy, enabling the surgeon to successfully address free fragment disc pathology

and lateral recess stenosis. The endoscopic approach allows for a smaller incision and less tissue trauma than standard open microdiscectomy. Routine outpatient application and the avoidance of general anesthesian lower hospital stays and costs. We conclude that MED is both feasible and efficacious for the management of lumbar disc disease.



48th Annual Meeting of the Congress of Neurological Surgeons October 3-8, 1998 Seattle Washington

Of Interest at the 48th Annual Meeting

*Scientific Program: Section on Pain I
Pain Management in a Clinical Practice*

Monday, October 5 1998

Moderator:	Jeffrey Brown
2:00-2:15PM	Understanding Pain Management: A Core Curriculum <i>Kim Burchiel</i>
2:15-2:30 PM	Building a Pain Practice <i>Robert Levy</i>
2:30-2:50PM	Outcomes Assessment <i>Richard North</i>
2:50-3:30 PM	Oral Posters
3:30-4:00PM	Coffee Break with exhibitors
4:00-5:30PM	Open papers (712-721)

*Section on Pain II and Topics of General Interest
Neurosurgical Management of Chronic Pain*

Tuesday, October 6 1998

Moderator:	Kenneth Follett
2:00-2:10PM	Pain Types and Basic Treatment Considerations <i>Kenneth Follett</i>
2:10-2:20 PM	Rational long-term Use of Opioids <i>Joel Seres</i>
2:20-2:35PM	Applications of Augmentative Techniques <i>Jamie Henderson</i>
2:35-2:50 PM	Applications of Ablative Techniques <i>Nicholas Barbaro</i>
2:50-3:30PM	Oral Posters
3:30-4:00PM	Coffee Break with exhibitors
4:00-5:30PM	Open papers (762-771)

*Section on Functional and Stereotactic
Neurosurgery II
Stereotactic Medial Thalamotomy for Chronic Pain:
Is it an Effective Procedure?*

Wednesday, October 7 1998

Moderator:	Kim Burchiel
2:00-2:25PM	Pro <i>Ronald Young</i>
2:25-3:00 PM	Con <i>Ronald Tasker</i>
2:50-3:30PM	Oral Posters
3:30-4:00PM	Coffee Break with exhibitors
4:00-5:30PM	Open papers (843-852)

Calendar of Events

November 5 - 8, 1998

*17th Annual Scientific Meeting of the
American Pain Society*

Location: San Diego
Contact: American Pain Society
4700 W. Lake Avenue
Glenview, IL 60025-1485
Phone: 847-375-4715
Fax: 847-375-4777
E-mail: info@ampainsoc.org

November 17-21, 1998

*International Pain Congress:
Pain Management towards 2000*

Location: Eilat, Israel
Contact: Professor D. Niv
Phone: 972-3-6104848
Fax: 972-3-7521577

April 24 - 29, 1999

*67th Annual Meeting of the American
Association of Neurological Surgeons*

Location: New Orleans, Louisiana
WWW: <http://www.neurosurgery.org/meetings/aans/summary.html>

August 22 - 27, 1999

9th World Congress on Pain

Location: Vienna, Austria
Contact: IASP Secretariat,
909 NE 43rd Street,
Suite 306, Seattle 98105
Phone: 206-547-6409
Fax: 206-547-1703
E-mail: iasp@locke.hs.washington.edu

October 21-24, 1999

*18th Annual Scientific Meeting
American Pain Society*

Contact: American Pain Society
4700 W. Lake Avenue
Glenview, IL 60025-1485
Location: Ft. Lauderdale, FL
Phone: 847-375-4715
Fax: 847-375-4777
E-mail: info@ampainsoc.org

REPORT OF THE JOINT SECTION ON
PAIN:CNS EXECUTIVE
COMMITTEE:SUMMER, 1998

I. Membership

A. Current membership is 310

II. Educational programs

A. *Professional Development Program*

1. Advanced Surgical Pain Management, Portland OR; September 11-13, 1998
 - a) The emphasis will be on practical training for neurosurgeons who have already incorporated aspects of neurosurgical pain management in their practices and who wish to update and refine their skills. It will build on the training received during the Satellite Symposia held in the past several years at the AANS and CNS annual meetings.

B. *CD-ROM: "Interventional Therapies in the Neurosurgical Treatment of Pain"*

1. The Joint Section on Pain has produced a CD-ROM entitled, "Interventional Therapies in Neurosurgical Pain Management". The CD is based on the highly successful and well-attended Satellite Symposium held preceding the AANS Annual meeting this past Spring. Each of the twenty-five lectures delivered at the symposium can be viewed. Speakers' slides are digitized and synchronized to the audiotaped presentations. Slides can be enlarged for clearer study. One may take as much time as needed to understand them best. The lectures can be easily reviewed on any computer with a CD-ROM drive. The CD should serve as an excellent curriculum for the neurosurgical treatment of pain for neurosurgeons with a general practice, for those with special interest in pain neurosurgery and for residents in every training program in neurosurgery. It can be purchased through the Joint Section on Pain and the AANS.
2. Sales at the symposium have covered costs of this effort. Further advertising will be done through Neurosurgery On Call and the section newsletter. The AANS will assist in developing a wider plan.

C. *CNS Annual Meeting Symposia*

1. We will integrate a mini-symposium on pain management into the two afternoon sessions sponsored by the Section. Topics will include, "Pain Management in a Clinical Practice," and "Neurosurgical Management of Chronic Pain." The first session will focus on what is needed to design a successful pain practice and to evaluate the outcome of treatment. The second session will review basic considerations of pain, rational use of opioids, and applications of augmentative and ablative techniques.
2. There will be a morning Scientific Session on the treatment of facial pain featuring John M. Tew, Jr. the honored guest of the Congress.

II. Awards

A. *Ronald Tasker Young Investigator Award*

1. \$1,000 award sponsored by ANS, Inc. given for the best presentation by an investigator within 5 years of completion of residency training at the CNS Annual Meeting.

B. *William Sweet Young Investigator Award*

1. \$1,000 award sponsored by Medtronic, Inc. given for the best presentation by an investigator within 5 years of completion of residency training at the AANS Annual Meeting.

III. Other Activities

A. *Ohio State Medical Board Policy on the Treatment of Intractable Pain with opioids*

1. We have reviewed the suggested policy and offered recommendations for modification to the Board and the Ohio State Medical Association

B. *Medicare Policy on Pain Management*

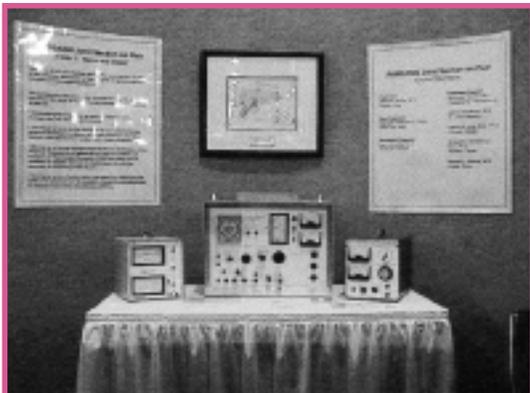
1. We have reviewed a suggested policy for appropriate treatment of intractable pain for the Connecticut Medicare Carrier, offering recommendations through the AANS Washington Committee.

The Joint Section on Pain has produced a CD-ROM entitled, "Interventional Therapies in Neurosurgical Pain Management". The CD is based on the highly successful and well-attended Satellite Symposium held preceding the AANS Annual Meeting last spring. Each of the twenty-five lectures delivered at the symposium can be viewed. Speakers' slides are digitized and synchronized to the audiotaped presentations. Slides can be enlarged for clearer study. One may take as much time as needed to understand them best. The lectures can be easily reviewed on any computer with a CD-ROM drive. The CD should serve as an excellent curriculum for the neurosurgical treatment of pain for neurosurgeons with a general practice, for those with special interest in pain neurosurgery and for residents in every training program in neurosurgery. It can be purchased through the Joint Section on Pain and the AANS.

At the annual meeting of the CNS in Seattle, we will integrate a mini-symposium on pain management into the two afternoon sessions sponsored by the Section. Topics will include, "Pain Management in a Clinical Practice," and "Neurosurgical Management of Chronic Pain." The first session will focus on what is needed to design a successful pain practice and to evaluate the outcome of treatment. The second session will review basic considerations of pain, rational use of opioids and applications of augmentive and ablative techniques.

The Section continues to offer awards for the most outstanding presentation by a young investigator at both the AANS and CNS annual meetings and we encourage investigators to compete for these. They are named The William Sweet and Ronald Tasker Young Investigator Awards, respectively for the work of these two distinguished neurosurgeons in the area of pain neurosurgery during their productive careers.

At the annual Business Meeting, Ken Follet was re-elected to the position of Vice-Chair and Kim Burchiel to the position of Secretary-Treasurer. Richard Osenbach was elected to join the Executive Council.



Joint Section on Pain AANS/CNS Booth

The Council of the Joint Section on Pain is looking for ideas regarding the further development of the booth which is on display at the AANS/CNS Meetings (see illustration). Please address your comments or suggestions to Kim Burchiel (burchiek@ohsu.edu).

Application for Membership

Section on Pain of the American Association of Neurological Surgeons

I. Biographical

Name _____

Birthplace _____ Birthdate _____ Citizenship _____

Home Address _____ Home Phone _____

Office Address _____ Office Phone _____

II. Category of Membership Requested

Active Associate Corresponding

III. Education

Premedical collegiate education (institutions/dates) _____

Final degree (institutions/dates) _____

Medical education (institutions/dates) _____

Final degree (institutions/dates) _____

Internship or equivalent (institutions/dates) _____

Residency or other graduate training (institutions/dates) _____

Residency training institution _____

Completion (or expected completion) Date _____

IV. Membership, Certification and Practice

Are you now certified by the American Board of Neurological Surgery? Yes/Year _____ No

Are you certified in neurosurgery by another examining board? Yes/Year _____ No

Are you a member of:

- American Medical Association
- Local or regional medical society Name: _____
- State or provincial medical society Name: _____
- American Association of Neurological Surgeons
- Congress of Neurological Surgeons
- American Academy of Pain
- International Association for the Study of Pain
- American Pain Society

Medical Licensure State _____ Dates _____

Signature _____ Date _____

*Please return completed application to :
Section on Pain, Membership Department, 22 South Washington Street, Park Ridge, IL 60068*

AANS/CNS
Joint Section on Pain
22 S. Washington St.
Park Ridge, IL 60068

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**Joint Section on Pain
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This newsletter is sponsored in part
by an educational grant from
Medtronic, Inc.