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SIG > NEWSLETTER

NEUROPATHIC PAIN

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The Chair's Column

Dear friends and colleagues,

This year, the general feeling around the world seems to be that times are difficult. On this background it may be reassuring to receive some pieces of good news.

On March 3, 2009, the international organization "Human Rights Watch" issued a report on chronic pain entitled "Please, do not make us suffer any more…", Access to Pain Treatment as a Human Right (http://www.hrw.org/en/node/81080/). In this 47-page report Human Rights Watch said that countries could significantly improve access to pain medications by addressing the causes of their poor availability. These often include the failure to put in place functioning supply and distribution systems; absence of government policies to ensure their availability; insufficient instruction for healthcare workers; excessively strict drug-control regulations; and fear of legal sanctions among healthcare workers. As examples, the sufferings from cancer pain and from HIV-related pain were quoted. Both topics are relevant for the work of NeuPSIG: HIV-related pain is a major scope of our new subcommittee on developing countries (chair: David Simpson) and we become increasingly aware that cancer pain can be neuropathic as well as nociceptive.

Human Rights Watch called on governments to establish, where this has not yet been done, a working group on palliative care and pain management, to improve education on pain therapy and assure adequate distribution programs for medications, in particular opiates. Moreover, human rights groups should include access to pain treatment and palliative care into their work. Organizations such as IASP and EFIC had previously stated that access to pain treatment should be considered a human right. It is a major step forward that human rights organizations are now promoting the same cause.

The second piece of good news came from the United Kingdom, where the Chief Medical Officer in the 150th annual report identified pain treatment as one of

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five priority areas. “Every day, millions of people experience disabling chronic pain, which imposes a heavy burden on them, their families and the economy at large. Although we now have effective means of tackling both pain and the consequences of pain, services have not kept up with demand and too many people struggle to cope with their symptoms.” This important first step can be regarded as a model for other governments to follow.

A third piece of good news is from Germany. The 2009 German version of the International Classification of Disease (ICD-10 GW 2009) contains a code for “Chronic pain disorder with somatic and psychological factors” (F45.41). With this code, doctors can identify those patients who need comprehensive pain treatment programs because their chronic pain has evolved beyond being a symptom of bodily damage.

Inside this newsletter you will find reports on the activities of NeuPSIG, including a joint meeting with ASEAPS in Sanur, Indonesia, and information on the Third International Pain Congress, to be held in Athens, Greece, in May 2010.

With kind regards,
Rolf-Detlef Treede

3rd ASEAPS Congress, 17th.-20th. April 2009 Sanur, Bali, Indonesia

NeuPSIG joined with ASEAPS (Association of South East Asian Pain Societies) and IASP to co-sponsor the 3rd ASEAPS Congress during April 2009 in Bali, Indonesia. This important Congress was a resounding success, attracting in excess of 700 delegates to the wonderful and friendly region of Bali. Each of the three groups that joined to co-sponsor this Congress can justifiably feel very satisfied at the success of every element of the meeting; educational content, networking opportunities, and from the viewpoint of NeuPSIG, the opportunity to further develop the diagnosis and treatment of neuropathic pain in this region. The NeuPSIG members who attended this Congress left with an enhanced understanding of the cultural perspectives, not to mention vivid memories, of this unique area.

A few years ago, the major ASEAN countries that already had established IASP chapters saw the benefit of holding combined meetings to further their individual and combined aims in the region, and to this end they created ASEAPS - this was their third Congress with the next one to be held in Thailand in 2011. We all appreciate that the Asian region has a large population, but do we really precisely understand to what extent these congress attendees can improve the diagnosis and treatment of Neuropathic pain in this region? To illustrate this point, I have just looked at Wikipedia, and I provide the following details. Indonesia is the fourth most populated country in the world with a population of 230 million. The Philippines (12th position, 92 million), Thailand (21st position, 63 million), Malaysia (43rd position, 28 million) and Singapore (115th position with a population of 5 million) -

NeuPSIG Management Committee with IASP Councilor, Dr. Cynthia Goh

collectively, the majority of attendees at the Bali congress provide pain services to 6.2% of the world’s population. However, it is a fact that this region is an area of significant need as assessed by an under representation within the IASP in terms of membership statistics. Moreover, for various reasons, a number of Asian countries are trying very hard to form national chapters, and events such as this ASEAPS Congress are crucial in this endeavour, but more of that a little later. The ASEAPS committee in general, and the Indonesian Pain Society as hosts, were justifiably elated at the interest in and success of this Congress, and we wish them well for the next congress in Thailand.

IASP would also be very pleased with their involvement in the meeting and, and a more detailed report is provided below (page 6) in this Newsletter. Briefly, IASP provided specific sponsorship for key folk from a number of countries that do not have existing IASP Chapters to attend the Bali meeting. Immediate Past President Troels Jensen and Michael Bond, along with the Executive Director Kathy Kreiter, took the opportunity to hold meetings to see precisely how IASP can facilitate, inter alia, pain education, diagnosis, and treatment initiatives in this region. I was fortunate to sit in on one of these meetings, and the enormous interest of these folk in improving all aspects of pain management in their countries was clearly on view. They have quite a number of logistical issues to contend with, but I think the Bali meeting will ultimately be seen as a crucial step in the evolution of pain services to these countries.

NeuPSIG was also delighted with our involvement in the Bali meeting. Consistent with IASP policies and procedures, we have our own educational program which takes many forms. As explained in previous Newsletters, one of these is that we have elected to hold one of our Management Committee Meetings in a region of need during each triennium. I have previously spoken about how Management Committee Members provide presentations to a local Congress at no cost to the organizers. We did this previously in Guatemala in association with Fedelat, and this time we joined ASEAPS in Bali. Specifically, we took responsibility for a Neuropathic Pain Day that was formulated in consultation with the local Scientific Committee and embedded in the middle of the Bali scientific program. Moreover, a number of

Management Committee Members also participated in sections of the scientific program on other days. The NeuPSIG Management Committee has come to the view that the easiest option in the future is to replicate this model. The inescapable conclusion is that our hosts, in this case viewed in the widest context as the various countries that form ASEAPS, greatly appreciate our contribution. Realistically our involvement does make a significant impact on the diagnosis and treatment of neuropathic pain in this region from many points of view, not least in gaining maximum impact from NeuPSIG's modest budget for educational initiatives.

Geoff Gourlay
NeuPSIG Liaison for the Bali Congress

Neuropathic Pain Assessment Scales: An Update

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Neuropathic pain is defined as "pain arising as a direct consequence of a lesion or disease affecting the somatosensory system" [Treede et al 2008]. This entity includes highly difficult-to-treat clinical conditions associated with a large variety of peripheral or central nervous system lesions. The heterogeneity of neuropathic pain syndromes is also apparent from the clinical history and examination of the patients who may present with various painful symptoms including spontaneous pain, either continuous or paroxysmal, and various types of evoked pains (allodynia/hyperalgesia to brush, pressure or thermal stimuli).

To date the traditional aetiology-based categorization of neuropathic pain still prevails for clinical, experimental, and pharmacological studies (Attal et al 2006; Finnerup et al 2005b; Dworkin et al 2007). Therapeutic studies have generally evaluated neuropathic pain as a global and uniform symptom, but only one third of patients are responders to active drugs in meta-analyses (Finnerup et al 2005). This has raised the question of whether a different strategy, in which pain would be analyzed according to underlying mechanisms, could provide a more suitable approach for examining and classifying patients, with the ultimate goal of obtaining a better treament approach (Baron 2006). Such a mechanism-based approach of NP is based on the assumption that a precise phenotypic profile of neuropathic patients should help better select drugs targeting particular mechanisms (Woolf and Mannion 1999; Baron 2006; Attal et al 2008). Specific neuropathic pain questionnaires, combined with quantitative sensory testing, may probably be relevant tools in the clinic to better characterize multiple neuropathic phenotypes. Such phenotypic mapping is probably an important step to establish in the future a mechanism-based classfication and therapy of neuropathic pain.

A number of assessment tools have been proposed to assess pain qualities associated with neuropathic pain, some of them being specific while others aim to assess both neuropathic and non-neuropathic pain conditions. These measures are reviewed here, with emphasis on their strengths and limitations (Table 1, p 6). Screening tools also based on pain quality but only validated for diagnostic purposes will not be discussed here (see Bennett et al 2007 for a review).

Non-Specific Pain Quality Assessment Questionnaires

The McGill Pain Questionnaire (MPQ; Melzack 1975) was the first self-rating multidimensional instruments to assess pain quality and rapidly gained an immediate and large success among clinicians. However, one limitation of the MPQ was its length, hampering its use in daily clinical practice. This led to the validation of the **short-form McGill questionnaire** (SF-MPQ) (Melzack, 1985), which is now more commonly used for pain assessment. The SF-MPQ includes 15 pain descriptors; 11 are sensory, and 4 are affective. Responses are rated on a scale from 0 (non) to 3 (severe) and can be used to assess individual pain qualities. However, sensory and affective subscores which correspond respectively to the sum of sensory and affective items are more often provided in clinical studies.

The MPQ and SF-MPQ were conceived as generic questionnaires applicable to any type of pain and have not been validated for NP assessment. Despite this limitation, the SFMPQ has been to date the most commonly used quality assessment tool, particularly in recent large-scale therapeutic studies of NP (eg Dworkin et al 2003; Goldstein et al 2005). However, the total score or subscores of the SF-MPQ are not more sensitive to change or less sensitive [eg, Simpson et al 2003; Backonja et al 2008] than unidimensional intensity scales. One reason may be related to the scoring of individual items, which is probably less sensitive than numerical 0-10 scales. Another reason is related to the fact that the SFMPQ is not fully adapted to neuropathic pain because many items common to NP are lacking in this questionnaire.

Specific Neuropathic Pain Assessment Scales

The Neuropathic Pain Scale (NPS) (Galer and Jensen 1997) was the first pain quality assessment tool specifically devoted to NP assessment. It includes 10 pain quality items rated on 0-10 numerical scales and a temporal assessment of pain. In the NPS, each item is rated separately, but in further studies, various composite scores using selected items were proposed although not formally validated (Galer et al 2002). A recent validation study of the NPS in multiple sclerosis identified 3 factors for NPS items ("familiar", "superficial" and "alien" perception) (Rog et al 2007). The NPS has been translated into 24 languages other than the original English (Jensen 2006), and an Italian version has been published (Negri et al 2002). The NPS has been used in several NP trials [e.g. Rog et al. 2005, Levendoglu et al. 2006, Galer et al. 2002, Vinik et al. 2007, Jensen et al. 2006], some of them reporting better sensitivity of some descriptors compared to others

in response to treatments such as gabapentin, cannabinoids, or opioids [Levendoglu et al 2006, Rog et al 2005, Jensen et al 2006]. The main limitation of the NPS is that it lacks several pain qualities that are commonly seen in neuropathic pain, particularly those associated with the paroxysmal dimension of NP. Therefore authors have developed the pain quality assessment scale as an expanded version (see further).

The **Neuropathic Pain Symptom Inventory** (NPSI) contains 10 descriptors representing 5 distinct dimensions on the basis of factor analysis: burning pain, deep pain, paroxysmal pain, evoked pain, paresthesia/dysesthesia, and 2 temporal items designed to assess pain duration and the number of pain paroxysms (Bouhassira et al 2004). It was originally validated in a French-speaking population, but has been translated and submitted to linguistic validation in 50 languages other than French. Its conceptual adequacy has been confirmed in 6 different languages including English (Crawford et al 2008), and it has been formally validated in German (Sommer et al submitted) and in Italian (Padua et al 2009).
The NPSI has been validated in patients with definite neuropathic pain of peripheral or central origin (Bouhassira et al 2004; Attal et al 2008). The 3 items used to assess evoked pain have also been validated against clinical examination and quantitative sensory testing, thus making them suitable for assessment of allodynia and hyperalgesia (Attal et al 2008). The NPSI has been used in 3 published double-blind trials, but 2 of them are negative ; one positive study found that several NP dimensions were particularly sensitive to treatment effect [Ranoux et al, 2008]. Interestingly the factorial structure of the NPSI makes it suitable to capture different aspects of NP that may have distinct pathophysiological mechanisms (Truini et al 2009; Attal et al 2009). For example, it has recently been found that the various pain qualities of neuropathic pain as assessed with the NPSI were distinctly correlated to neurophysiological data in patients with carpal tunnel syndrome: paroxysmal pain was associated with impairment of non-nociceptive A-beta fibers as indicated by nerve conduction velocity while spontaneous ongoing pain was related to damage of nocicetive fibers, as indicated by laser-evoked potential amplitudes (Truini et al 2009).

Assessment Tools Aiming To Assess Neuropathic and Non-Neuropathic Pain

The **SF-MPQ 2** (Dworkin et al 2009) is an expanded and revised version of the SFMPQ that was recently developed as a measure of symptoms of both neuropathic and non-neuropathic pain in order to overcome the limitations of the SF-MPQ particularly in neuropathic pain. This new questionnaire contains 7 additional items more specifically related to neuropathic pain, and the scoring of each symptom is based on 0-10 numerical scales. The sensitivity to change was confirmed in a double-blind trial in diabetic neuropathic pain. Factor analysis identified 4 subscales: continuous pain, intermittent pain, predominantly neuropathic pain, and affective descriptor. The SFMPQ-2 is promising but has limitations for use specifically in neuropathic pain. Thus it is not clear whether the 4 dimensions of this tool may apply indistinctly to any type of chronic pain (Bouhassira and Attal 2009), particularly as neuropathic pain itself can be subclassified into distinct dimensions (Bouhassira et al 2004). The affective subscale is the same as in the SFMPQ, was not revalidated in neuropathic pain and has not been found more sensitive to change than the sensory scale of the SFMPQ in neuropathic clinical trials (eg Dworkin et al 2003 ; Richter et al 2005). Finally, the validation study of the SFMPQ-2 was mainly based on a very large web survey, but the representativity of the sample was not controlled and participants were asked to self report their pain conditions (80% had more than one pain) without possibility to check the validity of this categorization. Therefore, this validation can be considered as preliminary, and further studies are necessary to confirm the psychometric properties of the SFMPQ-2 in properly diagnosed groups of patients with neuropathic or mixed pain syndromes.

The Pain Quality Assessment Scale (PQAS) has also been recently developed as a tool derived from the Neuropathic Pain Scale to assess pain qualities associated with both neuropathic and non-neuropathic pain conditions (Jensen et al 2006). The PQAS includes several similar pain qualities as the the SFMPQ 2, although some items are worded differently (see table 1, p 6). An exploratory factor analysis was initially performed in non-neuropathic pain and confirmed in neuropathic pain due to carpal tunnel syndrome: it identified 3 pain quality factors representing paroxysmal pain, superficial pain and deep pain (Victor et al 2008). As is the case for the SFMPQ-2, the 3 factor dimension may be too broad to capture specific dimensions of NP. To date no data exist regarding the use of this scale in blinded NP trials.

Conclusion and Perspectives

Several lines of evidence suggest that neuropathic pain quality measures are useful to discriminate among various pain mechanisms associated with distinct dimensions of NP experience. Furthermore, the increasing use of some of these tools in clinical trials has indicated that several current treatments may not necessarily have the same efficacy against all neuropathic symptoms, which may be regarded as a first step toward a mechanism-based approach of NP. However, one of the main reasons for the moderate efficacy or failure of many neuropathic pain treatments probably stems from insufficient information regarding the responders' profiles to specific therapies. Under these conditions, not only the effects of treatments against specific neuropathic dimensions or symptoms should be analyzed using validated scales, but these tools should aim at identifying the predictors of response to therapeutic agents based on particular clusters of symptoms or dimensions in individual patients at baseline. For example, it would be important to determine in carefully conducted studies whether patients with predominantly burning pain combined with brush-evoked allodynia are more prone to respond to certain therapeutic agents than those with

predominant deep pain or with paroxysmal pain. This approach will certainly be ultimately helpful in clinical practice to help better select therapeutic agents in patients identified on the basis of their symptom patterns, and not merely on the basis of the aetiology of their pain.

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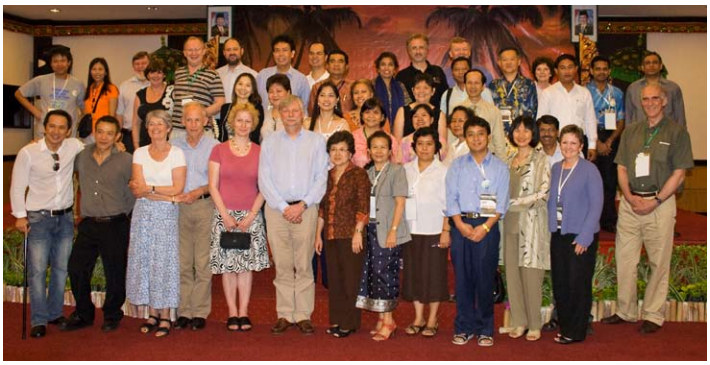
MEASURES OF PAIN QUALITY USED TO ASSESS NEUROPATHIC PAIN

	SFMPQ	SFMPQ-2	NPS	CPAQ	NPSI
AUTHORS	Melzack 1987	Dworkin et al 2009	Galer & Jensen 1997 Victor et al 2007	Jensen et al 2006 Victor et al 2008	Bouhassira et al 2004 Attal et al 2008
VALIDA-TION	Validation in chronic pain Not validated in NP	Initial validation in in a web survey (n = 882, 349 self reported NP) Sensitivity to change in diabetic NP (n = 226)	Initial validation in peripheral NP (n = 288 + 78 CRPS for sensitivity to change) Further validation in multiple sclerosis (n = 141)	Factor analysis in osteoarthritis and low back pain Confirmed in carpal tunnel syndrome (n = 138)	Validation in peripheral & central NP (n = 176) Confirmation in 485 patients with NP
ITEMS	15 items *11 sensory items* Throbbing Shooting Stabbing Sharp Cramping Gnawing Hot/burning Aching Heavy Tender Splitting *4 affective items* Tiring/exhausting Sickening Fearful Punishing/cruel	SFMPQ items modified by adding the word « pain » (except for tender) + 7 additional items Electric shock pain Cold-freezing pain Piercing Pain caused by light touch Itching Tingling or pins & needles Numbness	10 items Sharp Dull Sensitive Deep Hot Cold Itchy Surface + 1 temporal item : constant with intermittent increase intermittent constant with fluctuations	NPS items + 10 additional items Tender Shooting Numb Electrical Tingling Cramping Radiating Throbbing Aching Heavy	10 items Burning pain Squeezing pain Pressure pain Electric shocks pain Stabbing pain Evoked pain to brush Evoked pain to pressure Evoked pain to cold Tingling Pins and needles + 2 temporal items Duration of ongoing pain Frequency of paroxysms
SCORING	Cagtegorical scales (0 : none ; 3 : (severe)	Numerical 0-10 scales for each item Scores per item, total score and subscale scores	Numerical 0-10 scales for descriptors Categorical scales for temporal items Scores per items and total score Composite scores proposed	Numerical 0-10 scales for each item Scores per item or dimension	Numerical 0-10 scales for descriptors Categorical scales for temporal items Scores per item or dimension (average of items) and total NPSI score
FACTOR ANALYSIS IN NP	No	Performed for sensory items in a web survey 4 subscales : Continuous pain Intermittent pain Predominantly neuropathic pain Affective descriptors (not revalidated)	Performed in multiple sclerosis 3 factors : Familiar Superficial Alien	Performed in non NP and confirmed in carpal tunnel syndrome 3 dimensions : Paroxysmal pain Superficial pain Deep pain + one item (sensitive) not loaded in a dimension	Performed in the initial validation study and confirmed in a larger group 5 dimensions Burning pain Deep pain Paroxysmal pain Evoked pain Paresthesia/ dysesthesia
SENSITIVI-TY TO CHANGE	In several double blind trials in NP - sometimes less sensitive than pain intensity	In one double blind trial in diabetic NP (with use of translated versions)	In several double blind trials with some descriptors being more sensitive than others	In one unblinded trial in carpal tunnel syndrome	In one double blind trial in peripheral NP with some dimensions being particularly sensitive to change

IASP Initiative South East Asia: Joint Meeting of ASEAPS and NeuPSIG, Bali, April 2009

The Association of South East Asia Pain Societies (ASEAPS), consisting of Malaysia, Singapore, Thailand, Indonesia, and Philippines, held their 3rd meeting in Bali, Indonesia, during a 3-day meeting April 18-20, 2009, in conjunction with NeuPSIG. The meeting had close to 700 participants mainly from the South East Asia region. While some of the ASEAN countries have developed programs for pain management – in part due to the active IASP chapters behind ASEAPS – others like Vietnam, Laos, Cambodia, Brunei, Bhutan, and Myanmar still lack the infrastructure for improved pain education and management. To improve pain in these countries, IASP identified and invited 11 individuals in the ASEAN region from Myanmar, Sri Lanka, Cambodia, Laos, Vietnam, and Bhutan to come to Bali and attend the ASEAPS meeting. In addition, IASP headed by Troels S. Jensen and supported by councilors Cynthia Goh, Maged El Ansari, Michael Bond, and R-D. Treede and Srinivasa Raja from NeuPSIG, met with these representatives to explore the need for pain management and education in their respective countries and to see how IASP possibly can help and support perhaps by forming chapters.

All invitees expressed their gratitude for this IASP initiative, and everyone was enthusiastic about establishing pain groups in their respective countries. This has already happened in Myanmar and in Sri Lanka. IASP will follow up on this so that concrete initiatives can be established.



IASP sponsored participants at the ASEAPS meeting were the following:
Jampell Tshering, Thimphu, Bhutan
Sovandy Chan, Pnom Penh, Cambodia
Khantey Om, Pnom Penh, Cambodia
Vanpheng Norasingh , Vientiane, Laos
Bouathep Phoumindr, Vientiane, Laos
Khin Myo Hla, Yangon, Myanmar
Thaung Myint , Yangon, Myanmar
Tuan Nguyen, Ho Chi Minh City, Vietnam
Dat Le Huu, Ho Chi Minh City, Vietnam
Ranjith Pailegama ,Pweradeniya, Sri Lanka
Anura Ariyawardana Peradeniya, Sri Lanka

On behalf of the IASP Outreach program toward the ASEAN region,Troels S. Jensen, IASP Past President , July 13, 2009

Third International Pain Congress, Athens, May 2010

The Special Interest Group on Neuropathic Pain (NeuPSIG), of the International Association for the Study of Pain (IASP), is proud to announce its third international meeting.

The first two NeuPSIG meetings were held in Madrid, Spain, in 2004 and in Berlin, Germany, in 2007. Since then, there have been many exciting new developments in science and in patient care. Updates on present evidence-based research and medicine will be covered by world-renowned experts. There will be ample time for discussion during the workshops.

At the 2007 Berlin Congress, over 1,600 professionals from diverse fields of pain management enjoyed a stimulating scientific and social program. We expect a similar number of participants at the Athens Congress and an equally inspiring program.

The scientific program (see details in p8) is designed to meet the aims of NeuPSIG, which are “to advance the understanding of mechanisms, assessment, prevention, and treatment of neuropathic pain”; it will consist of plenary sessions, topical workshops, and poster presentations. This third congress in the series should yet again prove to be an important milestone for basic scientists, clinical scientists, and practicing health care workers from all disciplines with an interest in furthering the understanding and care of patients with neuropathic pain. The Plenarists are now confirmed, workshop subjects are agreed, and Workshop speakers are presently being invited and will be confirmed by the end of August.

Plans for the Congress are now well established, and details are available at www.kenes.com/neuropathic.

Abstract submission is also now open. Take the time to look at the congress website and consider presenting a poster. Abstract Submission is open until November 2, 2009.

Athens, the birthplace of democracy, has been inhabited since 3000 BC and as such offers many magnificent monuments and archaeological sites, which have survived the centuries. Highlights include the Acropolis with the Parthenon, the Ancient Agora, the Temple of Olympian Zeus, and the Ancient Stadium. It is also the birthplace of evidence-based medicine! Consider a trip to the beautiful island of Kos, where Hippocrates lived and taught.

We look forward immensely to welcoming you to historic Athens and to a very successful Congress.

Dr. C. Wells and Dr. R. Baron on behalf of the NEUPSIG management committee

NeuPSIG Bursaries for Trainees/Fellows and for Physicians/ Scientists from Developing Countries to Attend the Athens Congress 2010.

NeuPSIG Bursaries for Trainees/Fellows and for NeuPSIG has provided significant financial support for Trainees/Fellows to not only attend, but fully participate in NeuPSIG scientific meetings since its inception. Fostering interest in all aspects of neuropathic pain in this important group has been a focus of NeuPSIG’s educational initiatives, as our leaders of tomorrow will emerge from these individuals. The Bali (April 2009) Management Committee Meeting reviewed the level of support that we would provide for Trainees/Fellows to attend the Third International Congress on Neuropathic Pain to be held in Athens (27th-30th, May 2010). The Management Committee has elected to provide enhanced levels of financial support for Trainees/Fellows to encourage attendance at this meeting – the total budget for Bursaries amounts to €50,000, which reflects the importance that we place on this initiative. NeuPSIG Bursaries will be made available on a competitive basis to attend the Athens Congress. It is obligatory for applicants to be NeuPSIG members (also requires IASP membership) and also an author on a Poster to be presented in Athens to be considered for Bursary support.

In addition, the Management Committee recognized that Physicians and Scientists in developing countries face significant financial impediments to attend international meetings. Moreover,

they could gain valuable insights and education from NeuPSIG sponsored scientific meetings that will ultimately help them better diagnose and treat neuropathic pain in patients under their care. Consequently, we have elected to provide a limited number of bursaries for Physicians and Scientists from developing countries to attend the Athens Congress. While preference will be given to applicants presenting a Poster in Athens, this is not essential to be considered for bursary support.

Each bursary will cover registration, accommodation support (four nights at a hotel selected by NeuPSIG or our Professional Conference Organizer, Kenes), a maximum of €300 (UK/Europe) or €600 (rest of the world) toward travel support and €100 for living expenses.

Please see the NeuPSIG website (http://www.neupsig.org) for conditions that pertain to both bursary groups–specific requirements must followed otherwise applications may be rejected. Application Forms can be downloaded from the Kenes website (http://www2.kenes.com/neuropathic/Pages/NeuPSIG_Bursaries.aspx).
Bursary applications can be made online via the Kenes website and also via hard copy. However, the Scholarships Awards Subcommittee greatly encourages electronic submission of bursary applications.

Geoff Gourlay on behalf of the NeuPSIG
Scholarships Awards Subcommittee

KEY	Workshops & Interactive Session	Plenary Session	Ceremony / Social Event	Sponsored Symposium
	Breaks	Poster Session		
	Workshop Tracks			
	T - Treatment	**C - Syndromes**	**M - Mechanisms**	**A - Assessment (inc. Psychology)**
	S - Structure and Organisation of the CNS	**B - Interventions**		
	Thursday, May 27, 2010	Friday, May 28, 2010	Saturday, May 29, 2010	Sunday, May 30, 2010
7:00		Parallel Sponsored Breakfast Symposia		
9:00	Parallel workshops and Interactive sessions T - Local Anesthetics C - Radicular Pain M - Primary Headaches S - Astrocyte Regulation via neural glial interactions	The Spinal Cord Peripheral Sodium Channels as Gate-Keepers for Pain - Suleyman Dib-Hajj Chemokines in Neuropathic Pain - Steve McMahon Novel opioid actions in the spinal cord - Jürgen Sandkühler Spinal cord injury pain - from symptom to pathology - Gunnar Wasner	Genetics and Epidemiology Epidemiology of Neuropathic Pain. What do we really know? - Blair Smith Pain Genes - Marshall Devor The threat of chronic pain - Johann Vlayen	**Parallel workshops and Interactive sessions** T - Cost Effectiveness of Treatment C - HIV Sensory Polyneuropathies M - Endogenous Pain Modulation A - Spontaneous Activity in Nociceptors S - Genetics & NPP B - (Pulsed) Radiofrequency
10:30	COFFEE BREAK	COFFEE BREAK	COFFEE BREAK	COFFEE BREAK
11:00	**Parallel workshops and Interactive sessions** T - Management of Central Pain C - Diabetic Neuropathy M - NP and other pathophysiologies A - How to diagnose NP S - Autonomic & microvascular dysfunction in CRPS B - Neuropathic Pain Management	Industry Sponsored Symposia	**Parallel workshops and Interactive sessions** T - Opioid-tolerance and Hyperalgesia C - Mechanisms of TGN M - Surrogate Models A - Attention to Pain S - Genetic Risk Factors B - Which Blocks Work for NPP?	Drugs Neuropathic Pain Clinical Trials and Tribulations: There's Many a Slip 'Twixt Cup and Lip - Robert Dworkin Drug treatments for NPP – looking at the evidence with a cold and fishy eye - Andrew Moore Peter Nathan, His Life and Work - Geoff Schott
13:00		LUNCH BREAK	LUNCH BREAK	Closing Ceremony - poster awards, bursary awards
13:30	Opening Ceremony including talk: Greek Pain Medicine and Art Through the Ages - Manos Stefanidis	Poster Session 1	Poster Session 2	
14:30	Keynote Theme:Stimulation of the Central Nervous System-Mechanisms and Management Spinal Cord Stimulation - Richard North Motor cortex stimulation for chronic pain: can we proceed from phenomenology to mechanisms - Luis Garcia-Larrea	**Parallel workshops and Interactive sessions** T - Personalized Treatment C - Complex Regional Pain Syndrome M - Sodium Channels A - Sensory Testing by Primary Care doctors S - The Spinothalamic Tract B - NP in Cancer Patients	**Parallel workshops and Interactive sessions** T - Opioids for Chronic NP C - Postsurgical Pain M - Abeta Fibres in Paroxysmal Pain A - NeuPSIG Recommendations S – CPSP B - Treatment for Trigeminal Neuralgia	
15:30	Industry Sponsored Symposium			
17:00	COFFEE BREAK	COFFEE BREAK	COFFEE BREAK	
17:30	**Parallel workshops and Interactive sessions** T - Emerging Drug Treatments C - Post Herpetic Neuralgia M - Non Dermatomal Somatosensory Deficits A - Learning & Placebo Effect S - Trigeminal Pains B - Which patients might benefit from SCS?	Parallel Industry Sponsored Symposia	Parallel Industry Sponsored Symposia	
19:00	**WELCOME RECEPTON**			

MARK YOUR CALENDARS!

12th International Meeting on Mechanisms and Treatment of Neuropathic Pain
November 19-21, 2009, San Francisco, USA
Third International Neuropathic Pain Congress
May 27 – 30, 2010, Athens, Greece

Please submit your contributions, ideas, and comments for the NeuPSIG newsletter to the Newsletter Editor:
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