NEUROPATHIC PAIN

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NEWSLETTER of the IASP Special Interest Group on Neuropathic Pain

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Chair's welcome

It is a great honor to be able to serve as Chair of the IASP's Special Interest Group on Neuropathic Pain (NeuPSIG). NeuPSIG's mission statement is that "The SIG will advance the understanding of mechanisms, assessment, prevention, and treatment of neuropathic pain." To more specifically guide NeuPSIG in carrying out this mission, our Constitution and Bylaws includes a list of specific aims and objectives:

- Collaboration for basic and clinical research.
- The study of the underlying mechanisms of neuropathic pain.
- The exchange of information and experience about the assessment and treatment of neuropathic pain.
- The identification and implementation of programs to prevent the development of neuropathic pain.
- Furthering the educational objectives of the SIG via international meetings, an annual symposium, workshops at the IASP World Congress on Pain®, Congress satellite meetings, a newsletter and the IASP Web site.

NeuPSIG's mission statement and its Aims and Objectives are intended to include just about everything that members and potential members would agree is important in advancing understanding of neuropathic pain. The task that NeuPSIG has set for itself is therefore a very ambitious one. Now that it has been in existence for over 3 years, it is reasonable to ask how well it has accomplished these goals. NeuPSIG is the largest of IASP's Special Interest Groups, with approximately 750 members from over 50 countries. It is also a very active Special Interest Group, with well-attended meetings held once or twice each year, several committees that are generating publications of various sorts, a newsletter, and a website. Details about most of these activities are provided elsewhere in this newsletter. I want to emphasize, however, that the management committee hopes that these diverse activities provide something of interest for each one of our members. For this reason, we very much want to hear your feedback about how NeuPSIG has been doing so far, and we especially want you to send us your ideas for additional activities that we should consider. NeuPSIG meetings have been and will continue to be held all over the world—Berlin, Bermuda, London, Madrid, San Francisco, Sydney, and Uluru—and we look forward to seeing you at an upcoming meeting.

Bob Dworkin
Chair, Neuropathic Pain SIG

NeuPSIG satellite meeting in Uluru a big success!

The SIG's first IASP satellite meeting "Expanding Vistas in Neuropathic Pain", took place in Uluru (Ayres Rock) August 17-20, 2005. There were 220 registrants with approximately one-third from Australia and a significant number of basic scientists. Feedback regarding the meeting was excellent. The meeting costs were completely covered by registration fees and industry support and the SIG made a small profit. The program and abstracts from this meeting are available on the SIG's website: www.neupsig.org

The NeuPSIG General Meeting

The first regular General Meeting of NeuPSIG was held during the 11th World Congress on Pain® (WCP) at the Sydney Convention Center, Wednesday, August 24, 2004, 16:30-17:30. **The minutes of this meeting are included at the end of this newsletter**.
Thanks were given to the outgoing members of the SIG's first management committee Turo Nurmikko (Chair), Edmond Charlton (Secretary), Allen Hord, Pedro Bejarano, and Philip Siddall.

New NeuPSIG Management committee:

Executive Committee
Robert Dworkin (Chair, USA)
Rolf-Detlef Treede (Vice-Chair, Germany)
Jonathan Dostrovsky (Secretary, Canada)
Chris Wells (Treasurer, UK)

Management Committee
Ralf Baron (Germany)
Sara Bistre (Mexico)
Geoff Gourlay (Australia)
Maija Haanpää (Finland)
Troels Jensen, Council Liaison (Denmark)
Andrew Rice (UK)
Gary Strichartz (USA)
(plus members of the Executive Committee)

Management committee meetings:

The new management committee met on November 3 2005 in San Francisco, in conjunction with the 8th International Conference on the Mechanisms and Treatment of Neuropathic Pain. At the full day meeting the committee discussed future meetings, subcommittees, and use of SIG funds. Another meeting of the committee is scheduled for April 21-22, 2006 in London. The committee will evaluate possible venues for the planned Satellite meeting to the 12th IASP World Congress on Pain which will take place in London in August 2008 immediately preceding the congress, as well as discuss the upcoming Berlin meeting and focus on the subcommittee activities.

NeuPSIG sub-committees

Research
The committee chaired by Gary Strichartz was involved in awarding the three trainee travel awards for the Uluru meeting and will be providing travel awards for the Berlin meeting. Other roles for this committee are currently under discussion

Upcoming Meetings

June 6 - 9, 2006
Centenary of Central Post-Stroke Pain. (Fifth IASP Research Symposium). Toronto, Ontario, Canada .
See: fhs.mcmaster.ca/paininstitute/

November 2-4, 2006, Bermuda
9th International Conference on the Mechanisms and Treatment of Neuropathic Pain. For further details, see: www.neuropathicpain.org.
(The 8th International Conference on the Mechanisms and Treatment of Neuropathic Pain**.** This SIG co-sponsored meeting took place in San Francisco, November 3-5, 2005 and had a very high attendance of about 450.)

June 7-10, 2007, Berlin, Germany
2nd International Neuropathic Pain Congress. Further details are included below and at www.kenes.com/neuropathic/

August 2008, London, UK
NeuPSIG is planning to apply for a Satellite meeting to the 12th IASP World Congress on Pain to take place immediately preceding the congress. A committee chaired by Andrew Rice and consisting of Maija Haanpää, Chris Wells, Sara Bistre, and Geoff Gourlay, has already started planning this meeting.

2010
The 3rd International Neuropathic Pain Congress. The committee has started to make plans for this congress, at a location still to be finalized.

Topical Reviews

As a new feature of the NeuPSIG newsletter we will publish short reviews of topics related to neuropathic pain. Our first review is by Dr. Ralf Baron on CRPS. Submissions are welcome

NeuPSIG Subcommittees cont.:
Classification and taxonomy
This subcommittee, chaired by Rolf-Detlef Treede met in London on January 20, 2005. It has produced a new definition of neuropathic pain that avoids ambiguities around the terms "dysfunction" and "nervous system":
Pain arising as a direct consequence of a lesion or disease affecting the somatosensory system.

The new definition clearly specifies that there must be a pathological process in the nervous system that goes beyond its normal acute plasticity, and that this process has to affect the somatosensory system. The latter specification was necessary, because under the current IASP definition, muscular pain due to spasticity or rigidity in motor disorders would technically be classified as neuropathic. During the WPC in Sydney, the IASP task force on tax-

onomy gave some favorable preliminary comments on this redefinition, so we expect to get it rapidly accepted within IASP. A manuscript is in preparation that will publish this new definition along with a grading system of possible, probable and definite neuropathic pain.

Assessment
Maija Haanpaa has recently agreed to chair this committee and its composition is currently being finalized. The committee plans to use the EFNS guideline as a starting point.

Treatment
This committee which is chaired by Bob Dworkin met in Boston in April and a draft manuscript has been prepared. The committee hopes to get the endorsement of the British and American Pain Societies prior to submitting it for publication. The next task of the subcommittee is to review non pharmacological treatments

Website
Thomas Toelle has taken over from Jonathan Dostrovsky as chair of this committee. The website has undergone some changes over the past few months. Plans are to expand the material provided on the website. Any suggestions from the membership are welcome and should be addressed to the SIG's secretary who will forward them to the chair of the subcommittee.

Education
This new subcommittee has just been struck and Sara Bistre has agreed to chair it with Geoff Gourlay, Andrew Rice, and Chris Wells. It was felt that the SIG could play an important role in disseminating information on the assessment and treatment of neuropathic pain. Specific objectives would be to disseminate information on neuropathic pain to both developed and developing nations, provide guidelines on treatment, encourage younger health professionals to become interested in neuropathic pain and provide/seek sponsor for travel awards and fellowships. Sara Bistre would also like to see guidelines translated into other languages, in particular Spanish, for Latin American countries.

Classification and Diagnostic Tools in Complex Regional Pain Syndromes

Ralf Baron**,** Dr med
Klinik fur Neurologie, Christian-Albrechts-Universität zu Kiel, Kiel, Germany

Introduction
The term Complex Regional Pain Syndrome describes a variety of painful conditions following injury which appears regionally with a distal predominance of abnormal findings. The symptoms exceed in both magnitude and duration the expected clinical course of the inciting event and often result in significant impairment of motor function. The disorder shows a variable progression over time. These chronic pain syndromes comprise different additional clinical features including spontaneous pain, allodynia, hyperalgesia, oedema, autonomic abnormalities and trophic signs. In CRPS type I (reflex sympathetic dystrophy) minor injuries or fractures of a limb precede the onset of symptoms. CRPS type II (causalgia) develops after injury to a major peripheral nerve (Baron et al. 2002; Janig and Baron 2003; Stanton-Hicks et al. 1995).

Diagnostic criteria
The definition of standardized diagnostic criteria for CRPS in 1995 was a major advance in the classification of regional pain disorders associated with vasomotor or sudomotor abnormalities (Stanton-Hicks et al. 1995). However, these criteria were derived based upon the consensus opinion of a small group of expert clinicians. While this was an appropriate first step it is important to continuously improve the criteria, i.e. to validate and, if necessary, modify these initial consensus-based criteria based upon results of systematic validation research. The CRPS diagnostic criteria were adequately sensitive (i.e., rarely miss a case of actual CRPS). However, both internal and external validation research suggests that CRPS was overdiagnosed (Bruehl et al. 1999; Harden et al. 1999). For example, an external validation of the IASP criteria in 117 patients with CRPS and 43 patients with neuropathic pain without CRPS-etiology demonstrated a sensitivity of 0.98 and a specificity 0.36. The inclusion of a category "motor and trophic signs and symptoms", e.g., improves specificity considerably without losing sensitivity (Bruehl et al. 2002). Based on this validation research a novel diagnostic algorithm was recently proposed (Tab. 1) (Burton et al. 2005; Wilson et al. 2005). In addition to the improved clinical categories it became clear to distinguish between criteria for clinical use and a classification for research purposes. For the clinician and in particular for the patients it is important to have a high sensitivity value combined with a fair specificity (e.g., 0.85 vs. 0.60, Table). For research purposes, however, it is much more important to have a high specificity in order to perform studies in a precisely diagnosed population (e.g., 0.7 vs. 0.96, Table 1).

Standardized diagnostic tests help to confirm the clinical diagnosis

The current criteria of CRPS I and II are mainly based on the patient´s history and a careful physical examination. There is no diagnostic gold standard nor an objective test procedure for CRPS. However, some diagnostic tests could add valuable information to confirm the diagnosis although the absence of abnormal results does not argue against the diagnosis of CRPS (Table. 2).

Autonomic function tests

These tests comprise infrared thermometry, infrared thermography, quantitative sudomotor axon reflex test (QSART), thermoregulatory sweat test (TST) and laser Doppler flowmetry.

Skin temperature differences could be assessed easily by infra-red thermometry or thermography (Gulevich et al. 1997). These are dependent on the environmental conditions, could change dynamically within minutes and are most prominent in thermomoderate environment. Skin temperature side differences at rest (22-24°C room temperature, 30 supine position for 30 minutes) of less than 2°C show a poor sensitivity of 32% but specificity of 100%. Under controlled thermoregulation temperature side differences of >2,2°C achieve a sensitivity of 76% and a specificity of 100%. Thus to improve the sensitivity, i.e. the attempt to assess the maximum asymmetry, in clinical practice repetitive measurements should be carried out at the beginning, in between and at the end of the patient`s visit. If detected, differences of more than 2,2°C are specific and sensitive for the diagnosis of CRPS (Fig. 1) (Wasner et al. 2002; Wasner et al. 2001).

In a study in 21 patients with CRPS the QSART and the TST could show an enhanced sudomotor output compared with the contralateral limb within a mean disease duration of 5 weeks. At a mean duration of 94 weeks the TST remains pathological whereas the QSART shows no side differences (Birklein et al. 1998).

We used the laser Doppler flowmetry to assess the vascular reflex response in 25 patients with CRPS I. By controlled whole-body cooling and warming the sympathetic vasoconstrictor-activity was altered and the cutaneous blood flow in the upper or lower extremities was monitored simultaneously. We emphasise three different vascular regulation patterns in CRPS I. In short-lasting CRPS, the so called “acute” phase with a mean disease duration of 4 months, the affected limb showed higher skin perfusion values. In patients with a history of 15 months (mean), the “intermediate” phase, the affected limb showed either higher or lower skin perfusion. If the duration was longer with a mean of 28 month, the affected limb showed lower perfusion of the skin at the affected side. Subsequently the skin temperature was altered the same way (Wasner et al. 2001).

Bone scintigraphy

Osseous changes are common in CRPS. Thus a three-phase-bone scintigraphy can provide valuable information (Kozin et al. 1981). A homogenous unilateral hyperperfusion in the perfusion- (30sec post inject.) and blood-pool-phase (2 min post inject.) is characteristic and will help to exclude differential diagnosis, e.g. osteoporosis due to inactivity. 3 hours post inject. the mineralization-phase will show an increased unilateral periarticular tracer-uptake. A pathological uptake in the metacarpophalangeal or metacarpal bones is thought to be highly sensitive and specific for CRPS (Todorovic-Tirnanic et al. 1995; Zyluk 1999). It should be noted that it only shows significant changes in the first year of the disease. However a gold standard to compare with is not known yet but it is useful to rule out pain syndromes of other origin.

The value of this test in children seems to be of minor value than in adults showing a higher variability and interestingly often decreased diffuse uptake. Therefore, it should be performed in children mainly to rule out other aetiologies (Wilder 1996).

Plain radiographs

Endostal and intracortical excavation, subperiostal and trabecular bone resorption, spotty and localised bone demineralisation or osteoporosis have been thought to be specific signs of CRPS. However, a comparison of radiography and three-phase-scintigraphy in early post-fracture CRPS, although performed in a small cohort, showed a lower sensitivity (73% vs. 97%) and specifity of the radiography (57% vs. 86%) (Todorovic-Tirnanic et al.1995). Furthermore, these signs are only positive in chronic stages of CRPS.

MRI

MRI scans have demonstrated changes in joints (joint effusion) and soft tissues very sensitively but with very low specificity (Graif et al. 1998). Bone marrow edema is inconsistent in the acute phase and is never present in chronic stages.

Quantitative sensory testing (QST)

A bedside testing should be part of the physical examination as outlined above to confirm e.g. allodynia and hyperalgesia. Additionally standardised psychophysical tests of the thermal, thermal pain and vibratory thresholds to assess the function of large, small myelinated and unmyelinated afferent fibers are practicable. Impairment of warm and cold sensation as well as heat pain has been demonstrated frequently in patients with CRPS. Further detailed sensoric testing, including static, dynamic allodynia, pin-prick allodynia, heat and mechanical hyperal-

gesia and temporal summation have shown abnormal results. However, no characteristic sensoric pattern of CRPS has been identified so far but is still useful to determine and quantify the individual signs of each patient and to document the successful response to treatment.

Psychological investigations

In 1996 Covington (Covington 1996) drew several conclusions on the psychological factors in CRPS: (1) No evidence was found to support that CRPS is a psychogenic condition, (2) Because anxiety, stress and chemical dependency increases nociception, relaxation and antidepressive treatment is helpful, (3) The pain in CRPS is the cause of psychiatric problems and not the converse, (4) Maladaptive behaviour by the patients, such as volitional or inadvertent actions, are mostly due to fear, regression or misinformation and do not indicate psychopathology, (5) Some patients with conversion disorders and factitious diseases have been diagnosed incorrectly with CRPS. Their poor response to treatment sometimes leads the pain specialist to the opinion that CRPS is a psychiatric condition. In summary the author conclude that the widely proposed ““RSD personality” is clearly unsubstantiated”. Accordingly, an even distribution of childhood trauma, of pain intensity and psychological distress was confirmed by Ciccone et al. (Ciccone et al. 1997) in patients with CRPS in comparison to patients with other neuropathic pain and chronic back pain. Further studies demonstrated a high psychiatric comorbidity, especially depression, anxiety and personality disorders, in CRPS patients. These findings are also present in other chronic pain patients and are more likely a result of the long and severe pain disease (Monti et al. 1998). In comparison to patients with low back pain CRPS patients showed a higher tendency to somatization but did not show any other psychological differences (Bruehl et al. 1996). In 145 patients 42% reported of “stressful life events in close relationship to the onset of CRPS and 41% had a history of chronic pain before” (Birklein et al. 2000). Thus stressful life events could be risk factors for the development of CRPS (Geertzen et al. 1998).

Significant emotional dysfunction was demonstrated in a small number of children with CRPS (Barbier et al., 1999). Wilder et al. (Wilder 1996) hypothesized a possible relation of intensive, parental forced, sports and leisure activities to the occurrence of trauma leading to CRPS as a sign of escape from parent`s excessive demands.

Differential diagnosis

Due to the lack of a gold standard in diagnosis of CRPS the risk of overdiagnosing has to be taken into account. To differentiate CRPS from other neuropathic and other pain syndromes the detailed history and physical examination according to the specifications outlined above are mandatory.

Post-traumatic neuralgia. It is important to recognize that many post-traumatic neuropathy patients have pain but do not have the full clinical picture of causalgia (CRPS II). In these cases, in contrast to causalgia patients, the pain is located largely *within* the innervation territory of the injured nerve. Although these patients often describe their pain as burning, they exhibit a less complex clinical picture than patients with causalgia and do not show marked swelling or progressive spread of symptoms. The cardinal symptoms are spontaneous burning pain, hyperalgesia and mechanical and especially cold allodynia. These sensory symptoms are confined to the territory of the affected peripheral nerve although allodynia may extend beyond the border of nerve territories for some centimeters. Spontaneous and evoked pain are felt superficially and not deep inside the extremity and the intensity of both is not dependent on the position of the extremity. The patients occasionally obtain relief with sympatholytic procedures although much less often than those with CRPS.

Following the IASP classification it is possible to use the name ”neuralgia” for this type of neuropathic pain (pain within the innervation territory of a lesioned nerve, e.g. post-traumatic neuralgia). However, the new definition of CRPS II includes the statement that symptoms *may* also be limited to the territory of a single peripheral nerve. Therefore, the term CRPS II provides space to include these localized post-traumatic neuropathies. An inherent weakness of this definition of CRPS II is that different syndromes with different underlying mechanisms are obviously included. Neuropathies, like the diabetic polyneuropathy may also present with spontaneous pain, skin colour changes and motor deficits but are distinguished by the symmetric distribution and the patient`s history. Furthermore, all kinds of inflammations or infections (e.g., rheumatism, phlegmones) might induce an intense unilateral skin warming. Unilateral arterial or venous occlusive diseases can cause unilateral pain and vascular abnormalities and have to excluded. Repetitive artificial occlusion of the blood supply to one limb (as in the psychiatric factitious disorders, artefact syndrome) might induce secondary structural changes of the blood vessels with consecutive abnormalities in perfusion and, therefore, mimic CRPS symptoms and signs.

Acknowledgments

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Table 1
Revised diagnostic criteria of CRPS
Clinical signs / symptoms

1. Positive sensory abnormalities:
   - spontaneous pain
   - mechanical hyperalgesia
   - thermal hyperalgesia
   - deep somatic hyperalgesia

2. Vascular abnormalities
   - vasodilation
   - vasoconstriction
   - skin temperature asymmetries
   - skin color changes

3. Edema, sweating abnormalities
   - swelling
   - hyperhidrosis
   - hypohidrosis

4. Motor, trophic changes
   - motor weakness
   - tremor
   - dystonia
   - coordination deficits
   - nail, hair changes
   - skin atrophy
   - joint stiffness
   - soft tissue

Interpretation:
For clinical use
≥3 symptoms of each category and ≥2 signs of each category
Sensitivity 0.85 Specificity 0.60

For research use
4 symptoms of each category and ≥2 signs of each category
Sensitivity 0.70 Specificity 0.96

Table 2
Diagnostic tests In CRPS

	Sensitivity	Specificity
Plain radiograph (only chronic stages)	73	57
Bone scan (only acute stages)	97	86
Quantitative sensory testing (QST)	high	low
Temperature differences (during sympathetic stimulation)	76	93
MRI (skin, joint, etc.)	91	17

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Minutes of the 2005 General Meeting

Neuropathic Pain Special Interest Group of the IASP General Meeting at the 11th World Congress on Pain which was held in the Harbourside Auditorium at 1630 hrs on Wednesday 24 August, 2005 in the Sydney Convention Centre, Sydney, Australia.

1. Chairman's welcome. Dr Nurmikko welcomed members to the meeting and outlined the procedure to be followed.

2. Apologies for Absence – P. Evans, G. Gourlay

3. Approval of the Draft Constitution and Bylaws. These had been circulated previously and were approved unanimously. The adoption of the Constitution and Bylaws means that these come into effect immediately.

4. Minutes of the General Meeting held in San Diego 20 August, 2002. These were approved as an accurate record.

5. Matters arising from the Minutes. There were no matters arising

6. Secretary's report Dr Charlton reported that membership of the SIG was 722 at the end of July 2005. This represented an increase of over 200 members in the last three years. 41 disciplines and 54 countries were represented. The Neuropathic Pain SIG was not only the largest special interest group within IASP, but by far and away the most active. He noted the Management Committee meetings were usually held in association with a scientific meeting to keep expenses down. He summarized these meetings and outlined the commitment of the SIG to high class educational meetings, noting that the next one will be held in Berlin in early June 2007. Dr Charlton noted that the SIG now has active committees looking at classification, assessment, treatment and research. He drew the attention of members to the SIG website. This was looked after by Dr Jonathan Dostrovsky with help from Dr Thomas Toelle and Dr Rolf-Detlef Treede. He reported that newsletters had been produced regularly. He concluded by offering his thanks to the Officers and the Management Committee of the SIG for their help and support over the preceding three years

7. Treasurer's report Dr Wells gave a comprehensive report of the SIG finances. These were extremely healthy due to a substantial profit from the Madrid Scientific Meeting. He outlined plans for further meetings.

8. Election of Officers The Secretary reported that he had received properly seconded nominations for each of the three posts. The candidates had indicated their willingness to stand. Under the terms of the Constitution and Bylaws adopted earlier no elections were required and the following were duly elected.
   Vice-Chair – Dr Rolf-Detlef Treede.
   Secretary – Dr Jonathan Dostrovsky
   Treasurer – Dr Chris Wells.

9. Any Other Business.
The Committee Chairs reported the constitution and activity of their subcommittees:
   a. Research - Gary Strichartz
   b. Classification – Rolf-Detlef Treede
   c. Assessment - Turo Nurmikko
   d. Treatment – Bob Dworkin

e. Website – Jonathan Dostrovsky.

Dr Charlton announced the formation of a provisional SIG on Animal Pain which he thought might be of interest to members of the Neuropathic Pain SIG.

Dr Nurmikko handed over the Chairmanship of the SIG to Dr Dworkin. Drs Nurmikko and Charlton were presented with engraved coasters in appreciation of their contribution to the SIG.

10. Date and venue of next general meeting. This was provisionally arranged for the 20th of August, 2008, in the Glasgow Convention Centre.

June 7-10, 2007, Berlin, Germany
The 2nd International Neuropathic Pain Congress

The Congress will take place at the InterContinental Berlin which is located in the heart of Berlin, between Potsdamer Platz and Kurfürstendamm, near the embassy district, government offices and the historic section of the city. Ralf Baron chairs the Scientific Program Committee and Rolf-Detlef Treede chairs the Local Organizing Committee. The detailed membership of these committees is listed on the website.

The Main topics of the meeting are:
- Postherpetic neuralgia
- Diabetic neuropathy
- Complex regional pain syndromes
- Central pain syndromes
- Animal models in neuropathic pain
- Mechanism-based classification and therapy
- Clinical assessment in neuropathic pain
- Quantitative sensory testing in neuropathic pain
- Genetics of neuropathic pain
- Design of clinical trials in neuropathic pain
- Novel molecular drug targets in neuropathic pain

The first international meeting organized by the Special Interest Group on Neuropathic Pain (NeuPSIG) of the International Association for the Study of Pain (IASP®) took place in Madrid, Spain in May 2004.

Over 1,000 clinicians and researchers participated in plenary sessions, topical workshops and poster presentations designed to fulfill NeuPSIG's aim "to advance the understanding of mechanisms, assessment, prevention and treatment of neuropathic pain**".**

Following the success of the first Congress we now invite you to join us in Berlin, June 7–10, 2007 for the Second International Congress on Neuropathic Pain.

Berlin is the capital and the largest city in Germany, a city on the cutting-edge where constant change is a given. A fascinating mix of architectural and life-styles, the massive rebuilding since 1990 has swiftly erased nearly all traces of the Wall. The city spills north and south of the Spree River, which winds through some of the magnificent parkland that comprises a third of the municipal area. Unter den Linden, the fashionable avenue of aristocratic old Berlin, extends from the Brandenburg Gate to Alexanderplatz, once the heart of socialist East Germany.

Some of Berlin's finest museums are here, on the Museumsinsel in the Spree, the original center of the metropolis. West of the Brandenburg Gate, the boulevard runs through Tiergarten, a huge landscaped park with the impressive Victory Column at its center. The commercial center of West Berlin glitters just to the south. Cafés, restaurants, concerts, theatre, nightclubs – Berlin has much to offer visitors, making even the shortest visit a memorable one.

Berlin's center, Potsdamer Platz has been the site of massive building with business centers, hotels, movie theaters etc., employing some of the most famous contemporary architects. This construction activity is now reaching its end, leaving one of the most impressive metropolitan centers in Europe. We look forward to welcoming you at what promises to be a most stimulating and enjoyable meeting in one of the most interesting of European venues.

MARK YOUR CALENDARS! June 7-10, 2007, Berlin

Current SIG information

As of February 15, 2006, the NeuP SIG has 757 members in 56 countries representing 38 specialties.

SIG Treasurer's report: On December 31, 2005 the SIG account had a balance of US$ 209,488.26

The SIG Web site is: www.neupsig.org

Please submit your contributions, ideas and comments for the NeuP SIG newsletter to the SIG Secretary/ Newsletter Editor:

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