**Collection of abstracts 2024**

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**Conference**

**Inaugural lecture Jean-Marie BESSON**

**Neuropathic pain: yesterday, today and tomorrow**

N. Attal 1

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The notion that pain can be secondary to damage to the nervous system dates back to the High Middle Ages, with the term "Auojae Asab" [nerve pain] already being used in Persian medical literature to describe such pain. More recently, the terms "deafferentation pain", "neuralgia" and "neurogenic pain" have been used to describe this type of pain. Recent history has been marked by significant clinical and therapeutic advances, with a new definition (2008) and classification (2021) of this pain, as well as major conceptual changes. Pain of this kind, which has a variety of symptoms and is linked to a number of aetiologies, is now defined as a "trans-etiological" entity, which means that it needs to be treated in a specific way, independently of the aetiology. The last two decades have seen diagnostic and epidemiological advances, with the development of specific screening questionnaires, including the DN4 in France (2005), which makes it easier to recognise pain in a variety of contexts, and to estimate its prevalence in the general population for the first time. Other specific questionnaires and the development of techniques for the quantitative assessment of sensitivity disorders (QST), coupled with research into anatomical or functional biomarkers, are making it possible to better assess and understand the pathophysiological mechanisms of this pain. The therapeutic management of neuropathic pain has been boosted by the advent of gabapentinoids, with the setting up of large multicentre studies for the first time (JAMA 1998), the development of topical or local treatments which are increasingly widely used (lidocaine, capsaicin, botulinum toxin A), and various neuromodulation techniques. In the future, we can already count on pathophysiological advances, with a better understanding of the genetic determinants of this pain, and therapeutic advances with the demonstration of the value of an individualised therapeutic approach, the development of pharmacological treatments acting on new targets, such as certain sodium channel blockers, and new invasive or non-invasive neuromodulation techniques (1, 2).

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**Conference**

**Closing conference**

**When forensic medicine explores history**

P. Charlier 1

1 Chu R. Poincaré (AP-HP) - Garches

Forensic medicine is not limited to the study of bodies in legal contexts. The Laboratoire Anthropologie Archéologie Biologie (LAAB) at the University of Versailles-Saint-Quentin-en-Yvelines specialises in the study of skeletons and mummies from archaeological digs and in historical contexts. By using biomedical techniques on these ancient samples, it is possible to reconstruct the state of health of populations of the past.

This lecture will present the latest data from the examination of the remains of Lucy, Richard the Lionhearted, Henri IV, Robespierre, Voltaire, Hitler... and many others.

Poisoning or natural death? Tumour or malformation? Suicide or disguised crime? From prehistory to the twentieth century, palaeopathology allows us to explore the health records of these unusual deceased, taking us on a fascinating scientific and historical journey.

**Plenary session**

**Plenary session 1**

**Vascular Algebra of the Face**

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Clinical features

Facial vascular angina (FVA) is characterised by extremely intense unilateral attacks of pain, mainly in the orbital region and temple. These attacks are associated with dysautonomic symptoms ipsilateral to the pain (lacrimation, conjunctival redness, palpebral oedema, nasal congestion or rhinorrhoea, sweating, miosis, ptosis). In addition to the intensity and location of the pain, AVF is characterised by a particular temporal profile. Attacks last from 15 minutes to 3 hours and occur several times a day, particularly during sleep, often at fixed times. In the majority of cases, attacks develop episodically, with episodes occurring several times a day over periods of 2 weeks to 2 months, followed by pain-free intervals that can last several months. Painful periods often occur in spring and autumn. As a result, patients have a dual periodicity, with both a circadian and a circannual course. Another peculiarity of this condition is that it mainly affects young men, with a prevalence of smoking observed in 60 to 88% of cases.

Pathophysiological mechanisms

Anatomically, three structures are particularly involved during seizures: the trigeminovascular system, the trigemino-autonomic reflex and the hypothalamus. Genetically, eight susceptibility laws have recently been identified. It is interesting to note that a genetic correlation has been observed between AVF and certain traits such as smoking. The genes involved in the mechanisms responsible for maintaining circadian rhythms are being studied in particular. A recent study showed that the fluctuation in CLOCK gene expression over the year differed from that of controls.

Treatments

Crisis treatments include subcutaneous sumatriptan and/or oxygen therapy. Transitional treatment with corticosteroids per os or by injection into the greater occipital nerve is often proposed, particularly in cases of episodic AVF. The first-line preventive treatment is verapamil, while teralith is offered in cases of chronic AVF. In cases of drug resistance, neuromodulation by stimulation of the large occipital nerves may be considered.

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**Plenary session**

**Plenary session 1**

**Vicarious trauma and compassion fatigue in carers**

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Carers are often in contact with people who are in pain or distress, or who have been through upsetting experiences or violent trauma. These confidences, these contacts with intense emotions, are not trivial and can affect any healthcare professional. This conference will help us to better identify the possible reactions of exhaustion and to distinguish them from the symptoms of vicarious trauma and compassion fatigue experienced by carers. A distinction will also be made with post-traumatic symptoms as such.

We will then try to understand why some carers are more vulnerable or more affected than others in similar contexts. The protective and risk factors associated with the development of these two syndromes will be presented. The factors will be divided into predisposing, triggering and maintaining vulnerability factors.

In conclusion, the conference will look at ways of self-assessment and psychological self-care.

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**Plenary session**

**Plenary session 2**

**Osteoarthritis pain: from fatality and shame to hope**

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Osteoarthritis pain is very common. It is associated with fatalism (intractable pain), shame (pain linked to ageing or obesity), and often little recognition (1). Given the frequency of this pain and its very negative image, it is important to provide clinicians and patients with scientific data and tools to improve their management.

Osteoarthritis pain: what is the link with osteoarthritis?

The pathophysiology of osteoarthritis pain is of course linked to the deterioration of joint structures during osteoarthritis, but in many cases is not directly correlated with this deterioration. It is important to make it clear to patients that just because they have a lot of pain does not mean that it is very serious or very deteriorated (3).

Osteoarthritis pain: a spectrum of pain

Osteoarthritis pain is often reduced to mechanical pain, exacerbated by effort, but in fact there are many different types of osteoarthritis pain. All the structures in the joint (bone, tendons, synovial membrane, muscles, etc.) are involved in the peripheral pain mechanisms, with central sensitisation in chronic or recurrent forms (2).

Osteoarthritis pain: what tools are needed to better understand and treat it?

The management of any pain requires an in-depth assessment to clarify the mechanisms, both peripheral and central.

There are several questionnaires for assessing osteoarthritis and its pain, depending on the location. We have developed the OASIS9 tool (2), a 9-question questionnaire which identifies the mechanisms involved in osteoarthritis pain and has shown that there are 3 dimensions to osteoarthritis pain: peripheral nociceptive pain, neuropathic pain and nociplastic pain. The aim of the OASIS9 questionnaire is to guide treatment according to the predominant mechanisms.

Pain treatment :

Drug treatments are not very effective for osteoarthritis pain (4), particularly chronic pain. It is therefore important to develop multidisciplinary and multimodal approaches tailored to patient profiles. Dietary measures, physical activity, therapeutic patient education and patient support are major factors in osteoarthritis pain. Complementary approaches such as yoga, TENS (with a specific system for gonarthrosis) and acupuncture are very useful.

In conclusion, although osteoarthritis remains a disease that is still difficult to treat, the pain of osteoarthritis is not inevitable and should no longer be hidden: it can be assessed and improved. We now know more about this pain, and its specific mechanisms represent therapeutic targets, whether pharmacological or otherwise.

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**Plenary session**

**Plenary session 2**

**Grief and acceptance in pain**

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There are two different links between grief and mourning:

Chronic pain often involves loss (of activity, independence, previous lifestyle). Patients may go through phases of mourning similar to those experienced when losing a loved one. Accepting chronic pain means going through a real grieving process, which takes time.

Loss and bereavement are often at the root of chronic pain problems [1] [2]. Persistent pain can be seen as a "complication of a previous mourning process", as an indication of "what could not be transformed by the mourning process"[3].

There is a clear need for carers to better understand the concept of the grieving process in order to support chronic pain patients. Mourning is not something that can be decreed by will. It unfolds at a pace that neither the patient nor the carers can control. It must be accompanied, and each person's time frame must be accepted. Any pressure to hasten mourning, even if implicit, is likely to provoke resistance from patients. By having difficulty accepting a lack of therapeutic efficacy, carers may, on the one hand, manifest a negative emotional response [4], and on the other, echo patients' difficulties in grieving. In this case, through a mirror-image relationship dynamic, they unwittingly encourage patients to reject the situation rather than accept it. By bringing together the classic relational difficulties faced by carers dealing with these complex situations, on the one hand, and reflections on the concepts of bereavement and acceptance, on the other, we can identify some fundamental principles of care.

First of all, the acceptance by carers of their powerlessness, particularly in the face of therapeutic failure, is an essential condition for supporting patients. This presupposes acceptance of patients' unique situations, even (and especially) if they do not correspond to the most conventional standards or expectations [5].

Understanding the subjective meaning of each person's situation also means putting up with, welcoming and accepting complaints. There is also a need to broaden one's understanding of the situation beyond the biomedical reference model [6]. Finally, it appears that support from professionals can be useful in helping them to grieve for their effectiveness and in encouraging them to adopt an accepting stance. This support can take various forms (training, Balint groups, analysis of practices, theatre and simulation workshops, etc.) and will be all the more beneficial if it frees up the professionals' power to act.

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**Plenary session**

**Plenary session 3**

**Intractable cancer pain: what are the respective roles of methadone and intrathecal analgesia?**

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Pain is a major symptom during and after cancer, whether related to the cancer itself or to its treatment [1]. The majority of patients are relieved by first- or second-line strategies, but around 10% may experience intractable pain [2]. Their management requires a multidisciplinary approach [3]. Specific RCPs have been developed, involving algologists, interventional radiologists, anaesthetists, neurosurgeons and palliative care specialists. When local treatment is not possible, two major options are often discussed: methadone and intrathecal analgesia. The choice between them is not always easy.

Methadone is a synthetic opioid that also has an anti-NMDA and mono-aminergic action. It is particularly indicated when the pain involves several sites, when there is tolerance to opioids with long-term administration of high doses, or when there is hyperalgesia. It is available orally and parenterally. It is difficult to introduce and requires hospitalisation for several days. Its side effects are those of opioids, particularly cognitive and digestive. It has numerous drug interactions, particularly with targeted anti-cancer therapies [4].

Intrathecal analgesia is aimed at loco-regional pain, whether somatic, visceral or neuropathic, with no restriction on anatomical location. It is particularly useful when the pain is not very morphine-sensitive or when side effects limit the adaptation of opioids. It improves the analgesic effect while reducing undesirable effects, and improves patients' quality of life and autonomy. It requires a complex organisation involving not only the pain/palliative care team and the oncologist, but also a circuit for fitting the pump, preparing the products, initiating treatment in hospital, monitoring and iterative refills, and risk management [5].

The choice between techniques may be based on the location of the pain, the intensity of opioid impregnation, the link with the oncology plan, any contraindications, accessibility and, of course, the patient's preferences. It is not out of the question to use first one and then the other in the event of failure, bearing in mind, however, the sometimes limited life expectancy, the complexity of the treatment process and the impact of successive failures on patients.

While technical solutions must always be discussed, even at a very advanced stage, they can sometimes become unreasonable and it is essential to know when to abandon them.

Finally, cancer is an ordeal in which the psychological, social and existential dimensions are all part of the painful experience. Losing sight of these dimensions can lead to an escalation of suffering as technical suggestions fail.

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**Plenary session**

**Plenary session 3**

**Relational care versus technical care: what thoughts for our society? Or health beyond AI.**

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After a brief reminder of what care is and how it differs from treatment, we will show how, paradoxically, progress is accompanied by the emergence of complex situations and sometimes gives rise to situations of vulnerability. We will look at the way in which complex situations are apprehended, which is very much marked by uncertainty as to the validity of action; and how, with reference to the work of Edgard Morin, complexity requires interdisciplinary approaches. Reference will be made to how this complexity and these situations of vulnerability can lead to "ethical suffering at work" on the part of healthcare professionals.

This introduction will enable us to reflect on the future of our healthcare system, part of which lies in the need to value relational rather than technical care. At present, our healthcare system values (overvalues) technology. In so doing, it fails to value care and reflection. This runs the risk of leading people to do things just because they know how to do them, even though doing them can cause suffering. In a context where performance is the watchword, time no longer intersects: the constrained time of the carer intersects with increasing difficulty with the time of patients, who need it because their situation is complex and their ability to understand is sometimes impaired. Making the most of care time; making the most of interdisciplinary time: time for deliberation in complex situations often marked by ethical tensions

The well-thought-out development of AI could, by freeing up time for diagnosis and certain types of care and treatment, refocus healthcare professionals on their core business.

**Members' session (former ATS)**

**Pregnancy, the perineum and pain?**

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The epidemiology of pain in pregnant women is poorly understood. Studies show a frequency of between 56 and 72%, mainly in the pelvic area (lumbar, pelvic, ligament pain, etc.), with little information on the factors that contribute to this pain (1).

The proportion of women presenting with acute pain is very high in the immediate postpartum period, affecting around 90% of deliveries on D1 [1]. In 85% of cases, this acute pain has an impact on maternal activity. This pain is perineal, but not exclusively, and most often peaks in the first 72 hours after birth.

This post-partum perineal pain is often associated with a tear, an episiotomy, a perineal haematoma, a disunion or an infection at the episiotomy site. Inflammation of the suture can cause oedema and neuropathic pain in the scar, which then becomes painful. Perineal pain increases with the severity and complexity of the perineal trauma and the history of pain (mainly during pregnancy and menstruation) (2).

Catastrophism is a risk factor for pain (4).

Acute pain, which is very common in the postpartum period and often disabling, can develop into chronic pain with pelvic-perineal hypersensitivity.

Preventing perineal injury during childbirth, particularly during release of the foetal head, is a priority for all obstetricians in the labour ward. Various measures have been proposed before and during delivery (perineal massage, episiotomy, etc.) to prevent this risk, but their effectiveness is still debated (3).

It is also necessary to relieve acute pain, thereby facilitating early rehabilitation, improving mother-child interaction and encouraging breastfeeding (4). The first line of drug treatment for pain after vaginal delivery is based on paracetamol and NSAIDs. Morphine can be administered peridurally after delivery in the event of perineal lesions, or orally on demand in the postpartum period. Infiltration of the perineum with local anaesthetics has limited effects over time. The pudendal block is effective after episiotomy. Breastfeeding is not a contraindication to the use of most analgesics (4).

The aim of this workshop is firstly to explain the anatomical basis of the perineum, and then to explain the different aetiologies of pain during pregnancy and partum, and how they can be treated from the perspective of the gynaecologist, midwife and algologist.

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4 Postpartum pain: an often forgotten symptom? Pain after delivery: A forgotten symptom?Agnès Legouez

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**Members' session (former ATS)**

**Tele-expertise in chronic pain**

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In this session, two pain structures present their practice using a tele-expertise platform. Almost a year on, we will share the impact of this practice on the operation of the SDC, the patient pathway and the advantages and disadvantages. The aim here is to present an approach put in place by the TCSs in response to a problem in the field and to try to encourage a town-hospital link by providing elements in the context of the TCSs' mission to support primary care.

After a brief presentation of the regulatory framework for tele-expertise and the tool used, we will give a multi-voice presentation of the operating procedures and feedback, followed by a discussion of practices to remind us of the difficult link between the principles of intervention in chronic pain and the constraints in the field in terms of resources and availability.

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**Members' session (former ATS)**

**MBPM programme to support chronic pain patients using Mindfulness: 3 years of Semi-structured Mindfulness Groups at the Pitié Salpêtrière Pain Clinic**

**Mindfulness Meditation for Chronic Pain Patients**

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OBJECTIVES

-Present the Mbpm programme (Mindfulness Meditation in the Care of Pain Patients)

-Raising awareness of qualitative research methods and techniques through recorded and anonymised clinical experiences.

-Present the initial results of the quantitative evaluation questionnaires administered at the first and last sessions of the programme, and of a qualitative survey sent to all participants at least 3 months after their participation in the programme.

- Feedback on 3 years of running the MBPM programme at La Pitié Salpêtrière

SUMMARY

-Principles and structure of the Mbpm programme, with video examples of the sessions

-Leading and guiding model exercises, in particular on complete breathing, and to teach the patient to break down the different parts of his or her painful complaint.

Medium- and long-term effects: presentation of the results of a

qualitative questionnaire sent to patients after the session (between 3 months for the

recent and 3 years after the session for the first groups

-Video testimonials from former patients taking part in the regular support meetings organised after the programme

-Debate with the audience, questions and answers

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**Members' session (former ATS)**

**Preventing and reducing the risks of opioid misuse and overdose: what can be done?**

E. Frauger 1, S. Mezaache 1, V. Piano 2

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Opioids are essential drugs in the management of pain and addiction. However, their use can expose patients to the risk of drug use disorders and health risks such as overdoses. These overdoses occur in a wide variety of contexts and can lead to severe clinical symptoms. The antidote naloxone has been available in ready-to-use form since 2016 (1).

The POP programme "Prevention and risk reduction of opioid-related overdoses in the PACA region" is run by CEIP-Addictovigilance PACA Corse (APHM) and has been funded by ARS PACA since 2020. This programme, in conjunction with a number of partners in the region, is a territorial and operational application of the Ministry of Solidarity and Health's 2019-2022 roadmap "Preventing and responding to opioid overdoses" (2). It is also based on the HAS recommendations "Bon usage des médicaments opioïdes : antalgie, prévention et prise en charge du trouble de l'usage et des surdoses" (3). The aim of the POP programme is to put in place local and outreach initiatives to improve the management of patients at risk of overdose, improve professional practices and facilitate the distribution of naloxone. These initiatives target patients and the various professionals involved in the care chain (general practitioners, specialist pain and addiction management structures, CLUDs, pharmacists, etc.).

The programme is based on a number of actions: i) taking stock of professional practices, difficulties and needs; ii) reaching out to professionals and patients/users (training, interactive workshops); iii) creating and disseminating information tailored to the needs expressed; iv) providing feedback.

The main findings of the review were that the scales for identifying opioid misuse were not widely used and that naloxone was not widely available (4). A number of needs emerged (providing patients with more information, training professionals, practical tools, etc.). Based on these findings, a number of initiatives have been developed jointly with partners in the field.

The aim of this session is to raise participants' awareness of opioid analgesics, misuse, overdoses and the antidote naloxone. First of all, an interactive quiz will be carried out to test their knowledge. Next, the operational actions carried out as part of the POP programme will be presented. These actions target patients (information workshops, fun games, information materials on the proper use of opioids, overdoses, naloxone, etc.) and professionals (training, how to spot the risk of misuse? Who should prescribe naloxone and how?) Finally, the Centre Hospitalier de la Dracénie will provide feedback on a multidisciplinary approach involving algologists and addiction specialists.

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**Members' session (former ATS)**

**Music and Pain: Evaluation and practical experience of using a medical device (MD)**

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The literature on the benefits of music in relieving acute and chronic pain is growing daily with the addition of new scientific and medical publications (1,2). This is particularly true of its effects on the central nervous system, in terms of sensory, affective, cognitive and behavioural aspects, knowledge of which has progressed considerably in recent years, driven in part by advances in brain imaging. At the same time, care teams are gaining more and more practical experience in the use of music as a care tool.

Recent publications have also described the impact of digital therapies (DTx) using music on pain (3,4). Digital technologies and other emerging innovations are playing an increasingly important role in our healthcare systems. Designed on the basis of scientific research and clinical recommendations, Music Care© is a personalised digital music intervention application offering a catalogue of original musical sequences of varied cultural inspiration specially composed and arranged according to standardised specifications (the U-shaped sequence) (5). The Music Care© application is used in a variety of clinical situations.

The aim of this session is to provide an update on what is known from the literature about "pain and music" and the tools available today, and to give a voice to healthcare professionals who have experience of using music to manage pain in their day-to-day practice. The methodology for developing a medical device for pain management using music will also be presented.

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**Advanced courses**

**What prospects for complementary and integrative medicine in the pain clinic?**

**Integrative medicine: definition and misunderstandings**

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The term "integrative medicine" is used internationally to describe the combination of certain complementary therapies with so-called conventional medicine. The development of integrative medicine in France is clearly lagging behind that in many European and Anglo-Saxon countries. There are a number of reasons for this, not least of which are misperceptions and misconceptions about this particular form of medicine. While the health authorities are keen to combat misleading information about certain so-called non-conventional healthcare practices, there is still a lack of clarity in media communications, including those of the health authorities, about the definitions of "conventional medicine" and "non-conventional healthcare practices", a lack of clarity which also, in its own way, feeds this misinformation. The term "fake medicine" has also gained a certain notoriety in media communications, even though this concept is itself vague and therefore misinformative. Deconstructing these concepts raises a number of issues, notably the scientific proof of efficacy, the compatibility or otherwise of these therapies with Claude Bernard's reductionist model, and the potential risks of aberrations (particularly sectarian aberrations, a typically French political and media issue). We will attempt to present these different issues in order to clarify these definitions.

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**Advanced courses**

**What prospects for complementary and integrative medicine in the pain clinic?**

**IMIC , an integrative medicine institute in a university hospital**

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Non-drug therapies have been developed at Bordeaux University Hospital since 2008, with strong support from healthcare professionals and institutions. Building on this momentum, an Institute of Integrative and Complementary Medicine (IMIC) will open in 2019 within the Pain and Integrative Medicine Department in the Clinical Neurosciences Unit.

IMIC's mission is to coordinate existing initiatives concerning complementary therapies (mainly psycho-body therapies such as hypnosis and meditation) within the hospital, to promote and federate a new range of care based on hypnosis and meditation, and to promote research into these approaches and others that we would like to develop, to contribute to the promotion of quality of life at work and the prevention of psycho-social risks for hospital staff, to teach and pass on these approaches in a qualified manner to nursing staff and health students, and finally to promote other validated complementary care techniques.

IMIC provides patients with individual consultations (counselling, hypnosis, meditative and compassionate follow-up (1)) and group programmes, mainly for chronic pain and neurodegenerative diseases, within organised care networks. For CHU staff, IMIC offers special access to therapeutic hypnosis or meditation programmes through the Occupational Health Service or continuing education (2).

Research is also one of IMIC's strong pillars, with 4 funded protocols and others in the process of being submitted (3). Teaching and training are the initial foundations of IMIC and are constantly being re-evaluated (4).

The rapid increase in care activity means that we need to think about group care, which is proving to be very interesting and will be the subject of future research and evaluation protocols.

In conclusion, the members of IMIC are driven by the conviction that it is necessary to exemplify the values and virtues of complementary practices for the well-being of carers and patients in hospitals and universities, by participating in a global and inescapable movement in the search for meaning and the refocusing of care on the human being, which only requires to be regulated and federated.

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**Advanced courses**

**What prospects for complementary and integrative medicine in the pain clinic?**

**What institutional framework for integrative medicine in 2024?**

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Public and private hospital structures must contribute to the development of an integrative approach to patients with acute or chronic pain, for the management of their pain and associated symptoms (in particular insomnia, anxiety, depression, etc.). The aim is to offer patients an integrated approach combining the recommendations of conventional medicine and complementary therapies relevant to these indications.

Since the DHOS circular of February 2005 on the organisation of cancer care, supportive care (corresponding to all the care and support required by cancer patients throughout their illness, in association with specific cancer treatments) has been widely accepted by patients, professionals and health authorities alike. It is covered by the health insurance system. Supportive care can be extended to any serious illness requiring multidisciplinary management and supportive care.

In 2012, the Assistance Publique-Hôpitaux de Paris report (1) proposed recommendations, which are still valid, for the supervised practice of complementary medicine in university hospitals. These practices: 1. must be implemented by a practitioner with regulated training, if possible leading to a diploma. 2. Must be integrated into a service project and have been validated by the institution. 3. The health care organisation must be committed to evaluating them and contributing to the development of clinical and paramedical research. 4. it must also develop and prioritise the provision of complementary therapies in validated invitations to tender.

We now need to extend this approach to all public and private establishments, as well as medico-social establishments, so that patients suffering from pain, whether acute or chronic, can benefit from optimised, personalised care from trained, competent professionals.

The Comité Ministériel d'Appui à l'encadrement des Pratiques de Soins Non Conventionnels en Santé, set up by the Ministry of Health in 2023, has set itself the following objectives: 1. Draw up a map of these practices, in towns and hospitals. 2. Regulate and regulate them. 3. Supervise their training and promote clinical research (including dedicated calls for tender), and 4. Consider whether they should be reimbursed for validated indications, in conjunction with the CNAMTS.

The Collège Universitaire de Médecine Intégrative et Thérapies Complémentaires (CUMIC) (2) has joined forces with the Fédération Hospitalière de France (FHF) to propose a guide to Good Practice for the implementation and supervised development of integrative medicine and complementary therapies in hospitals and medico-social establishments, which should help establishments to improve their services for the benefit of patients, to the Ministry of Health during 2025.

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**Advanced courses**

**National cooperation protocol**

**Cooperation between healthcare professionals: cooperation protocol, advanced practice: what's going on?**

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Since the 2000s, in order to meet the challenges facing the healthcare system as a result of an ageing population, an increase in chronic diseases and a predicted decline in medical resources, cooperation between healthcare professionals has emerged as a means of improving the system.

However, over time and with the development of scientific and technical knowledge, professionals have increased their skills and refined their know-how, but without changing their practices, i.e. neither entrusting nor delegating what could have been entrusted.

Since 2003, experiments in cooperation have been conducted between paramedical and medical professionals, demonstrating the feasibility of such cooperation, not only in terms of benefits for the patient - and in complete safety - but also in terms of the attractiveness of these professions.

Indeed, by envisaging more links between professionals and a better knowledge of each other's jobs, certain pitfalls such as overlapping activities have been limited or redundancies or losses of activities avoided.

To achieve this, it is essential to redefine the areas of expertise of each profession, with the aim of enabling each profession to refocus on its core business, to the benefit of patients and the professionals themselves.

To date, cooperation models exist and are proposed either on the basis of substitution through the transfer of tasks under cooperation protocols, or on the basis of complementarity through the development of new skills and therefore the evolution of core professions with advanced practice.

However, if they are to work, these models of cooperation require real adjustments, with the introduction of a new frame of reference that reexamines not only the training system but also the legal and economic framework within which they operate. Each of these models exists in its own way, and it is important to distinguish between them.

The aim of this presentation is to shed some light on these models of cooperation, which still seem perhaps a little obscure today.

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**Advanced courses**

**National cooperation protocol**

**National cooperation protocol "Management of patients with chronic pain by expert pain nurses in cooperation with doctors in approved chronic pain structures (SDC)".**

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For many years, the SFETD's Commission Professionnelle Infirmière (CPI) has been working towards recognition of the activities and skills of Pain Resource Nurses (PRNs) as advanced practice. It has worked on 2 reference frameworks in order to list and standardise the actual activities of pain resource nurses in France: in 2016, the reference framework for nursing clinical consultation activities; in 2020, the reference framework for the activities and skills of pain resource nurses.

In 2021, the ICC drew up a set of arguments entitled "Applying recognition of advanced practice to the work of pain resource nurses (PRNs) in SDCs". It was submitted to the DGOS representative at the structures forum at the Montpellier congress in 2021,

In April 2022, the DGOS proposed to the SFETD that a protocol for cooperation between professionals be drawn up, "which could be considered as a solution pending the start of work on pain IPAs. A nationwide cooperation protocol would also free up medical time for the structures".

Article 51 of the HPST law of 21 July 2009 allows for the transfer of healthcare procedures or activities and the reorganisation of patient care methods, on an exceptional basis and at the initiative of professionals in the field (listed in art. L. 4011-1 of the Public Health Code). It allows medical procedures to be delegated to nurses, subject to certain training and organisational conditions.

Throughout 2023, five teams selected by the National Committee for Interprofessional Cooperation (CNCI) worked with the DGOS to draft this protocol.

This protocol will raise a number of issues for nurses, doctors and patients. 12 derogations are proposed within a secure framework and with flexibility of application. Additional theoretical and practical training, depending on the skills to be acquired for the derogations introduced, will be provided by the delegating authority on the basis of the assessment of the knowledge acquired by the delegates through the validation of the DU/DIU in pain.

At the time of writing, the draft national cooperation protocol is still being validated by the HAS and the CNP (National Professional Councils).

What will happen on the date of the congress?

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**Advanced courses**

**National cooperation protocol**

**National cooperation protocol: point of view of a delegate/delegate pairing**

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The draft national cooperation protocol "Care of patients with chronic pain by pain expert nurses in cooperation with the doctor in labelled chronic pain structures (SDC)" is a work developed by the SFETD's Nurses (IDE) Commission, which takes into account the quality and safety requirements of cooperation protocols between healthcare professionals specified by the decree of 27 December 2019 (HPST law), and whose fundamental objectives are: for patients: optimising their care pathway and providing better access to different care modalities, including innovative treatments, and making their care more secure; for delegating nurses: consolidating and enhancing their professional expertise, and making their practice more secure; for delegating doctors: freeing up medical time for the care of new patients; overall: improving links between members of the SDC team and its correspondents in hospital and in the community. Any patient over the age of majority, or younger patients awaiting referral to a paediatric facility or in the absence of a local paediatric facility, presenting with chronic pain and referred to and monitored by a SDC, may be concerned. The aim is to implement derogations, in addition to the usual practice of IDEs, open to SDCs implementing the protocol. Depending on their practices and the decisions of each TCS team, they may choose to apply only some of the 12 derogations described in the protocol and/or to apply them gradually.

**Advanced courses**

**Neuropathic pain in oncology**

**Pathophysiology of neuropathic pain in cancer patients**

B. Calvino 1

1 Professor Of Neuroscience

Cancer pain is based on the observation that this pain is "mixed", inflammatory pain linked to the inflammation generated by the tumour, and neuropathic pain linked to the compression of tumours on the surrounding nerves. Treatments for this type of pain are adapted to this concept. This strategy is evolving because since 2019 research has shown that tumours have their own sensitive innervation. A tumour functions like a differentiated organ and is surrounded by a tumour microenvironment that it generates: vascularisation of the tumour to nourish its cells thanks to the endothelial growth factors it secretes (such as VEGF, Vascular Endothelial Growth Factor), development of tumour growth and development of a vegetative nervous system that controls the development and composition of this microenvironment.

Bilateral interactions between tumour cells and nerve cells are the cornerstone of cancer pain. Studying the molecular mechanisms underlying tumour-nerve interactions is a promising avenue of research for understanding and treating cancer pain.

The VEGF family of signalling molecules plays a fundamental role: VEGF plays a crucial role in vascular development during embryogenesis and angiogenesis during cancer, and in regulating the activity of numerous non-endothelial cells, particularly developing neurons or in developing tumours.

The identification of VEGFR receptors expressed by peripheral sensory neurons has led to an understanding of their functional role. Systemic blockade of VEGFR prevents tumour-induced remodelling of sensory nerves and reduces cancer pain in in vivo mouse models. These results highlight the therapeutic potential of molecules inhibiting VEGFR activity in cancer pain and suggest a palliative effect for tumour anti-angiogenic therapies targeting the VEGF/VEGFR signalling pathway.

Current work on anti-VEGFR antibodies that block the biological activity of VEGFR is of therapeutic interest in the treatment of cancer pain. The administration of Bevacizumab, a humanised monoclonal antibody that sequesters a VEGFR agonist, VEGF-A, improves the quality of life of cancer patients, but its effectiveness in treating pain has not been evaluated. Monoclonal antibodies that bind to the extracellular domain of EGFR have been shown to prevent activation of the receptor, which is responsible for EGFR inhibition; of these monoclonal antibodies, Cetuximab is currently the only one approved by the FDA (Food and Drug Administration) and the EMA (European Medicines Agency) for the treatment of oral cancers in combination with radiotherapy.

**Advanced courses**

**Neuropathic pain in oncology**

**Neuropathic pain in progressive cancer: the role of opioids**

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Opening remarks:

- We will not question the basic opioid treatment prescribed, which should be in line with HAS recommendations [1].

- The term "opioid" refers to any "opioid agonist" treatment, activating opioid receptors (µ, δ, ƙ) with or without an associated mechanism of action.

- The opioid will be chosen according to the intensity of the pain: the use of a low dose of a strong opioid may be preferred to the use of a high dose of a weak opioid.

- Methadone is mentioned separately because the initiation of treatment is more complex, requiring monitoring during the first week (titration), and because of specific interactions and toxicities (QT prolongation, tolerance, etc.).

Opioid efficacy:

Opioids are effective in treating neuropathic pain: in a heterogeneous population, the NNT is 4.3 [2]. However, the benefit/risk ratio must be assessed according to each clinical situation, with caution in patients at risk of addiction, and taking into account the risk of induced hyperalgesia. Other specific treatments may be considered in addition (antidepressants, antiepileptics, topicals, etc.) [3].

Neuropathic pain secondary to cancer treatment:

1- Opioid-naive patients :

- Last-line opioid after failure of specific non-opioid treatments.

- Tramadol and/or methadone (not approved as first-line treatment) may be considered because of their specific mechanisms of action.

- Methadone requires a specialist team to implement it.

2- Patients already treated with opioids :

- Increase in first-line opioid: the effectiveness of interdoses taken justifies maintaining and increasing the dose.

- Introduction of methadone: as a second-line treatment if opioid augmentation is insufficient or leads to adverse effects, or as a third-line treatment after failure of specific non-opioid treatments.

Mixed pain linked to cancer:

1- Patients not treated with opioids :

- First-line opioid: titration required.

- In the event of insufficient relief or poor tolerance: introduction of a specific non-opioid treatment or tramadol/methadone by a specialist team.

2 - Patients already treated with opioids :

- Ongoing opioid increase: the effectiveness of interdoses supports dose maintenance and increase.

- In the event of insufficient relief or poor tolerance, consider :

. Complemented by specific non-opioid treatments for neuropathic pain,

. Switch to methadone by a specialist team (AMM).

- If the pain responds to opioids but needs to be increased rapidly, the introduction of methadone should be considered.

Neuropathic pain unrelated to cancer:

Neuropathic pain unrelated to cancer requires in-depth clinical assessment and consideration of appropriate analgesic treatments. The SFETD recommendations on neuropathic pain should be followed [3].

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**Advanced courses**

**Neuropathic pain in oncology**

**Place of intrathecal pumps in neuropathic cancer pain**

A. Balossier 1

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There are currently more than 400,000 new cases of cancer each year in France. 40-70% of cancer patients will experience pain during the course of their disease, whether at diagnosis, during the course of the disease, or at the terminal stage, and 30% of these will experience pain described as moderate to severe. Despite the development of new compounds and galenic forms, this pain remains particularly resistant to well-managed medical treatment, and the management of cancer pain is still too often sub-optimal. As a result, 10-20% of patients will suffer debilitating refractory pain. This pain is most often mixed, and the neuropathic component is sometimes more difficult to relieve than the nociceptive component, whether it arises in the aftermath of a progressive cancer or as part of cancer-related pain in a patient in remission or cured. Improving quality of life and pain management is one of the four key areas of development in oncology support care.

Intrathecal analgesia is a highly effective technique for relieving patients with intractable pain, particularly in oncology. This invasive technique has demonstrated its superiority in the event of failure of strong opioid treatments or their side effects. In France today, intrathecal analgesia is regrettably not being used to the extent that it could be used to relieve pain.

We will review the literature on the benefits of intrathecal analgesia specifically for neuropathic pain in progressive cancer and sequelae, and present a number of clinical vignettes illustrating situations in which intrathecal analgesia has made a major contribution to pain management and improved quality of life.

**Advanced courses**

**The chronically painful child and his family: does a child exist on his own?**

**Pain consultations in paediatrics: treating whom and why?**

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Most paediatric consultations are triangular: the carer, the parents and the child. This is what makes it so complex, but also so interesting. In the case of chronic pain, the presence of the child and parent(s) is essential. The links between the child's expression of pain and family experiences are major and bi-directional.

On the one hand, children receive a genetic and epigenetic heritage from their parents, a socio-cultural environment, learn from their family how to react to adversity and pain, and go through life events with or without their parents[1].

On the other hand, because of their child's experience of chronic pain, parents are going through an unusual period of crisis. Their child becomes ill, and they go from being parents to being carers, with the added difficulty that the pain often cannot be seen, cannot be explained and has no name. Parents often report feeling distrusted or even blamed by healthcare professionals for their child's persistent chronic pain [2].

During consultations, carers treating children or adolescents for pain know that they must listen to and treat the various types of pain they are presented with.

There is also room for those who are absent from the consultation: siblings and unborn children.

The siblings of children with chronic pain are often also at risk of experiencing significant difficulties. They also experience the guilt of being spared, while at the same time having to make room at home for one more person: their brother or sister's pain [2].

Lastly, the question of future generations may arise in the background when the analysis of the family tree shows systematic repetition of medical or social situations and adolescents ask us about the parents they could be and what they could do to put an end to this painful legacy.

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**Advanced courses**

**The chronically painful child and his family: does a child exist on his own?**

**Support for families by psychologists: from the city to the hospital**

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In the context of the chronic pain clinic, we soon realise that support is not limited to the child. Winnicott had already expressed this when he said that a baby cannot exist on its own; it is essentially part of a relationship (1). First and foremost, the child comes to the clinic accompanied by his or her parents, or even siblings or blended families. They come to us with their own story, in which the pain appears at a given moment. From the story they tell us, they reveal how they function, how they relate, their expectations and the explanations they give for this pain. During the consultation, which is carried out in pairs (doctor-psychologist) or even in trios (with the nurse), the family will be able to perceive the back-and-forth that we do between the body and the psyche (2). Pain can thus be seen as the interweaving of bio-psycho-social elements. The psychologist's aim is to help the child and his or her family to work through the pain (3), so that the system can regain a certain dynamic by re-establishing interactions.

The interviews show just how much the chronicity of the pain affects the young patient and his relationships. The pain disrupts the balance of the family's functioning and changes the rules that had previously been established. This disorganisation of the system leads us to work with them to provide guidance. The psychologist can offer them a place to listen and support. He helps them to use their own resources to reorganise the family system and readjust to the pain. The psychologist can also encourage parents to reflect on their own childhood and how it influences their attitudes towards their children (4).

Families may also be referred to family therapy when their relationships are suffering, and the family balance is fragile or frozen. The family is not always able to adjust to the improvement in their child's pain, or when the pain seems to be a mobile and transitory symptom. In such cases, this treatment is aimed at all members of the family, including siblings. The aim is to break the relational deadlock and reduce the conflicts likely to trigger or exacerbate the pain. The family therapist is vigilant to ensure that the separation-individuation process prevented by the pain can take place. They explore the process of parentification of the children and the degree of relational exhaustion in the family (5). We will look in more detail at systemic family therapies (6/7), as well as existing services both inside and outside hospital.

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**Advanced courses**

**The chronically painful child and his family: does a child exist on his own?**

**Clinical nursing reasoning for children and their families**

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Clinical reasoning has become central to the management of complex chronic pain situations in children. All the medical and paramedical health professions, as part of a multi-professional pain assessment and treatment team, use clinical reasoning to define the strategies best suited to the situation.

Nurses' clinical reasoning is often implicit and invisible in day-to-day practice, since only actions count. Care actions based solely on assessing the intensity of pain, without using clinical reasoning, are often inappropriate or ineffective, and can contribute to the feelings of powerlessness, injustice, incomprehension and misinterpretation felt by parents and children. In paediatrics, caring for the child is inextricably linked to caring for the parents (the term "parent" refers to all those who exercise a parental role in relation to the child). Thus, data collection, the first stage in clinical nursing reasoning, focuses on the child and its parents. The bio-psycho-social model makes it possible to collect data from interviews with the child and his/her parents, data collected in the patient's file, data collected with school health professionals, PMI or socio-educational teams.

Clinical reasoning in nursing science links these data with knowledge from several disciplinary fields in order to develop hypotheses and then make nursing diagnoses. Clinical nursing judgement contributes to the construction of a care project within a multi-professional team. Actions with parents and children will focus on their needs and resources. They will be carried out by professionals whose skills are appropriate to the situation. This individualised approach to care is reflected in the various proposals made by the nurse for the development of a care plan co-constructed with the child and his or her parents.

Clinical situations will be presented to illustrate this nursing clinical reasoning and how it is put into practice in work with parents and children in chronic pain situations.

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**Advanced courses**

**Back to basic : Is a patient in pain always depressed?**

**Can we talk about depression as a reaction to pain?**

F. Hirsch 1

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Françoise Hirsch

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Title

"Can we talk about depression as a reaction to pain?

Summary

When pain is defined as chronic, it imposes itself massively on the patient and represents a syndrome, a real illness in itself likely to completely overwhelm the patient.

Pain has an impact on the subject's psychic economy. As early as 1926, in Inhibition, Symptoms and Anguish [1], Freud emphasised that pain has a narcissistic refocusing function, with the painful area draining all libidinal investment. From a psychoanalytical point of view, pain is thought to be linked to a depressive position in which it is necessary to mourn the loss of a previous state.

Anxiety and depression are co-morbidities frequently found during consultations in pain centres. In this sense, it is clear that in clinical encounters with these patients, the aim is not to draw a distinction between depression and pain, but rather to understand the special links that seem to unite them.

Pain and depression are best thought of as two entities, at once dual and complementary, responding to each other in the manner of an ouroboros (an ancient symbol representing a snake biting its own tail, this metaphor designating a denouement that inevitably leads back to the starting point, highlighting an endless loop).

It goes without saying that, as each depression is unique, there is no such thing as a specific depression reacting to pain. Pain is expressed by classic depressive symptoms which are in no way pathognomonic, and for this psychological suffering to be understood, it is inseparable from the person experiencing it.

However, we should not forget to point out that clinical experience has shown us that there are also chronic pain patients who do not present with characteristic depressive disorders. Once again, this highlights the uniqueness of each patient and their ability to be less vulnerable and more resilient in the face of the aversive and upsetting situation that chronic pain represents in the real sense of the term. In this context, we need to consider the patient in all his or her bio-psycho-social components as part of the response.

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**Advanced courses**

**Back to basic : Is a patient in pain always depressed?**

**Is it possible to be depressed without experiencing pain-related loss?**

B. Lionet 1

1 Centre Hospitalier De Dunkerque - Dunkerque (France)

Pain and depression have always been with humanity. One person in five suffers or will suffer from depression during their lifetime. The association between pain and depression is estimated at between 13% and 85% of comorbidity, depending on the degree of intensity and severity taken into account (1). Chronic pain and depression are clinically closely linked (2) and feed off each other (3).

Beyond the epidemiological findings, what is the clinical understanding of these two dimensions and how do they fit together? Can there be chronic pain without depression? Can there be depression without experiencing pain-related loss?

This 'back to basics' approach is based on current psychopathological thinking, with a view to re-examining the issues of loss and psychic reorganisation in chronic pain sufferers (4). To do this, we will explore the contributions of psychiatry (5), then look at the different currents of psychology before attempting a synthesis through child psychology. Our common thread will be a simple question: what purpose does depression serve in chronic pain (6)?

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**Advanced courses**

**Back to basic : Is a patient in pain always depressed?**

**What are the prospects for clinical practice?**

P. Sauvajon 1

1 Pain Consultation - Vienne (France)

Advances in clinical practice seem to confirm the interdependence between pain and depression. This observation is in line with the need for a "polyvalent" and "multidisciplinary" approach to patient care. This approach is promoted by the recent HAS report (HAS, 2023). Given the situation of patients referred to chronic pain consultations, many teams would agree with these intentions.

However, their implementation is not always so straightforward.

From the attention paid to the physiological body, to the attention paid to the patient's individual feelings, is the uniqueness of care obvious in the face of the diversity of players and techniques available?

In practice, although the tools for coordinating practices exist (RCP, in particular), a juxtaposition of interventions seems to prevail, despite the attention paid to exchanges.

Can chronicity and patient wandering as signs of depression explain this finding?

Practice sometimes shows how much the attention paid to the depressive experience influences the painful complaint.

This aspect is particularly important in the current context of pain structures, as are the expectations of health agencies.

From these clinical realities, we will attempt to shed light on practice.

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**Advanced courses**

**Pain in the dyscommunicative patient (continuing education session)**

**"Pain in the dyscommunicative patient**

D. Fernandez Fidalgo 1

1 Ch Evreux - Vernon (France)

"Disabled people and people with mental illnesses have been left out of the plan. Very few measures have been taken for the former, and none for the latter, despite the fact that these populations are very concerned by pain (...) Pay particular attention to people who are 'dyscommunicative': new-born babies and very young children, patients in intensive care, patients with psychiatric illnesses, people with multiple disabilities, and patients with dementia".

These few words, found in the HAS assessment of the pain plan that preceded 2011, are still relevant today. And yet it is already 13 years since this observation was made.

What makes it so difficult to support and deal with the pain of patients with impaired communication, particularly those who have no means of communication?

Based on 20 years' experience of working with children with multiple disabilities and their families, this presentation aims to provide a better understanding of what makes working with this population so difficult, even for experienced carers.

Drawing on the work of Dr George Saulus, sociologists Sabine Delzescaux and Frédéric Blondel and Dr Djea Saravane, we will lay some foundations for understanding the structural dimension of this difficulty. The asymmetrical dimension inherent in this care relationship and the extreme dimension of otherness push us de facto to go beyond our usual ethical frame of reference, which can become overwhelmed.

Yet there are options, tools and solutions to overcome this situation. Faced with such extremes, the trans-disciplinary dimension and cross-disciplinary viewpoints are essential and provide an opportunity for a salutary paradigm shift: expertise is no longer just on the medical side, it is shared by all the carers who know and accompany these patients.

And what if caring for the pain of these patients gave us the opportunity to become better, quite simply? The pain clinic could learn a great deal from our dyscommunicative patients, by looking not only at the fragility of these patients, but also at our own fragility as carers.

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Useful links :

Handiconnect.fr: factsheets for carers on psychiatric disabilities, intellectual development disorders, autism spectrum disorders and multiple disabilities.

SantéBD.org: fact sheets and videos for people with disabilities and their families to help them better understand pain, care...

CNRD: National Pain Resource Centre

SFETD: French Society for the Study and Treatment of Pain

anp3sm: National Association for the Promotion of Somatic Care in Mental Health

Pédiadol: learned society for the treatment of pain in children

**Advanced courses**

**Pain in the dyscommunicative patient (continuing education session)**

**Assessing pain when patients lack the words to express their ailments**

K. Constans 1

1 Ird - Beauvais (France)

In 2020, the IASP (International Association for the Study of Pain) proposed a new definition of pain, to better include people who cannot describe their feelings verbally.

"An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage"

Pain is a subjective, multi-dimensional experience, unique to each individual.

"Everyone has the right to receive treatment and care aimed at relieving their suffering. In all circumstances, this suffering must be prevented, taken into account, assessed and treated". Users' rights Article L1110-5-3 of the Public Health Code

Assessment using validated tools will help to identify, quantify, qualify or describe the pain. However, before doing so, it is necessary to assess the patient's understanding and cognition, and to take account of their age and context.

There are two types of assessment: self-evaluation and hetero-evaluation.

Self-assessment is preferred. Where this is not possible, pain assessment should be carried out using pain management tools:

- Hetero-assessment of the child

- Hetero-assessment of the non-communicative adult or elderly person

- Hetero-assessment of people with disabilities

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**Advanced courses**

**Pain in the dyscommunicative patient (continuing education session)**

**Focus on drug treatments for neuropathic pain in dyscommunicative patients**

D. Gillet 1

1 Chu Grenoble (France)

The management of neuropathic pain in dyscommunicative patients poses particular challenges in terms of pain assessment and management. This requires a careful, multidisciplinary approach, as well as adaptation on the part of carers in terms of assessment, prescription and monitoring.

**Advanced courses**

**Pain in the dyscommunicative patient (continuing education session)**

**Focus on the use of non-medicinal means with dyscommunicative patients: Simple tools for carers!**

A. Guion 1

1 Ide, Cadre De Santé, Consultant-Formateur À L'atelier Des Pratiques - Nantes (France)

For a number of years now, healthcare professionals have been looking at how to provide better support for patients, especially those who are dyscommunicative (1).

In this context, non-medicinal interventions (2) are frequently used to prevent and treat pain. They are now widely used by carers and patients alike. As long ago as 2011, the French National Authority for Health (HAS) (3) recommended non-drug interventions as a first-line treatment.

Many techniques have long been used by healthcare professionals, often spontaneously. The aim is very often to help carers identify the non-pharmacological means currently available, which can be easily used in their daily practice.

Healthcare professionals very often need to understand the benefits, identify the clinical effects and the particularities to be taken into account when choosing a method, particularly in the case of pain problems in dyscommunicative patients.

His interventions aim to modify the unpleasant perception of pain and reduce anxiety, which is a major problem for these people:

- Adapting your communication style (4): verbal and non-verbal language, reformulation and listening

- Touch and massage (5)

- Breathing (6), Wintrebert Passive Relaxation

- Distraction: games, music (7), smells, images, etc.

- Reassurance objects

All these simple interventions can complement each other. They are simple, yes, but so effective! Let's not forget that!

The aim is to develop a science of "local support" for these suffering, dependent people using the techniques mentioned above.

It also means recognising that the person being cared for who is dyscommunicative has capacities and resources that we are committed to supporting through our interventions, in order to help them maintain biological, psychological, social and spiritual harmony.

Knowing about them, valuing them and having tried them out enables carers to multiply their therapeutic responses and encourage their autonomy.

In this collaboration between carers and patients, there are still many avenues for developing non-pharmacological practices in the treatment and prevention of pain that can be explored and evaluated.

In the years to come, it will be essential to establish a scientific and methodological framework for greater recognition of these various non-medicinal proposals.

In this complex context of care, non-medicinal interventions will develop, so we healthcare professionals must believe in our skills and be a force for change!

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**Advanced courses**

**Pain in primary care**

**What is at stake in the management of CHRONIC PAIN in PRIMARY CARE?**

Mr Dutech 1.

1Fécop - Nailloux (France)

The increasing scarcity of specialist services to meet the ever-growing needs of more and more patients with chronic and complex pathologies and chronic pain.

They are usually managed by general practitioners and rheumatologists, and often require specialist advice too late.

How can we respond to an often paradoxical situation that combines a scarcity of expert structures, healthcare desertification and increasingly numerous and complex needs?

The challenge is to structure a response based on coordinated primary care teams working with researchers and expert teams in the field of chronic pain.

Using primary care as the starting point for building a relevant and effective response is highly unusual these days,

CHICHE!

**Advanced courses**

**Pain in primary care**

**An example of a care pathway for a complex pain patient at the MSP in Les Mureaux**

P. Clerc 1, S. Akrich 2

1 Doctor - Les Mureaux (France), 2 Physiotherapist - Les Mureaux (France)

The care pathway in an MSP is facilitated by the proximity of healthcare professionals and the exchanges possible throughout the working day. Complex pain patients can be identified by one of the team members (physiotherapist, nurse, chiropodist, doctor), some of whom have developed complementary skills: manual therapy (physiotherapist), hypnosis (doctor) and therapeutic education.

Informal on-site exchanges between physiotherapists and doctors may be of an aetiological or therapeutic nature, and concern the coordination of care and its development. The team's information and exchanges are shared with the patient throughout the treatment process, leading to the co-construction of a care programme.

This multi-professional work incorporates the referral from the pain centre and informs it of the care activities put in place by the primary care team.

The case of Mrs J. is illustrative of this approach.

After treatment for breast cancer with painful post-treatment sequelae, a left coxarthrosis was discovered during a medical consultation. The attending physician discussed treatment by one of the team's physiotherapists. The patient's recent medical history and the existence of left foot neuropathy treated by the pain centre with Capsaicin led to a physiotherapy diagnostic assessment. Following this assessment, the patient informed the physiotherapist of her disabling scapulalgia. The physiotherapist suggested a course of treatment.

Treatment plan proposed by the team :

Follow-up with the pain centre and information for the primary care team.

Physiotherapist: Manual therapy on the ankles and right shoulder, thorax, drainage, postures, stretching, neuro-sensory re-education of the left lower limb, therapeutic education in order to establish a self-education programme for the arm and ankle, then general activity, resumption of physical activity.

-Doctor: regular monitoring of the patient with reassurance and support for the request to return to work by mourning the previous state of health. Hypnosis sessions for anxiety and pain. Adjustment of treatments for pain and anxiety.

Conclusion: Results at 12 months - the patient has regained her autonomy and self-confidence, is able to work part-time again in an adapted manner, can move her upper limb as before, can sleep on her shoulder, and is no longer bothered by the pain caused by the fibrosis and hypoextensibility associated with breast surgery. Her return to physical activity is no longer interrupted by neuropathic pain, which has diminished and which she is managing better.

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**Advanced courses**

**Pain in primary care**

**The new nursing professions: A key role in pain management in primary care.**

P. Channel 1

1 Msp Nailloux-Saint Léon - Nailloux (France)

The HAS estimates that nearly 70% of patients with chronic pain do not receive appropriate treatment for their pain, and that less than 3% of them benefit from care in a chronic pain facility (CPF).

The HAS also identifies that multi-professional and multi-disciplinary care for chronic pain can be structured on 3 levels, the first of which is primary care. They should be able to provide care and coordination for the majority of people with chronic pain or at risk of developing it. (1. Scemama et al., 2023)

To date, everything remains to be done in primary care for these care pathways. Nurses, in their core profession but also in their various specialities, represent an undeniable asset in the structuring of this emerging care offer.

The growing development of nursing science over more than a century, first in the English-speaking world, then in Europe and now in France, has enabled nurses to expand their knowledge, skills and art, drawing on both the sciences and the humanities (2. Pepin et al., 2003).

Two nursing professions now seem to represent a definite asset in the care of people suffering from chronic pain or pain that is becoming chronic, in primary care. These are the Asalée public health nurse delegates (IDSPs) and advanced practice nurses (IPAs).

These two professions have different, albeit sometimes overlapping, histories, training, expertise and skills. Nevertheless, they share a holistic approach to caring for the individual. They complement each other in this innovative inter-professional approach to pain management in primary care as part of a coordinated care pathway.

Although the skills of these nurses appear to be relevant in optimising patients' care pathways, there are still structural obstacles to the management of chronic pain by RPNs or IDSPs.

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**Advanced courses**

**Pain in primary care**

**Speech Therapy & Algology: Incongruity, Opportunity or Necessity?**

B. Rossi-Bouchet 1

1 Speech and language therapist, C2r, Sfetd - Mont De Marsan (France)

In the current context, it is crucial to optimise the resources available in the French healthcare system. Far from being incongruous, the inclusion of private practice speech and language therapists in pain screening and assessment represents a strategic opportunity to improve patient care, while responding to current challenges.

Speech and language therapists, experts in communication and functional assessment, are on the front line in detecting signs of pain, which are often complex to assess, particularly in vulnerable populations (children, the elderly, dyscommunicative patients). Their ability to identify verbal and non-verbal expressions of pain, and then to assess their functional and psychosocial impact, makes speech and language therapists particularly well-suited to this role. By intervening early and frequently, speech and language therapists can facilitate faster, more appropriate treatment, thereby reducing the need for patients to wander from one doctor to another, delaying diagnosis and reducing the risk of complications or chronic pain. For patients, whether adults or children, closer collaboration between speech and language therapists and private practitioners would enable more rapid and better-targeted multidisciplinary care, particularly in areas with a shortage of doctors, or with an embolised expert centre. This approach would help to improve patients' quality of life, by encouraging better detection of pain and earlier prescription of appropriate treatment, avoiding recourse to self-medication. For private practitioners, working with speech therapists saves valuable time. By delegating part of the pain screening and monitoring to appropriately trained speech and language therapists, doctors could concentrate on more complex cases, thereby improving their clinical effectiveness. At the same time, this synergy with other healthcare professionals (nurses, physiotherapists, etc.) would enhance the overall effectiveness of care and optimise the care pathway for the patient. From a financial point of view, the involvement of speech therapists in pain management would help to reduce healthcare costs. By reducing the need for multiple consultations and costly hospitalisations, a comprehensive and coordinated approach would contribute to more effective outpatient care, thereby meeting the growing need to optimise healthcare expenditure.

Recognition of the role of private practice speech and language therapists in the detection and monitoring of pain is not just a strategic opportunity. It is a necessity if we are to meet the demands of a changing healthcare system. This approach would strengthen inter-professional collaboration, improve the quality of patient care and contribute to more rational management of healthcare resources. Adopting this approach would be a pragmatic response to the current challenges facing the healthcare system. The profession is well aware of this, and its representative union, the FNO, has launched an awareness campaign and a national training course on pain.

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**Advanced courses**

**Pain and endometriosis**

**Pelvic hypersensitisation, uterine visceral pain syndrome and endometriosis**

E. Bautrant 1

1 Aix-En-Provence - Aix-En-Provence

Pelvic pain of the uterine type, with no obvious lesions, or with negative imaging or laparoscopy, has been a major enigma for gynaecologists for over half a century.

The temptation to relate this type of pain to a nociceptive mechanism has guided all attempts to understand this type of pain and its treatment.

For more than 50 years, numerous aetiological lesions have been suggested, such as the ligament tears of Masters and Allen syndrome, anomalies in the position of the uterus, pelvic adhesions, varicose veins and, more recently, endometriosis. However, none of them provide a real answer to the problem of this chronic pelvic pain symptomatology, or to its treatment.

Visceral, intestinal and bladder pain are well known and widely reported in central pelvic hypersensitivity and fibromyalgia.

Various authors now tend to link intestinal pain syndromes (irritable bowel) and bladder pain syndromes (painful bladder syndrome/interstitial cystitis) to nociplastic mechanisms of visceral pain by isolated sensitisation (1,2).

It therefore seems logical to think that, just as there is a painful bladder syndrome (PBS) or irritable bowel syndrome (IBS), there is also a painful uterine syndrome (3).

The main symptom of this syndrome is severe dysmenorrhoea, whether primary or secondary, of Andersch and Milsom grade 3. Associated symptoms include pain on palpation of the organ and, above all, profound dyspareunia. However, the symptoms may also include pelvic pain of the uterine type outside the period, in the form of cramps, period pain without menstruation, or contractions.

A great deal of research over the last ten years has shown that young patients with grade 3 primary dysmenorrhoea are centrally hypersensitised (4-13).

As with IBS and VDS, which are accompanied by hypercontractility of the detrusor and intestinal musculature respectively, uterine hypersensitivity mechanisms may be accompanied by myometrial hypercontractility. This is responsible for the severity of dysmenorrhoea, as well as the pain of contractions and uterine cramps outside the period.

This hypercontractility of the uterine myometrium is well documented in patients with primary dysmenorrhoea (14,15).

Finally, hypercontractility is associated with an increase in pressure in the uterine cavity, confirmed by a clear increase in pressure measurements recorded by numerous authors in dysmenorrhoeic patients (16,17).

This increase in intrauterine pressure may result in the expulsion of endometrial foci into the myometrium and its vascularisation or via the retrograde tubal route, making severe dysmenorrhoea a precursor of endometriosis for several authors (18).

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**Advanced courses**

**Pain and endometriosis**

**Comorbidities and endometriosis**

C. Lacoste 1

1 Hpsj - Paris (France)

Women suffering from endometriosis frequently have co-morbidities which have an even greater impact on their daily quality of life. This presentation will focus on painful co-morbidities, which it is important to diagnose and treat. They respond to mechanisms of central and peripheral hypersensitisation, viscero-visceral sensitisation and somato-visceral sensitisation. We will briefly look at the diagnosis and treatment of the main painful comorbidities: painful bladder syndrome, bladder overactivity, irritable bowel syndrome, provoked vulvodynia and myofascial syndromes.

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**Advanced courses**

**Pain and endometriosis**

**Pathophysiological mechanisms of neuropathic pain in endometriosis**

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1 Chu Nantes - Nantes

While the inflammatory component of endometriosis is universally accepted as a source of pain due to excess nociception, the notion of neuropathic pain in endometriosis remains a subject of debate.

The term neuropathic pain is probably misused in many situations. In fact, as we shall see, it can be used for types of pain whose semiologies differ in obvious ways from one another. So which is neuropathic pain and which is not? Is this a matter for specialists or pure intellectual satisfaction? After all, what difference does it make if the treatment is always the same?

It is this challenge, perhaps not only rhetorical, that I propose to take up during this advanced course on pain and endometriosis.

**Advanced courses**

**From suicide to euthanasia in pain clinics**

**How does the question of death arise in pain clinics?**

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Pain, whether acute or chronic, always requires the subject to evaluate, more or less consciously, the threshold of his or her possibilities. Thus, the pain clinic is part of the clinic of the psychic and somatic thresholds of life, in reference to situations in which the subject's reflexive capacity, his ability to maintain a continuum of identity, his feeling of being part of a human suffering that can be shared, is questioned, interrupted or even annihilated.

In this work, we explore the conditions under which figures of death emerge when thresholds are diminished, non-existent or overwhelmed, or when chronicity attacks and decimates the very prospect of finding a way out.

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**Advanced courses**

**From suicide to euthanasia in pain clinics**

**Epidemiology of pain and suicide in children and adults**

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In the course of the clinical accounts heard by pain clinicians, the painful complaints of chronic sufferers are frequently accompanied by talk of death, whether in the form of suicidal ideations or thoughts, but also, and increasingly, talk of considering euthanasia or assisted suicide. Clinicians practising in situ, in a given socio-political context, are confronted with discourses tinged with the search for relief, or even avoidance, of pain and suffering present in our contemporary societies.

But what scientific, statistical and prevalence information do we currently have at our disposal to understand this in our practice? And how can we apply these parameters to the clinical situations we encounter on a daily basis?

This presentation will therefore attempt to review recent epidemiological data relating to suicidality in patients suffering from chronic pain, whether they are children, adolescents or adults. Through an examination of statistics, prevalence studies and empirical research, the aim will be to examine how this information can enrich day-to-day clinical practice, particularly when listening to patients' accounts of their pain. Particular attention will be paid to the ethical and deontological issues raised by these accounts, especially in relation to euthanasia and assisted suicide.

**Advanced courses**

**From suicide to euthanasia in pain clinics**

**Is the suicidal pain patient always a "shrink"?**

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Patients suffering from chronic pain are at high risk of suicidal behaviour. Reviews of the literature reveal a prevalence rate of suicidal ideation of around 20 to 40%, a lifetime prevalence of suicide attempts of 5 to 14%, and a risk of death by suicide that is twice as high in patients suffering from chronic pain as in non-painful patients. [1, 2] This association raises the question of the origin of suicidality in these patients, and in particular whether it is necessarily psychiatric in nature.

The concept of demoralisation, introduced by JD Frank in 1974, sheds light on this issue. Demoralisation is not a psychiatric disorder in the strict sense of the term, but rather a state of reaction to a prolonged inability to cope with stress. It manifests itself in feelings of powerlessness, despair and loss of meaning. [3] Unlike depression, demoralisation does not necessarily have the classic symptoms of a psychiatric disorder, but can be just as psychologically devastating. This means that suicidal pain patients may not be depressed or suffer from other psychiatric disorders in the strict sense.

Scientific research shows a close link between chronic pain and demoralisation. For example, studies associate demoralisation with chronic facial pain, [4] phantom tooth pain, [5] and myofascial pain. [6] Pain can trigger feelings of failure and helplessness that exacerbate emotional distress, although not necessarily clinical depression.

Kissane and his team have particularly highlighted the idea that demoralisation can lead to suicidal behaviour, even in the absence of a formal psychiatric disorder. In the context of palliative care or serious physical illness, some patients express a desire to die that is not necessarily linked to clinical depression but to profound demoralisation. [7]

The differentiation between depression and demoralisation is crucial. While depression is a psychiatric disorder with specific diagnostic criteria, demoralisation is a distinct psychological state, often reactionary. For example, a patient suffering from chronic pain and having suicidal thoughts is not necessarily 'shrinky' in the sense of depression or other psychiatric pathologies, but may be deeply demoralised. Discouragement, a key component of demoralisation, is sometimes a more powerful predictor of suicide than depression. [8]

In conclusion, suicidal pain patients do not necessarily suffer from psychiatric disorders. Many may present with profound demoralisation, a non-pathological but extremely debilitating psychological state, which may nonetheless lead to suicidal behaviour.

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**Advanced courses**

**Research methodology (Com recherche)**

**Participatory health research: why and how?**

F. Docagne 1

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Participatory research is a form of research that covers all scientific fields and all subjects in a variety of ways. It gives citizens the opportunity to produce knowledge, innovation and scientific know-how alongside researchers. In the context of health research, this approach encourages science that is attuned to societal issues and the reality of problems in the field. It can also give rise to new questions that would not have arisen without a dialogue between science and society. It can also help to reach audiences that are difficult to access and issues that are not addressed by "traditional" research. It can help to change public health practices and policies by scientifically evaluating empirical approaches or interventions. Finally, by involving the people concerned in the development of healthcare innovations, it encourages the deployment and implementation of these innovations.

Participatory research projects can be initiated either by a laboratory or by a group. The partners will then work together to co-construct and co-produce the research, by themselves defining the procedures for this construction and implementation. This participation can take place at all stages of the research: definition of the scientific question, choice and adaptation of the methodology, construction of questionnaires, protocols or experimental tasks, writing of instructions and forms, analysis and dissemination of results.

Through examples of participatory research projects supported by Inserm, we will discuss the issues and the contribution of participatory research to a science that is done with, for and by society.

**Advanced courses**

**Research methodology (Com recherche)**

**SNDS: From data genesis to research uses.**

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1 Chu Clermont-Ferrand - Clermont-Ferrand (France)

INTRODUCTION

The French National Health Data System (SNDS) is one of the richest repositories of health data in the world [1]. It combines hospital data (PMSI), health insurance data (SNIIRAM) and data on medical causes of death (CépiDC), with a historical depth of almost 20 years. Originally, these different databases were used for administrative and financial purposes. Their matching, exhaustiveness and simplified access make it possible to carry out studies that are useful for epidemiology, health monitoring and research, provided that the strengths and limitations of these data are properly understood.

METHODS

Using the SNDS for scientific research requires at least as much rigour as clinical research. It does not directly involve the participation of patients as in a clinical trial, but the conclusions may influence major decisions and have an impact on many people [2,3,4].

The definition of inclusion, evaluation and adjustment criteria requires knowledge of the methods of reimbursement and provision of care and their evolution over time, as well as an assessment of the robustness of their identification in the SNDS.

Exposures and outcomes require precise definitions that are sometimes complex to establish, or even arbitrary, and require informed clinical justification and modelling in line with the defined objectives.

The biases inherent in observational databases are pitfalls that must be anticipated and controlled using appropriate statistical methodology in order to minimise them. The randomised controlled trial, the only framework for demonstrating causality, is not feasible in the SNDS, but can be approached using propensity score methods [5] designed to limit bias (confusion, indication).

SCIENTIFIC APPLICATIONS

In research, the SNDS can be used to conduct epidemiological, medico-economic or pharmaco-epidemiological studies [6,7] which provide results in addition to clinical trials, or even make it possible to link the two by matching databases [8]. A few examples of articles will be presented, with a more specific focus on a publication relating to the management of pain using opioid analgesics [9].

CONCLUSION

The SNDS is a goldmine that can be complex to extract, but because of its exhaustiveness and historical depth, it can help us to understand healthcare pathways and expenditure, monitor practices and evaluate them in terms of effectiveness and safety.

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**Advanced courses**

**Research methodology (Com recherche)**

**Development of a self-assessment tool on a digital tablet for cognitive functions related to pain pathologies and their management.**

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Few data are available on changes in cognitive functions during chronic pain [1-3]. On brain imaging, several structures in the pain matrix appear to be altered [2-3]. These few observations explain the cognitive decline observed clinically in patients but too often not accurately assessed, due to a lack of time and, above all, of suitable tools. The MMSE (Mini-Mental State Examination) and the MOCA (Montreal Cognitive Assessment) are two tools available and recommended by the French National Authority for Health [4-5]. The MOCA has been used in patients suffering from osteoarthritis and fibromyalgia [2-3]. This test is time-consuming in the clinic, imprecise and insufficient to accurately discriminate cognitive impairment in patients.

With this in mind, our team developed E-MILE®, a digital tool on a tablet computer designed to measure the cognitive consequences of chronic pain in detail. The aim was to offer a tool in which patients could independently assess their cognitive functions in less than 20 minutes. To achieve this, the digital tool was adapted for anyone able to use a digital tablet. Voice recognition, integrated via an artificial neural network, has made it possible to standardise interaction with the patient, both when asking questions and when recognising verbalised responses. The design stages of E-MILE® were guided by the need to limit the number of questions while assessing cognitive abilities as comprehensively and accurately as possible. E-MILE® also assesses factors influencing cognition such as fatigue, stress and pain using intensity and discomfort scales and a body map. The tool also offers the possibility of completing a questionnaire on confidence in driving [6].

The validation study on a sample of healthy subjects aged 18 and over has been completed and has validated the EasyCOG score. The results of this validation have enabled us to begin a study of chronic pain patients with the aim of mapping their cognitive functions according to pathologies and treatments. We hope that this tool will lead to a more accurate assessment of the pain conditions encountered, and ultimately to better care for patients, whether in hospitals, institutions or outpatient clinics.

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**Forums**

**OFMA-SFETD Forum**

**Pharmacosurveillance and proper use of analgesics**

**Medical cannabis in the therapeutic arsenal by 2025**

N. Richard 1

1 Ansm - Paris (France)

The medical use of cannabis is the subject of a trial that began on 26 March 2021. By 27 March 2024, the end of the trial, 3209 patients had been included and 1929 are still being treated and monitored. Evaluations of the trial have shown that the prescription and dispensing circuit is operational and secure, and that the drug is effective in all indications for up to 18 months. Addiction and pharmacovigilance data confirmed an expected safety profile, albeit with an increased risk of suicidal ideation. More than half the patients treated are suffering from refractory neuropathic pain.

The French Social Security Finance Act of 26 December 2023 sets out the arrangements for medical cannabis to become part of common law in 2025, meaning that medical cannabis-based medicines can be prescribed like any other medicine. These medicines will have a specific status, with an authorisation for use for a temporary period of 5 years, issued by the ANSM. The pharmaceutical forms may be oral or sublingual, or forms for inhalation by vaporisation. Other pharmaceutical forms will be possible if justified. Cannabis-based medicinal products will contain delta-9-tetrahydrocannabinol (∆9-THC) and/or cannabidiol (CBD) in different ratios: dominant THC, balanced THC / CBD, dominant CBD. Finished products containing cannabinoids in the form of pure and isolated active substance will be excluded.

The initial prescription will be given in hospital by a specialised care centre, with a possible renewal in the community. Dispensing will take place in dispensing pharmacies. The indications will be defined by decree and will be the same as those for the trial: refractory neuropathic pain, drug-resistant forms of epilepsy in adults and children, intractable symptoms in oncology related to cancer or anticancer treatment, palliative situations and painful spasticity in multiple sclerosis or other central nervous system pathologies.

Patients must have reached a therapeutic impasse, i.e. insufficient relief or poor tolerance of authorised drugs.

It was observed during the experimentation that the efficacy of cannabis in refractory neuropathic pain was mainly linked to the optimal dose of THC. The usual doses are 15 mg/d of THC and 65 mg/d of CBD. Depending on the choice of the prescriber and the patient, treatment may be initiated with a combination of THC and CBD or with CBD.

The authorisation issued by the ANSM will be accompanied by the obligation for the authorisation holder to set up a system for collecting follow-up data on patients treated, the terms of which will be set by the ANSM.

**Forums**

**OFMA-SFETD Forum**

**Pharmacosurveillance and proper use of analgesics**

**Buprenorphine as a strategy for withdrawal from opioid analgesics after failure of gradual withdrawal in patients suffering from chronic non-cancer pain (SEVROP study)**

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Introduction

Opioid analgesics are frequently prescribed for prolonged use.

(≥ 3 months) in the context of chronic non-cancer pain, leading to

sometimes physical dependence and various unpleasant withdrawal symptoms

for patients [1]. There is currently no validated weaning strategy.

for the patients concerned. The aim of this study is to evaluate a strategy of

outpatient withdrawal using buprenorphine for patients suffering from

chronic pain which has not been gradually weaned off the analgesic

opioid to which they have become addicted.

Methods

All patients began the protocol with a gradual reduction phase

of their initial opioid, according to a 6-month reduction schedule, planned until

complete withdrawal. Patients who were unable to follow this weaning protocol

were offered buprenorphine, at an initial dose of 4

mg/day, replacing their opioid analgesic. This dose could be

modulated according to the patient's tolerance of the treatment and the appearance of symptoms of

withdrawal in the days following the start of buprenorphine (minimum: 2 mg,

maximum: 8 mg). A progressive buprenorphine weaning schedule was then established.

was proposed to the patient, with the aim of complete withdrawal in a maximum of 9 months. According to the

Fleming's statistics, this criterion was considered to have been met if at least 7 out of 11

patients had an opioid-free urinalysis, including buprenorphine, at the end of the treatment.

in the study, validating complete withdrawal from all opioids.

Results

Of the 20 patients included in the study, 16 failed to wean themselves off the drug.

gradually off their opioid analgesic. Of these, 11 agreed to

replace their opioid with buprenorphine. Of these, 7 succeeded in

wean off buprenorphine in less than 9 months.

Conclusion

This structured outpatient buprenorphine withdrawal protocol is effective for

wean patients suffering from chronic non-cancer pain off analgesics

opioid to which they had become dependent. The results concerning tolerance,

the impact of withdrawal on pain and other co-morbidities.

are currently being analysed and will be presented at the conference.

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prevention-and-care-of-usage-disorder-and-overdose

**Forums**

**APICIL Foundation Forum**

**Pain in mental health**

**Feedback from a Psychiatric Pain Centre**

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When the Pain Centre was set up in a psychiatric hospital in 2009, it wasn't taken for granted! However, 15 years' experience at the Saint Jean de Dieu Hospital in Lyon has confirmed the benefits: an integrative approach and a reduction in the somato-psychic divide, easier access to psychiatric care, fewer wandering doctors, expert advice on complex situations, networking with mental health professionals and team training are just a few examples of the contribution made by this specific facility. This specific approach also helps to reduce the stigma attached to mental illnesses by both patients and professionals: mental illnesses are still viewed in a rather negative light, which can have an impact on the quality of care provided and can even exacerbate symptoms. This system is currently the only one of its kind in France. However, feedback from experience suggests that better account should be taken of the specific nature of pain management in psychiatry throughout the country.

**Forums**

**APICIL Foundation Forum**

**Pain in mental health**

**The pain and ASD collective**

A. Sourty 1

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Pain management for people with Autism Spectrum Disorder (ASD), with or without Intellectual Development Disorder (IDD), requires a good understanding of the different profiles encountered: in sensory terms, in terms of communication, in terms of development, etc. The creation ten years ago of a Pain Collective comprising health professionals working in this field has made it possible to disseminate knowledge about the expression of pain and to take a different approach to the behavioural problems observed, so as not to overlook a hypothesis of pain and to look for its origin... People with ASD without IDD help us to understand the perception of pain for themselves... We will try to illustrate this with fables written by those who feel it.

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Pain assessment for children and adolescents with autism spectrum disorders(ASD): A systematic review Christelle Salaburaa,∗,b, Arnaud Sourty c,d,e, Flora Bat-Pitaultf,g, Kirsty Regnerya,h,Sandrine Mayeni,j, Sébastien Colsoni,jaCentre

**Forums**

**Patient Associations Forum**

**Patient vision of spinal cord neurostimulation in the treatment of chronic neuropathic pain.**

N.D. Deparis 1

1 Afvd - Parthenay (France)

Our EIQOL survey, carried out last year, showed that the undesirable effects of pharmacological treatments have a definite impact on the quality of life of patients suffering from chronic pain. As we all know, pain needs to be managed on a multidisciplinary basis: adapted physical activity, sophrology, hypnosis, meditation, but not only that. There are also medical devices such as patches and tens. But there is another solution for relieving pain: spinal cord or occipital neurostimulation. We take a closer look at this minimally invasive technique, which is often overlooked in therapeutic strategies. To better understand the issues involved, we have imagined a conversation between a patient awaiting implantation and another who already has a neurostimulator. We are therefore delighted to present the AFVD podcast!

**Forums**

**Patient Associations Forum**

**Fibromyalgia and depression: a fatality?**

C. Robert 1

1 Fibromyalgia France - Paris (France)

*"We have words to express light sorrow, but great sorrows know only how to remain silent". Seneca*

Looking back over 25 years of involvement with associations working in the field of chronic fibromyalgia pain, we can say that 80% of our time with associations has been spent informing, explaining and convincing people... in particular that our pain is not in our heads. The phrase "it's all in the head", which is still heard all too often, is devastating for chronic pain sufferers who have come looking for attention, help and justified, appropriate, legitimate and ultimately life-saving treatment!

Is it any wonder that the word 'fibromyalgia' is associated with 'depression'? But does depression accompany fibromyalgia, or is it the consequence of indifference, incomprehension, and the critical gaze of certain medical and social contacts, family relationships, friends, professionals, etc.?

Our role as an association is to defend and improve the quality of life of those we represent. So it's up to us to think about how we can ensure that physical pain is not compounded by psychological pain.

It is undeniable that believing patients and guiding them towards medical and psychological support is the gateway to greater well-being. Unfortunately, the management of chronic fibromyalgia pain is complex, and therapeutic failures are still all too common. This is a painful experience for the patient, who may react with reactive depression.

Yet we want to believe, and express it, that depression in people with fibromyalgia is not inevitable!

**Forums**

**Patient Associations Forum**

**Pain, a therapeutic world without limits**

F. Alliot-Launois 1

1 Aflar - Paris (France)

How can we help the 33 million French people who suffer from pain, particularly chronic pain? They are the result of life accidents, various pathologies, rheumatic diseases etc...

The biomedical model permeates the culture of our time and shapes the expectations and attitudes of practitioners, doctors and carers, and of patients. Chronic pain challenges an approach based exclusively on Cartesian dualism and an objective reductionist approach, and represents a formidable challenge for contemporary medicine. Pain is the cause of almost 2/3 of medical consultations and 80% of pharmacist consultations.

Research is essential if we are to gain a better understanding of the mechanisms involved in pain, improve therapies and develop personalised treatment pathways for patients suffering from pain.

Taking pain medication is a major asset in relieving pain and represents much more than swallowing a pill to treat or cure a bodily dysfunction. It is both the product of research and the culture of a society, a vast world, and in the face of therapeutics, the human relationship is at the centre of every painful complaint: the patient in relation to himself, in relation to others, whether a family member, carer or professional, and indeed, the patient requires comprehensive medicinal and non-medicinal management.

Assessing and combating pain is a difficult battle to wage, especially as techniques and scientific knowledge are often at odds with the untamed, inaccessible nature of the medical world and of patients themselves. Pain and its treatment escape the rational demands of Cartesian rigour on both carers and patients. It can be said that the human relationship is at the heart of every pain complaint and that treatments, whatever they may be, are based on this.

Pain is the cause of almost two-thirds of medical consultations, and 80% of patients consult their pharmacist. The challenge is to understand, in real life, the mechanisms involved in pain, the expectations and findings of patients, and to improve therapies and therapeutic proposals with the arsenal available, and to develop personalised treatment pathways for patients in pain.

**Forums**

**Patient Associations Forum**

**IBS and APSSII**

P. Renoul 1

1 Apssii - Bobigny (France)

Irritable Bowel Syndrome (IBS) is defined as a chronic condition that combines transit disorders (diarrhoea, constipation), bloating, gas and abdominal pain and cramps.

This disease affects more than 3 million people in France. Its chronic nature and its main and secondary symptoms can have a serious impact on the personal, family and professional lives of sufferers, sometimes necessitating recognition as a disabled worker (RQTH). The most severe forms of IBS account for 20 to 25% of cases.

The causes of Irritable Bowel Syndrome are multiple, multifactorial and partially identified, including micro-inflammation of the lining of the digestive tract, disturbed digestive motor function and abnormalities in the control of pain messages in the spinal cord and/or brain.

There is currently no cure for IBS. Current medical indications are to reduce the frequency and intensity of symptoms.

As the causes are multifactorial, managing IBS is part of a comprehensive approach:

- medical consultations in town, or in hospital, with the recent creation of Day Hospitals dedicated to functional digestive disorders;

- drug treatments and food supplements ;

- dietetic approach ;

- complementary treatments: physical activity, mind-body approach (hypnosis, meditation, etc.).

The APSSII (Association des Patients Souffrant du Syndrome de l'Intestin Irritable - Association of Patients Suffering from Irritable Bowel Syndrome) provides support and guidance to sufferers and helps them access scientifically validated complementary treatments.

That's why the APSSII has had four main missions since it was founded in 2010: to support and accompany sufferers, to promote research, to inform people about the disease and raise awareness of IBS, and to represent and defend the rights of sufferers.

**Focus**

**HAS recommendations on refractory pain in palliative care**

E. Treillet 1

1 Lariboisière Hospital - Paris (France)

The management of pain in palliative situations has benefited from a dusting off of the old AFSSAPS recommendations. In 2020, recommendations on molecules used outside the AMM were produced under the aegis of the HAS. At the time, the health spotlight was focused on the COVID pandemic. Here we present an updated version of these recommendations.

Careful assessment of pain is essential and must take into account

all the components of pain: cognitive-behavioural, affective-emotional and sensory-discriminative.

pathophysiological mechanisms, particularly neuropathic.

A change of opioid is recommended in cases of uncontrolled pain despite well-managed treatment, tolerance, significant side effects or medical necessity. It is preferable to use conversion tables such as Opioconvert to calculate doses.

Methadone is particularly useful for cancer-related intractable pain, as a second-line treatment after failure of a well-administered opioid. Its introduction requires hospitalisation and special monitoring, particularly because of the risk of delayed overdose. The initial dose and its adjustment should be determined by a specialist team.

Its implementation can be guided by an online converter www.metaconvert.eu and supported by the tools available in the metabox www.sfetd-douleur.org/douleurs-cancer/.

Ketamine can be used as a co-antalgesic with an opioid for intractable pain. Its main mechanism of action is NMDA receptor antagonism, which helps to reduce opioid-induced hyperalgesia. The initial dose varies from 0.15 to 0.5 mg/kg/day intravenously, and can be gradually increased. The maximum recommended dose is 5 mg/kg/d, beyond which the anaesthetic effect becomes predominant and the risk of adverse effects increases.

Peripheral nerve blocks should be considered for localized intractable pain. They act by interrupting the transmission of nociceptive impulses to the higher centres. The local anaesthetic can be administered as a bolus, continuous or continuous with a bolus.

For intractable pain not controlled by an equivalent of 300mg of oral morphine, intrathecal ntalgesia allows analgesics to be administered directly into the cerebrospinal fluid:

- Morphine: 1/100th of the IV dose, maximum 5 mg/d

- Ropivacaine: 6 to 8 mg/d

- Ziconotide: 0.25 to 0.50 μg/d[1].

Transmucosal fentanyl may be considered without background opioid treatment in the absence of background pain, particularly for induced pain of rapid and brief onset (<1h30). Its use must be carefully evaluated and monitored.

Managing pain in palliative care requires assessment, adaptation of treatments and close collaboration between the various healthcare professionals.

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**Focus**

**What TVE programmes for children and adolescents with chronic pain and their carers?**

**A.G.L.A.E.: the programme that gets you moving**

S. Berciaud 1, H. Capdupuy 1, A. Raynaud 1

1 Service Douleur Et Médecine Intégrative, Unité Centre D'évaluation Et De Traitement De La Douleur Pédiatrique Chu Bordeaux - Bordeaux (France)

The World Health Organisation's definition of therapeutic patient education (TPE) is reported by the HAS in its recommendations (1,2): "Therapeutic patient education aims to help patients acquire or maintain the skills they need to manage their life with a chronic disease as effectively as possible. It is an integral and permanent part of patient care. It comprises organised activities, including psychosocial support, designed to make patients aware and informed about their illness, hospital care, organisation and procedures, and health- and illness-related behaviours. The aim is to help them (and their families) understand their illness and treatment, work together and take responsibility for their own care, in order to help them maintain and improve their quality of life".

There are, however, specific features of paediatric programmes(3): the programme must be adapted to the development of the child and adolescent. We need to take into account the specific features of the child's dependence on the adult: the triangular relationship between carer, child and parent, the transfer of knowledge from the parent to the child, the importance of workshops for children and teenagers as well as parents, and the need to educate the "other" adults involved: nursery staff, childminders, in particular via individualised childcare plans (PAI).

The objectives of therapeutic education must be adapted to the children and their parents. The educational approach must be adapted to the child/adolescent: during the educational diagnosis, during workshops by age group, via group workshops, etc. The participation of the entire team developing and implementing the programme is essential at every stage. (4) As chronic pain is now recognised in the latest International Classification of Diseases (ICD) (5), we set about developing an ETP programme for children and adolescents with chronic pain on this basis. This is how the "A.G.L.A.E: Autonomiser.Guider.Lâcher-prise.Adapter. Listen". Since the end of 2023, we have been rolling it out at the Centre d'Evaluation et de Traitement de la Douleur pédiatrique (Paediatric Pain Assessment and Treatment Centre) at Bordeaux University Hospital. The programme includes individual workshops for children/adolescents, group workshops for children/adolescents and a parents' workshop. Some of the workshops are disease-specific (migraine/headache and complex regional pain syndrome), while others are cross-disciplinary (discovering mind-body techniques, learning about transcutaneous electrostimulation, learning about and managing treatment, living with a child with chronic pain, etc.).

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**Focus**

**What TVE programmes for children and adolescents with chronic pain and their carers?**

**Better understanding and assessing the pain of our intellectually disabled child**

P. Le Moine 1, F. Insogna 1

1 Chu Brest - Brest (France)

Since it was set up in September 2022, the Mobile Pain Handicap Intellectual Disability 0-25 team (MoDIDol) at Brest University Hospital has aimed to help parents and family carers of children, adolescents and young adults with moderate to severe intellectual disabilities to identify and assess pain. [1]

The initial format was a proposal to train parents in the form of 1 hour 30 minute seminars with a masterly presentation of the neurophysiological bases, adapted assessment tools and the APO application. Parents were invited to ask questions during or after the presentation. We trained 30 parents of 27 patients, the organisation being determined by the institutions where we worked. 1 parent was reviewed at 2 months to assess the impact of the training. The top-down nature of the training and the selection of parents by the institutions seemed to us to limit the impact of our proposal.

From December 2023 to March 2024, MoDIDol nurses and doctors attended a Level 1 therapeutic patient education (TPE) training course offered by the DéfiScience network.

Our ETP programme "Reconnaître et EValuer la Douleur de mon Enfant" (DouREVE) is offered by institutions, the CRDI and patient associations. Training locations (Brest - St Brieuc - Lorient) and dates are determined by our team.

We set up differentiated groups of parents with a maximum of 6 children, either with multiple disabilities or a severe autism spectrum disorder.

Following an initial shared educational assessment, the programme consists of 3 workshops spread over 2 half-days, 2 weeks apart. The first workshop, entitled "What is pain?", includes an introduction of the participants, a mind map of their representations of pain, and a theoretical input on the neurophysiological basis of pain. The following workshop on "Assessment tools in the context of moderate to severe intellectual disability" is based on a meta-plan of their observations, organised into sub-categories according to the assessment scale presented during the session: Profil Douleur Pédiatrique in the context of polyhandicap, and GED-DI in the context of ASD. A practical video test closes the session. The second half-day is used to assess the appropriation of the tool in a peer group feedback workshop, before offering the APO application with a group and individual demonstration.

We are starting ETP sessions in September 2024 in Brest, then in St Brieuc at the beginning of November. We will be presenting these initial experiences at the SFETD congress.

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**Focus**

**Pain referral nurse versus pain resource**

C. Bevis 1, M. Periot 2

1 Chu Montpellier - Montpellier (France), 2 Ch Chateauroux - Chateauroux (France)

The pain resource nurse (PRN) is often confused with the pain referent (PR) or pain correspondent (PC). These professionals are both motivated and interested in the field of pain, but their missions and places of practice are not the same.

The IRD, whom the French National Order of Nurses calls a "Nurse Expert in Pain", has a role defined by the Order, with the capacities and aptitudes, knowledge, training and experience required. The SFETD's professional nursing commission has updated the IRD's reference framework of activities and skills for 2020.

The roles and remits of the RD/CD are not really defined at national level, but are rather specific to each healthcare establishment.

The purpose of this Update is to clarify everyone's roles and responsibilities.

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**Focus**

**Acute pain: News**

**Perioperative opioid-induced hyperalgesia with opioid free analgesia (OFA). What is the right measure?**

S. Anaesthesia 1

1 Aphp Paris Saclay - Boulogne Billancourt (France)

Effective perioperative analgesia analgesia is not only a human necessity but is important to prevent short and long term complications. We should temper our enthusiasm for eliminating opioids altogether with practical considerations, realistic expectations and reliable evidence. We should focus on reducing opioid use with options that are known, safe, feasible and tailored to individual patient needs.

It took decades for opioids to become part of everyday life, but they are still useful for major surgery and severe pain.

The search for the optimal dose of opioids intra- and postoperatively is a legitimate quest. There is a benefit in terms of perioperative nausea and vomiting if there is total intraoperative abstention from opioids or effective multimodal analgesia.

The North American crisis should not lead us astray. Strict intraoperative DAO is a source of side effects. The unfounded accusations against opioids, such as exposure to cancer or DCPC, must be emphasised.

**Focus**

**Neuromodulation: Evidence from the literature**

**Evidence in the literature of Implanted Peripheral Nerve Neuromodulation**

B. Mouth 1

1 Dr - Poitiers (France)

The evidence available in the medical literature indicates that implanted peripheral neuromodulation is effective in treating certain forms of chronic pain, particularly neuropathic pain. Several recent clinical studies and systematic reviews have shown that this technique can significantly reduce pain intensity and improve quality of life in patients with chronic neuropathic pain. However, the quality of the evidence remains variable depending on the pathologies and types of device used. Larger-scale randomised controlled trials will be needed not only to confirm these results but also to optimise therapeutic protocols. Implanted peripheral neuromodulation is also beginning to extend its range of efficacy in osteoarticular nociceptive pain.

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**Focus**

**Neuromodulation: Evidence from the literature**

**Radiofrequency in the treatment of chronic spinal pain**

F. Di Maria 1

1 Hôpital Foch, Service De Neuroradiologie Diagnostique Et Thérapeutique - Suresnes (France)

Radiofrequency thermocoagulation is used to treat low back pain of facet origin. This method targets the vertebral facet joints, often a major source of lower back pain. The procedure involves applying controlled heat to the nerves responsible for the pain, inhibiting their ability to transmit pain signals. Radiofrequency thermocoagulation offers prolonged relief by temporarily destroying the sensitive nerve fibres in the facet joints.

Indications for radiofrequency thermocoagulation include cases of persistent chronic low back pain, particularly when the pain is localised to the facet joints and resists conservative treatments. Clinical studies have shown that this technique can significantly reduce pain and improve physical function in patients with persistent facet joint low back pain.

In terms of safety, radiofrequency thermocoagulation is generally well tolerated, with minimal risk of serious complications. Potential side effects are generally minor and temporary, including slight pain at the site of the procedure or a transient increase in the initial pain level.

For radiculalgia, on the other hand, conventional treatments include anti-inflammatory drugs, physical therapy and corticosteroid injections, but their long-term effectiveness can be limited, with potential side effects. Pulsed radiofrequency (PRF) is emerging as a promising alternative, particularly for neuropathic root pain. Unlike continuous radiofrequency, which destroys nerve tissue, RFP modifies the activity of sensory nerves without causing permanent damage. It is used to reduce the transmission of the pain signal, providing effective relief while minimising side effects.

In summary, both pulsed radiofrequency for radiculalgia and radiofrequency thermocoagulation for facet low back pain offer effective and relatively safe treatment options for patients suffering from chronic back pain. These techniques represent significant advances in the management of low back pain, offering lasting relief and improving patients' quality of life.

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**Focus**

**NSAIDs and infection**

**Should we really be afraid of non-steroidal anti-inflammatory drugs (NSAIDs) in the event of infection?**

S. Perrot 1

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The use of NSAIDs is associated with a number of risks, which justify caution, particularly in the case of prolonged administration. The COVID epidemic19 initially highlighted a potential risk associated with the use of NSAIDs in the event of COVID infection. This risk was subsequently denied, leaving patients and healthcare professionals in doubt. In the bacterial context, the risks seem to be more pronounced. So what is really the situation with regard to the risk of infection associated with the use of NSAIDs?

*NSAIDs and COVID 19:*

At the start of the epidemic, in a context of upheaval and emerging knowledge, signals emerged in favour of an excess risk linked to ibuprofen. This even led to an alert being issued by the Minister of Health at the time. This alert had a considerable impact on patients, doctors and pharmacists, who went so far as to ban all ibuprofen use in cases of suspected COVID infection19. The data was subsequently analysed, and we can now be completely reassured that there is no additional risk of morbidity or mortality associated with the use of NSAIDs in cases of COVID, and ibuprofen in particular (1).

*NSAIDs and other viruses*

As with COVID, initial data may have raised concerns about the risk of using NSAIDs during dengue infection. In fact, recent data are reassuring and do not impose any restrictions on use (2).

However, in the case of VZV infection, particularly in children, there is a real increased risk of Reye's syndrome and skin infection when NSAIDs are used, which justifies a contraindication.

*Bacterial infections*

Several pharmacovigilance studies have suggested that taking NSAIDs for fever or pain may play a role in aggravating streptococcal infections (3). A recent report from 2023 (4) indicates that infections and complications of bacterial infections account for a very large proportion of serious adverse reactions reported with ibuprofen, with an increase in cases of serious infections, and a high number of very severe forms, with ibuprofen and ketoprofen. This seems to be associated with high mortality, particularly in paediatric patients. Particularly robust experimental data underline the intrinsic risk associated with a specific effect of NSAIDs on amplifying the spread of streptococci (5).

In conclusion, the current data suggest that the risk when using NSAIDs in viral infections is insignificant, with the exception of VZV infection. This risk needs to be assessed for new viral infections in development, such as M-Pox. In bacterial infections, the risk appears to be greater, particularly in the case of streptococcal infections, and in paediatrics, which justifies the use of paracetamol rather than NSAIDs.

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**Focus**

**Pharmacological adaptation to patient characteristics**

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Recent data indicate that various new treatment strategies based on predictive biological and/or clinical markers could be useful for better personalising and therefore improving the management of neuropathic pain (1). The validation of objective biomarkers (using neurophysiological or anatomical techniques in particular) seems to be the most relevant. However, although promising results have been reported with these approaches, clinical validation of these biomarkers remains preliminary. Thus, the most well-documented therapeutic strategies are based on the development of clinical 'markers', based on self-questionnaires. In this update, we will summarise the different approaches based on objective biomarkers or clinical markers that can be used to tailor treatments to patient characteristics.

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**Focus**

**Prescribing physical activity: where do things stand?**

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1 Dr - Paris (France), 2M. - Cornouaille (France)

There is a great deal of evidence in favour of physical activity for most chronic pain conditions, such as low back pain, fibromyalgia and other musculoskeletal disorders. However, in everyday practice, it is difficult to implement physical activity in people with chronic pain, despite the expected benefits. There are many obstacles to this, including physical, cognitive and material barriers. There are a number of tools available to help implement and prescribe physical activity. Recently, the prescription of physical activity has been extended to include adapted physical activity educators, making it easier for as many people as possible to adopt regular physical activity, whatever their health condition. Vincent Boucherot, a teacher of adapted physical activity, and Florian Bailly, a rheumatologist and algologist, will discuss the tools, advice, resources and facilitators available.

**Focus**

**How can neuropsychology be integrated into the management of chronic pain patients?**

**Cognitive disorders and pain management: the contribution of neuropsychology**

S. Baudic 1

1 Inserm U 987-Cetd Hôpital Ambroise Paré - Boulogne (France)

The aim of this update is to explore cognitive impairment in the context of an inability to implement effective pain management strategies.

A third of chronic pain patients have at least one cognitive deficit. Short- and long-term memory, processing speed, information, attention and executive functions (inhibition, cognitive flexibility and updating) are among the areas most affected. In addition, over 88% of pain patients report forgetfulness and 60% complain of loss of concentration (Lourenco Jorge et al 2009).

However, cognitive deficits are rarely reported by pain specialists, with the exception of the diagnostic criteria for fibromyalgia (Wolfe et al 2010). Cognitive problems are assessed by patients on a scale from 0 to 3 (0: no problems and 3: severe cognitive problems assessed according to their intensity and frequency).

Clinical observations suggest that among chronic pain patients, some manage pain with difficulty while others seem to adapt better to the painful experience (Keefe et al 1989). Patients who do not adapt to pain are potentially those who have the most difficulty with cognitive tasks.

In addition, behavioural and cognitive therapy programmes are set up without any mention being made of any assessment of the cognitive functions of chronic pain patients, even if only by means of a self-questionnaire or a screening tool (MoCA: Montreal Cognitive Assessment).

Experimental studies highlight the role of working memory in the attentional control of pain, particularly in the individual's ability to disengage attention from nociceptive stimulation and redirect it to another task (Legrain et al 2011). Other authors mention inhibition (Verhoeven et al 2011).

The neuropsychologist has a key role to play in specialised chronic pain management structures. They can carry out neuropsychological assessments and develop cognitive re-education programmes tailored to the patient's particular difficulties. What remains to be done is to define the terms and conditions of their work within a multi-professional team.

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**Parallel sessions**

**CEDR session: Musculoskeletal pain**

**Men and women: are we equal when it comes to osteoarthritis pain?**

A. Courties 1

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Women have a higher level of musculoskeletal pain than men, particularly in the case of osteoarthritis, which is also more often symptomatic in women. One might intuitively think that this is due to the greater severity of the lesions in women. However, for the same radiographic severity, women describe more intense knee osteoarthritis pain than men (1). Although this difference seems to extend to many painful chronic diseases, few studies have explored the pathophysiological and sociological differences that might explain it.

Most preclinical studies on osteoarthritis are carried out on male mice aged around 3 months (equivalent to male adolescents), which are known to develop more severe osteoarthritis. However, osteoarthritis predominates in women over the age of 65, creating a major gap between preclinical data and human clinical observations, limiting our understanding of the pathophysiological mechanisms of osteoarthritis and associated pain (2).

Several hypotheses have been put forward to explain why women suffer from more painful osteoarthritis: genetic factors, hormonal factors or factors linked to the response to analgesics, but also neuro-immune differences (3), as distinct neuro-immune pathways are involved in pain in men and women. However, it is clear that there are also significant psychosocial and societal biases that influence gender-related behaviours and alter doctors' interpretation of symptoms. Thus, for an identical clinico-radiographic presentation of gonarthrosis, a man will be offered a total prosthesis 4 to 22 times more often than a woman (4).

The aim over the next few years is therefore to gain a better understanding of the differences in pain expression between women and men from a pathophysiological and societal point of view. As healthcare professionals, it is essential to reflect on the implicit biases that influence our assessment and management of patients on the basis of gender.

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**Parallel sessions**

**CEDR session: Musculoskeletal pain**

**From Cronos to Algos: towards a chronobiology of pain**

S. Perrot 1

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Biological rhythms play a major role in the functioning of living organisms, in the construction of habitual behaviours (eating, sleeping, etc), in immune defences, memory, etc. Biological systems vary from day to day, month to month, year to year... and pain is no exception (3,5).

*Temporal variations in pain: importance for diagnosis*

Many types of pain vary in intensity and characteristics. Certain variations make it possible to classify pain as inflammatory, when it is increased at night, or mechanical, when it increases throughout the day. These variations are important to know for diagnosis, but also to assess the impact of this pain on patients' quality of life, whether in osteoarthritis, cancer or inflammatory diseases.

Chronobiology highlights the important links between sleep and pain (5).

*Chronobiology: understanding variations in pain*

Evaluation of the biological clock and its genes shows the importance of the links between biological rhythms and the endocrine and immune systems, particularly through cytokines. Current changes in the amount of sleep people get, and the importance of artificial light and screens, modify not only biological rhythms but also the appearance or intensity of certain types of pain, such as fibromyalgia or chronic low back pain.

*Changing rhythms to improve pain and reduce inflammation?*

Recent studies show the importance of napping in reducing inflammation and improving certain types of pain. Conversely, certain anti-inflammatory treatments could reduce sleep disorders. We carried out a study showing the impact of a nap on restoring pain sensitivity in volunteers who had undergone sleep deprivation (2). Other authors have used different types of light, such as green light, to reduce inflammation and reinforce endogenous opioid systems (4).

*Chronopharmacology: an approach to be developed for pain?*

We know that the absorption and metabolism of certain drugs vary according to the time of day, particularly absorption, which is often faster during the day. Some studies also suggest that the efficacy of paracetamol varies throughout the day. Detoxification by CYP 450, which is important for analgesics, also undergoes significant variations that could influence both efficacy and the occurrence of adverse reactions (1).

In conclusion, chronobiological variations in pain must be taken into account in the assessment of pain and in its management, particularly to increase the effectiveness of treatments. In the future, the personalised approach to pain should incorporate these chronobiological data, to ensure a truly chrono-algological approach.

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**Parallel sessions**

**CEDR session: Musculoskeletal pain**

**WHO 2023 recommendations on chronic low back pain**

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1 Rheumatologist - Algologist - Paris

The use of analgesics, particularly opioids, in chronic low back pain is still controversial. In December 2023, the World Health Organisation published recommendations for the management of chronic low back pain. A particular focus was placed on the elderly, for whom certain specific treatments may be different.

There was no recommendation for paracetamol.

Non-steroidal anti-inflammatory drugs, which are widely used for acute low back pain, also have some data for chronic low back pain, as the authors found 4 randomised controlled trials lasting more than 12 weeks and involving 1,300 people. These studies found little efficacy in reducing pain, although the known renal, digestive and cardiac side-effects mean that these treatments should only be recommended for short courses, taking into account the patient's co-morbidities.

Similarly, no recommendation was made for benzodiazepines, as there were no trials in chronic low back pain. On the other hand, risks were mentioned, such as memory problems, falls, misuse, dependence and withdrawal syndrome after prolonged use.

Cannabis was not recommended either, as no trial had assessed either the benefits or the risks in chronic low back pain.

Anti-epileptic drugs such as pregabalin or gabapentin were not recommended for use.

Antidepressants also have a recommendation against its use.

Opioids are a recurrent subject of controversy. Here, the WHO has issued a recommendation against the use of opioids in chronic low back pain. A meta-analysis found them to be effective, but the opioid crisis in the USA and the recent OPAL Trial suggesting misuse have led to this recommendation being rejected.

The summary of these recommendations illustrates above all the very small number of existing studies (except for opioids) which do not allow any conclusions to be drawn in general. This is paradoxical given the prevalence and impact of low back pain.

Furthermore, a recommendation is a general guide, but cannot illustrate the singularity of treatment, which will obviously have to take account of each individuality. Drug treatments for low back pain can, in certain situations, help to introduce non-drug treatments, which are generally the most effective treatments for long-term improvement.

**Parallel sessions**

**CEDR session: Musculoskeletal pain**

**Myofascial pain**

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1 Aphp - Paris (France)

Myofascial pain is very common, especially localised pain. Everyone has experienced it at least once in their life (e.g. "trapezius pain"). They are due to localised muscular pain caused by neuromuscular hyperactivity and/or tension in the fascia. The pain is often spontaneous, aggravated by stretching or muscle contraction, with a sensation of muscle weakness. On palpation, there is an often painful muscle cord or even myofascial trigger points (nodules that are more or less palpable on pressure, causing local pain but also referred pain). They are particularly common in patients suffering from Minor Intervertebral Disorder (MID), radiculopathy or tension headache. The neurotonic terrain and hypersollicitations, particularly professional, postural and sporting, favour these pains (1). When the pain becomes chronic, the patient describes a handicap, which is all the greater if the diagnosis is not mentioned. In fact, such pain can easily cause anxiety because it is not recognised.

The treatment includes information, reassurance, analgesics, stretching, work on the fascia and possibly infiltrations. It is essential to eliminate stress factors and take into account the individual terrain. The help of an experienced physiotherapist is important. Transcutaneous neurostimulation of the muscle type on the taut cord is useful. The correct settings must be used to avoid causing pain. Ultrasound is also useful (2).

Diffuse myofascial pain, such as that seen in fibromyalgia, is 1.6% prevalent in France. It is the most common chronic diffuse pain condition. Fibromyalgia is now classified as "no disciplastic" chronic pain (3, 4, 5). This means that the pain is not accompanied by organic lesions, that it has been present for more than 3 months, that it is accompanied by allodynia and/or hyperalgesia with spontaneous and/or provoked pain in the regions concerned, that it is associated with significant emotional distress and/or functional disability and that no other diagnosis has been suggested. Chronic widespread pain is associated with a number of other symptoms, such as fatigue, waking up feeling unwell, sleep disorders and cognitive problems. The subjectivity of symptoms, the absence of a gold standard diagnosis and the lack of a specific biological marker can make diagnosis difficult. There are many differential and associated diagnoses. Treatment is essentially multidisciplinary, combining information, education, physical exercise, stress management and even cognitive and behavioural therapies. The psychotropic drugs (anti-epileptics and/or antidepressants) are usually used as second-line treatment.

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**Parallel sessions**

**Medication and psychological life in pain**

**Pain medication and its impact on the psyche and emotional life**

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Pain (particularly chronic pain) and emotions are complex constructs, sharing common biological pathways in the brain, which pain medication modulates[1]. The respective roles of pain per se, certain mental health co-morbidities and analgesic drugs in the impact on the emotional life of our patients are often difficult to establish, but certain "emotional effects" of pain drugs should be borne in mind and weighed against the limited overall effectiveness of the drug approach in chronic pain. A "simple" analgesic such as paracetamol appears to modify our capacity for empathy [2]. Antidepressants may be associated with initial anxiety or, conversely, with a syndrome of apathy and blunted affect [3]. More indirectly, opioids and antidepressants cause libido problems, which are often little explored [4]. The impact of painkillers on emotional life can also be seen from other angles, such as the legitimisation of the symptom and its attribution to a somatic entity, the way our patients perceive them, and the potential stigma attached to their use [5],[6].

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**Parallel sessions**

**Medication and psychological life in pain**

**What is the emotional and psychic life of chronic pain patients on painkillers?**

V. Barfety 1

1 Chu Lille

There are several types of pain medication, generally including analgesics, anti-inflammatories, anaesthetics, anti-epileptics and antidepressants. Prescribed very regularly to chronic pain patients, they have an impact on their emotional and psychological life. Can we then say that a patient on gabapentin and an antidepressant is emotionally unresponsive or even apathetic, or even aboulic, when even paracetamol produces a significant emotional blunting? How can we access the psychic life of the patient we are seeing in this context?

**Parallel sessions**

**Medication and psychological life in pain**

**Will we still need complementary practices once we've found a cure for pain?**

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The pain clinic is certainly one of the healthcare sectors where complementary approaches are best integrated, and also best accepted. While there are philosophical and ethical reasons for this, we cannot ignore the fact that the success of these approaches is also linked to a complex and sometimes uncertain clinical situation. And if there were a 'miracle' drug for chronic pain, would non-drug approaches be just as popular?

We show that the relationship with complementary approaches is more obscure and ambiguous than it appears, and that very often the hopes of medication diminish the scope for these singular approaches, which also reflect the desire to continue to offer something... when there is nothing else to offer. Even in the research that underpins their use, there are ambiguities, which we will address.

What next? Certainly by drawing on the integrative health and "One Health" movements to develop convictions and ways of practising that are different from what they are at present (and not just in response to a struggle against failure, exhaustion and the powerlessness we feel in the face of complex clinics). But are we ready to push back the walls and stop seeing drugs as a benchmark, and even, in certain specific cases, to see them only as "complementary"... at best?

**Parallel sessions**

**SFETD-SFAR joint session**

**The pathophysiological basis of chronic postoperative pain**

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Every year, around 312 million people undergo surgery worldwide, and the number is constantly rising (1). Despite increasing awareness of the need for effective management of post-surgical pain, chronic postoperative pain (CPOP), now recognised as a critical illness (2), represents a real public health issue because of its incidence (3) and its impact on patient recovery and quality of life, as well as the societal cost it represents. PCOD is defined as pain that persists for more than 2 months after surgery. The clinical symptoms of PCOD include hyperalgesia, allodynia and continuous pain, and provide information on the impact of tissue damage on the transmission of nociceptive information, via lasting changes not only at peripheral level but also within the central nervous system. Thus, the mechanisms involved in the chronicisation of postoperative pain are linked to two components. The first is the intensity of nociceptive inputs resulting from the incision (4). The second is specifically supported by the processes of peripheral and central pain sensitisation. Peripheral sensitisation, which occurs at the site of injury, corresponds in part to an increase in the activity of peripheral nerve fibres due to the release of numerous inflammatory mediators. This leads to an increase in the expression of pronociceptive receptors and ion channels, such as TRP and ASIC channels, reinforcing the transmission of nociceptive signals. Central sensitisation involves long-term changes in the central nervous system, particularly in the spinal cord. NMDA and AMPA receptors, as well as pro-inflammatory cytokines and chemokines released by activated glial cells, play a key role in the development and maintenance of neuronal excitability. The sensory and cognitive-emotional components of the pain transmission systems are then exacerbated, resulting in long-term hypersensitivity to pain and the appearance of anxiety-depressive disorders, which may aggravate the pain complaint. Interestingly, certain factors identified clinically as risk factors for PCOD are capable of modulating sensitisation processes (4-6). It also appears that dysfunction of the antinociceptive systems could also be an important factor in the maintenance of PCOD. Preclinical studies are therefore providing a pathophysiological basis not only for a better understanding of PCOD but also for the development of new therapeutic targets to improve its management.

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**Parallel sessions**

**SFETD-SFAR joint session**

**Clinical pictures of chronic postoperative pain**

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Chronic postoperative pain (CPOP) is defined as the persistence of pain for more than 3 hours after surgery, beyond the usual recovery period. The first step in treating POCD is to rule out late postoperative complications (infection, thromboembolism, fracture, loosening). PCOD can then take the form of different clinical pictures, often classified into three main types: neuropathic, nociceptive and nociplastic pain (1).

Types of pain

Neuropathic pain: This is caused by direct or indirect damage to peripheral nerve structures during surgery. Clinically, it is manifested by typical symptoms such as burning sensations, dysaesthesia, paraesthesia or electrical discharges in the operated area. Allodynia (pain induced by a normally painless stimulus) and hyperalgesia (increased sensitivity to pain) are frequent clinical signs. It can be detected by a DN4 postoperatively.

Nociceptive pain: This type of pain is related to tissue damage caused by the surgical procedure. It is typically localised in or near the area operated on.

Nondisciplinary pain, including complex regional pain syndrome (CRPS): Nondisciplinary pain is attributed to a disturbance in pain modulation, with or without clearly identifiable tissue or nerve damage. CRPS is a polymorphic joint and periarticular pain syndrome associated with various changes in sensitivity, vasomotor, sudoromotor, muscular and trophic changes (2). It is one of the most common examples in the post-operative setting, especially after limb surgery. CRPS can be diagnosed using the Budapest criteria (3). The syndrome has an unpredictable course and can become complicated if not managed early.

Impact of DCP

PCD has a considerable impact on patients' quality of life. In functional terms, it often leads to significant limitations in mobility and physical ability. Psychologically, it has a major impact: patients suffering from MCI are at increased risk of depression, anxiety and post-traumatic stress disorder. Impaired sleep and persistent pain create a vicious circle, aggravating physical and mental exhaustion. In addition, MCI is frequently associated with chronic consumption of analgesics, including opioids, exposing patients to adverse effects such as cognitive disorders , dependence and an increased risk of overdose. Finally, PCD has a significant impact on professional activities, with an increase in prolonged absence from work and the risk of social exclusion.

Knowing how to prevent it, detect it and treat it therefore seem to be major elements of care.

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**Parallel sessions**

**SFETD-SFAR joint session**

**Preventing and managing chronic postoperative pain**

G. Lebuffe 1

1 Chu De Lille - Lille (France)

Chronic postoperative pain occurs in approximately 10% of patients undergoing surgery (1). It is defined as pain after surgery that persists for more than 3 months in the absence of any evolutionary process. Chronicisation is characterised by fundamental changes in the neuronal phenotype and in the pain conduction and modulation pathways. The process is often initiated by acute postoperative pain that is difficult to control, favouring the peripheral and central sensitisation phenomena reflected in the neuropathic component of the pain.

The prevention of chronic postoperative pain is based on identifying patients at risk in order to adapt the management strategy. The main risk factors to look for are female gender, young age, the extent of surgical decay, the type of surgery, the presence of pre-operative pain, opioid use, psycho-social vulnerability, the neuropathic nature of post-operative pain and the persistence of an abnormally high pain trajectory after surgery. These criteria are now used in models for early detection of the onset of chronic postoperative pain (2).

Patients with a high-risk profile who experience abnormally intense and prolonged postoperative pain with a neuropathic component should be treated early, four to six weeks after surgery. This strategy currently forms part of the concept of intermediate structures or consultations, the aim of which would be to reassess the evolution of pain symptoms and their psychological impact with the therapies initiated in the immediate postoperative period, to rapidly propose different therapeutic approaches (TENS, Qutenza, analgesic blocks, etc.), raise awareness among attending physicians (Level 1 of the patient pathway) and, if necessary, anticipate referral to a chronic pain consultation (Level 2 of the patient pathway) or a CETD (Level 3 of the patient pathway) for patients in difficult situations requiring a multidisciplinary and multi-professional assessment.

Patients whose symptoms persist in spite of well-managed medical follow-up and early initiation of first-line anti-nociceptive and anti-hyperalgesic treatments should be referred to specialist facilities for chronic pain management.

Access to a Structure Labelled as Chronic Pain should be provided as soon as possible after the onset of the pain process, in order to offer multi-professional and multi-disciplinary care and the use of central and peripheral neuromodulation techniques. This early monitoring of patients developing chronic postoperative pain could also help to reduce the potentially harmful consequences of pain in professional, social and financial terms.

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**Parallel sessions**

**Links between the quality of pain management and the functioning of healthcare institutions**

**Emotional distance in our role as carers**

P. Brillon 1

1 Université Du Québec À Montréal - Montréal (Canada)

This conference will discuss the various conceptual models of the development of Vicarious Trauma and Compassion Fatigue in carers [1-2]. It will attempt to answer the following questions Why am I more at risk of suffering from one or other of these disorders at certain points in my career? Why do I seem to react differently to this profession and to patients than my colleagues? How can I better protect myself against compassion fatigue and vicarious trauma so that I can continue to enjoy my profession for a long time to come?

Consequently, this conference will present the explanatory models for these two syndromes, detailing in particular the models of emotional overload[1], the development of a traumatic fear structure[3], cognitive disruption[4-5], and finally the lack of self-care strategies among carers[6].

The notions of emotional distance, the differences between sympathetic and empathetic postures[1], and the role of body mimicry[7] and mirror neurons[8] will be discussed. The role of a fear structure in occupational distress on avoidance symptoms and post-traumatic reactivation will be described[3]. The weakening impact of professional moral wounds will also be presented[9]. Finally, the conference will conclude with a discussion of the role of self-care strategies and ways of integrating them into everyday life [1-10].

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**Parallel sessions**

**Links between the quality of pain management and the functioning of healthcare institutions**

**Experience of a team that has benefited from a Professional Practice Analysis.**

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1 Multidisciplinary Pain Consultation - Chateauroux (France)

The management of chronic pain patients is complex and requires healthcare teams to have a wide range of skills.

For this reason, the chronic pain structures (SDC), built around a core group of doctors, psychologists and nurses, are sometimes in need of support.

Their main mission is to take a holistic approach to the chronic pain patient, taking into account psychological, social and biological factors.

Despite the training required to work in a SDC, professionals can sometimes feel helpless and at a loss when faced with precarious social situations and find themselves at odds with the missions of the public hospital service in which they work.

To move forward on this subject, we will look at some of the factors that cause suffering in a multidisciplinary TCS team.

Then we'll look at the example and experience of our team, which has set up supervision as a means of analysing professional practice in an attempt to avoid this.

**Parallel sessions**

**Pain and the end of life**

**Is assessing pain at the end of life easy?**

S. Rochat 1

1 Sfetd - Metz (France)

Palliative care services provide care and support for a wide range of illnesses.

This multiplicity of illnesses can give rise to specific clinical situations that are complex to treat.

These situations, where patients are in the pre-terminal or terminal phase, are known to generate pain and create specific clinical situations.

Because of their impact and the way they evolve, illnesses pushed to their limits at the end of life weaken and alter patients' means of expressing their pain.

Neuropathic pain, mixed pain, intractable pain and acute pain may all be present in one and the same patient during their stay.

What's more, the same patient who is known to be communicative at the start of the stay may later become dyscommunicative or non-communicative in the middle of the stay.

In these situations, how can pain be properly assessed? Which scales should be chosen? Which pain should be assessed first? How can we ensure that the first and decisive stage of pain assessment is a success?

**Parallel sessions**

**Pain and the end of life**

**The burden on carers at the end of life**

C. Prunot 1

1 Clinical Psychologist - Beaune

Introduction: Family carers play a vital role in the palliative care of patients at home. However, psychological distress can sometimes emerge in the face of the difficulties encountered. Carers are recognised as being at risk of burnout. The aim of the pilot study is to gain a better understanding of the specific burden on carers.

in an end-of-life context, with regard to the risk of exhaustion.

Method: This qualitative study was based on semi-structured clinical interviews conducted with family carers during home support in a palliative setting. The verbatims were transcribed and analysed thematically.

Results: Two family carers described a burden marked by daily organisation, physical and mental fatigue, guilt and, above all, a major impact on their social life. Support at the end of life reveals a specific burden in the form of intensified daily organisation and intense emotional experience, particularly in terms of anger and aggression. In addition, both carers reported difficulty in coping with their partner's overall deterioration. These themes do not appear in the context of palliative care outside the end-of-life context. This underlines the need to pay particular attention to support for carers in order to prevent specific difficulties.

Conclusion: Identifying the burden of carers providing support at the end of life means that clinical guidelines can be put in place to care for this vulnerable population.

Bibliography

Key words: family carer, palliative care, home care, end of life, burden, vulnerability

**Parallel sessions**

**Pain and the end of life**

**Pain, suffering and autonomy at the end of life: from principles to ethics**

V. Lefebvre Des Noettes 1

1 Aphp - Limeil Brevannes (France)

Autonomy, the ability to make one's own laws (auto nomos), is the cult value of our agist and utilitarian society. It is also one of the pillars of medical ethics, along with beneficence, non-maleficence, justice and equity (Beauchamp and Chirldress 1979). It is established as a right legitimised by laws (Kouchner, protected adults, Léonetti 2005, Claeys-Leonetti 2016, etc.). It is in the name of this autonomy, associated with freedom and choice, that the national representatives are preparing to pass a law on aid in dying. But what is the situation in our care practices? Doesn't pain and suffering, whether psychological and/or somatic, at the end of life affect our autonomy? Is it possible not to depend on others, especially at the end of life? Doesn't broken autonomy (Pelluchon Corine 2014) become wounded and therefore resilient (Lefebvre des Noettes 2023)? We will question these principles in the light of our care practices.

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**Parallel sessions**

**Pain research in France: the year's discoveries**

**The year's discoveries**

R. Dallel 1

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DALLEL(1)

*Disruption of the subthalamic nucleus contributes to pain in Parkinson's disease*

Pain is a non-motor symptom that affects the quality of life of patients with Parkinson's disease, but the mechanisms underlying pain in this condition are still poorly understood. In these patients, pain could be linked to alterations in the processing of somatosensory information in the basal ganglia, in particular the subthalamic nucleus (STN). This study explored the role of the interaction between the STN and the dorsal horn of the spinal cord in the pathophysiology of pain in an animal model of Parkinson's disease. They demonstrated that the neurons of the NST are capable of detecting nociceptive messages, encoding their intensity and generating windup-type plasticity. These characteristics are completely lost after dopaminergic depletion. On the other hand, deep brain stimulation (DBS) of the NST, or its prolonged inhibition, reduces the pain induced by this depletion. This effect appears to be mediated by descending projections to the brainstem, thereby normalising the integration of pain messages in the dorsal horn. This study reveals for the first time the neural networks involved in DBS-induced analgesia and highlights the central role of the NST in nociceptive control.

This study was published in BRAIN: Charles et al. Brain. 2024

*Does the pain assessment method have an impact on postoperative pain?*

Studies have shown that negative words can influence the perception of pain. It is therefore relevant to question the systematic use of scales based on the term "pain", which has a negative connotation, to assess both painful and non-painful patients. The authors of this study hypothesised that the use of a comfort scale, as opposed to a numerical pain scale, could reduce postoperative opioid consumption. In this randomised trial, patients were divided into 2 groups: one group assessed using a comfort scale and the other using a numerical pain scale. The primary endpoint was opioid consumption in the recovery room. The results showed that opioid consumption was similar in both groups, irrespective of the type of surgery. The majority of patients did not use opioids after surgery. No significant differences were observed in terms of postoperative pain, nausea and vomiting, or overall patient satisfaction. This study suggests that the use of a comfort scale for pain assessment does not lead to a reduction in opioid consumption compared with standard assessment using a numerical pain scale.

This study was published in BRITISH JOURNAL OF ANAESTHESIA: Fusco et al. Br J Anaesth. 2024

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**Parallel sessions**

**Pain research in France: the year's discoveries**

**Chronic migraine: a communication anomaly in the brain**

L. Monconduit 1

1 Neuro-Dol Inserm U1107 - Clermont-Ferrand (France)

Migraine is much more than a simple headache. Its pathophysiology involves not only the trigeminal pain networks and their descending modulation pathways, but also the autonomic and emotional regulation systems. It is difficult to imagine how these different systems function without a central coordinator harmonising their communication. Of the brain regions likely to play this role, the locus coeruleus is of particular interest. This brain stem nucleus is the main source of noradrenaline in the brain and has the capacity to modulate, as well as being modulated by, regions involved in pain, regulation of the autonomic system and emotions. In a mouse model of migraine, we have shown that the locus coeruleus establishes direct and indirect connections with nociceptive pathways and maintains direct contacts with blood vessels joining the pie-mother. Functional studies using simultaneous extracellular recordings in vivo of the trigeminal-cervical complex - the first central relay for nociceptive information from the orofacial sphere - and the locus coeruleus reveal a high degree of synchronisation between their spontaneous activities, with a precession of the activity of the locus coeruleus, suggesting that the latter regulates the excitability of the TCC by activating noradrenergic receptors. After repeated trigeminal activation at the level of the dura mater, we observed a break in the coupling of activity between the locus coeruleus and the trigeminal-cervical complex.

These results highlight the crucial role of noradrenaline in the regulation and modulation of sensory information via direct and indirect pathways, which could explain the efficacy of beta-blockers as a background treatment for migraine. In addition, an alteration in noradrenaline levels could lead to an increase in cerebral excitability and a reduction in the migraine trigger threshold.

**Parallel sessions**

**Pain research in France: the year's discoveries**

**Remote control of pain in freely moving animals**

G. Sandoz 1

1 Cnrs - Nice (France)

Optogenetics and photopharmacology, techniques that use light to control the activity of neurons, are promising approaches for gaining a better understanding of pain transmission. However, their use remains limited due to their cost, the constraints associated with laboratory animals and ethical issues.

We present LAKI (Light Activated K+ channel Inhibitor), a revolutionary light-activated inhibitor that specifically targets potassium channels called TREK and TRESK, which are known to be involved in pain perception. In the absence of light or under ambient light, LAKI remains inactive. But by exposing the skin to flashes of ultraviolet (365 nm) and blue (480 nm) light, these channels can be blocked or unblocked instantly. This makes it possible to rapidly control pain in freely moving mice and worms (nematodes), without constraining them or modifying them genetically.

These results show that the TREK/TRESK channels are located at the nerve endings responsible for pain perception, and that blocking them is enough to trigger this sensation. What's more, LAKI makes it possible to control pain remotely, non-invasively and reversibly. This new tool is useful not only for pain research, but also for testing and validating new analgesic drugs in vivo, without the need for genetic manipulation or viral infections.

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**Parallel sessions**

**Pain research in France: the year's discoveries**

**Ketamine vs Morphine in pain management**

E. Montassier 1

1 Chu - Nantes

During the talk, we will present the results of our multicentre KETAMORPH study. Pain is a frequent symptom in pre-hospital patients, often treated with opioids such as morphine. However, the prescription of morphine, even for short periods, is a real public health problem. Intravenous ketamine represents an alternative for pain relief in pre-hospital trauma patients. We conducted the KETAMORPH study, which sought to compare the efficacy of ketamine with that of morphine in 251 adult patients treated by 10 emergency medical services in France. The results showed a similar reduction in pain in the two groups, with a mean difference of 0.1 points, indicating the non-inferiority of ketamine. However, side effects were more frequent with ketamine than with morphine, but none required any particular intervention. Ketamine could therefore be a viable alternative to morphine for the management of traumatic pain, particularly in the context of the opioid crisis. In this talk, we will also present other studies carried out in the same context of emergency medicine, showing that ketamine could be useful instead of morphine in patients treated by the SMUR or in emergency departments.

**Parallel sessions**

**Chronic pain structures**

**Contributions of the PIRAMIG activity report: DGOS, SFETD and SDC joint views**

A. Vitoux 1, C. Michel-Dhaine 2

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Since 2023, as part of the relabelling process, the DGOS has sought to standardise the methods used to collect activity data from Chronic Pain Structures (SDCs) and optimise them by integrating them into the "PIRAMIG" platform (management of activity reports for missions of general interest).

In conjunction with the ARS, the SFETD and teams in the field, a development process was steered by the DGOS. In 2023, this has enabled TCSs and their healthcare establishments to adopt the data entry tool in anticipation of the mandatory collection of activity data from 2024 onwards, in order to benefit from the appropriate funding.

The aim of this 2-part presentation by the DGOS and the SFETD is to enlighten participants on the objectives, contributions and limitations of PIRAMIG. The SFETD will also present its survey of TCS feedback after one year of use. The prospects for improvement and adjustment with a view to the next certification process will be discussed. Finally, there will be an opportunity for questions and answers on this subject.

**Parallel sessions**

**Musculoskeletal pain in the elderly: a fatality doomed to therapeutic failure?**

**Musculoskeletal pain in the elderly: diagnostic assessment strategies**

P. Bertin 1

1 Chu Limoges - Limoges (France)

Musculoskeletal pain in the elderly: diagnostic assessment strategies

Philippe BERTIN, MD, PhD, Rheumatology Department and Pain Centre CHU LIMOGES

As well as neuropathic pain (post-shingles, diabetes, post-stroke, iatrogenic, etc.), musculoskeletal pain is very common in the elderly and is often regarded as inevitable.

Of course, the main causes of musculoskeletal pain in the elderly are related to degenerative pathologies such as osteoarthritis of the limbs or spine, but other pathologies requiring specific treatment must be ruled out by a careful clinical examination and a number of additional tests, depending on the patient's overall state of health.

Osteoarthritis is very common, often painful and disabling, and should not be neglected. In fact, it exposes the patient to co-morbidities, particularly cardiovascular co-morbidities, which need to be taken into account in the overall management of the elderly patient. In addition to painkillers, certain therapeutic strategies specific to osteoarthritis can be proposed to reduce pain and improve function.

The frequency of degenerative joint or musculotendinous pathologies should not lead to a failure to look for other common pathologies in the elderly requiring specific potentially curative treatments.

During this session, we will look together at how to identify (and treat) the main pathologies listed below.

PPR or pseudo-rheumatoid arthritis and Horton's disease.

RS3PE (symmetrical seronegative relapsing-remitting synovitis with oedema).

Late-onset spondyloarthritis.

Microcrystalline pathologies.

Infectious arthritis and spondylodiscitis.

Rarefying osteopathies.

Tumour pathologies and paraneoplastic syndromes.

**Parallel sessions**

**Musculoskeletal pain in the elderly: a fatality doomed to therapeutic failure?**

**Update on drug treatments**

G. Pickering 1, F. Capriz 2

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Whether at home or in an institution, osteoarticular pain is a very common complaint among the elderly, impacting on their quality of life and independence, yet it is all too often trivialised in old age. Pain of osteoarticular origin accounts for more than 50% of pain in the elderly and is one of the most frequent reasons for consulting a general practitioner. But it can sometimes take a back seat in terms of symptoms, masked by more 'noisy' clinical signs (asthenia, depression, confusion, etc.).

Analgesic management will be described in detail. Old age is not in itself a contraindication to prescribing medication, although it does require greater vigilance. The iatrogenic risk is higher because of multiple comorbidities and secondary polymedication, but also because self-medication is more difficult to detect. Handicaps (memory problems, swallowing problems, etc.) need to be identified, and galenic formulations need to be taken into account to ensure compliance with prescriptions for optimum compliance. The co-prescription of a nurse to manage medication at home can reinforce compliance.

For osteoarthritis, short courses of oral NSAIDs, topical NSAIDs (for small and medium-sized joints) and paracetamol should be used as first-line treatments. Local treatments (infiltrative procedures) may be preferred in the event of a painful flare-up. For higher-risk drugs (corticosteroids, etc.), treatment should be given at the minimum effective dose. In addition, some osteoarticular pain is neuropathic in nature and will respond to specific treatments initiated at a lower dose than in younger patients.

Surgical management of elderly patients with osteoarthritis must always be discussed and the benefit/risk balance assessed, with better-known risk factors for perioperative morbidity and mortality, such as the duration of the operation, neurocognitive disorders and organ failure.

Non-drug analgesic techniques complement the analgesic effect of drugs, and should be offered according to the patient's abilities.

Understanding the fears and expectations of elderly patients will enable us to establish therapeutic priorities that are adapted to their objectives; they must remain a genuine partner in care.

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**Parallel sessions**

**Musculoskeletal pain in the elderly: a fatality doomed to therapeutic failure?**

**Education and rehabilitation: the keys to success**

E. Masquelier 1

1 Professor Emeritus Uclouvain - Yvoir

Chronic pain is very prevalent in the elderly and is accompanied by significant co-morbidities.

These include loss of mobility and physical deconditioning, social isolation, depressed mood and excessive drug use.

From the age of 60 onwards, there is a loss of muscle strength of 3.5 per cent each year, with an associated process of sarcopenia.

The interdisciplinary bio-psycho-social approach to rehabilitation is proving effective in managing chronic pain and improving functionality and quality of life. Health education and regular supervision by therapists are essential ingredients for therapeutic success.

**Parallel sessions**

**Pain and disability**

**Neuro orthopaedics: how can surgery help?**

F. Calé 1

1 Raymond Poincaré Hospital - Garches

Caring for disabled patients in neuro-orthopaedics has enabled us to develop a comprehensive approach to the delicate management of these patients. This pragmatic approach, based on a period of analysis and the establishment of care contracts and precise objectives, has much more general applications.

Faced with complex, multi-factorial situations, comfort and pain reduction are essential objectives.

Two pitfalls must guide our decisions:

-avoid giving up when faced with accessible solutions

avoid over-zealousness in the face of limited and irreversible situations

**Parallel sessions**

**Pain and digital**

**Digital health in assessment, diagnosis, research and pain management**

Y. Hadjiat 1

1 Inserm U987 - Paris (France)

Pain management is essential for social, psychological, physical and economic reasons. It is also a human right, with a growing incidence of untreated or undertreated pain worldwide. Barriers to the diagnosis, assessment, treatment and management of pain are complex, subjective and determined by patient, healthcare provider, payer, policy and regulatory challenges. In addition, conventional treatment methods pose their own challenges, including subjectivity of assessment, lack of therapeutic innovation over the past decade, opioid use disorders and financial access to treatment. Digital health innovations hold great promise as they provide complementary solutions to traditional medical interventions and can reduce costs and speed recovery or adaptation. There is a growing body of evidence on the use of digital health in the assessment, diagnosis and management of pain. The challenge is not just to develop new technologies and solutions, but to do so within a framework that supports health equity, scalability, socio-cultural consideration and evidence-based science. The significant limitations of personal physical interactions during the Covid-19 2020/21 pandemic demonstrated the potential role of digital health in pain medicine. This article provides an overview of the use of digital health in pain management and argues for the use of a systems framework to evaluate the effectiveness of digital health solutions.

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**Parallel sessions**

**Pain and digital**

**ChatGPT: a new tool to be integrated into care**

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ChatGPT, a natural language processing model developed by OpenAI, is emerging as a promising new tool in the healthcare sector. It has the potential to lighten the workload of healthcare professionals, particularly when monitoring patients suffering from chronic pain. Thanks to its ability to generate fast, accurate responses, it saves time on certain administrative and repetitive tasks, while promoting fluid communication between carers and patients.

ChatGPT can be used to provide educational information on pain management, explain different treatment options or answer patients' frequently asked questions. For example, for someone suffering from lower back pain, this tool can quickly suggest suitable stretching exercises or advice on improving posture. It can also be used to support remote monitoring, helping professionals to monitor the evolution of symptoms using automated questionnaires and personalised recommendations.

Finally, ChatGPT could facilitate the coordination of care by simplifying the drafting of reports and the summarisation of medical records, enabling professionals to concentrate more on providing human support to patients. In short, integrating this tool into care could not only increase the efficiency of healthcare teams, but also improve patient care by offering them rapid access to relevant, personalised information.

**Parallel sessions**

**Pain and digital**

**Evaluation of the impact of a smartphone application on adherence to an exercise programme in chronic low back pain patients: a randomised controlled trial**

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Introduction : In view of the observed decline in the positive effects of rehabilitation programmes over time [1] , we sought to evaluate the impact of a smartphone-based self-management application on exercise adherence for people with chronic low back pain (LBP).

Methods: 110 adult patients with non-specific LC were recruited and randomised into two groups: an experimental group (EG) where patients received education in the use of the self-management smartphone application in addition to a conventional multidisciplinary rehabilitation programme and a control group (CG) (conventional multidisciplinary programme only). The Exercise Adherence Rating Scale (EARS) was used as the primary endpoint at 6 months to assess exercise adherence [2]. The secondary endpoints measured were function (Oswestry Disability Index) [3], beliefs about physical activity (Evaluation of Physical Activity Perception EPAP) [4], pain (numerical rating scale), physical capacity and qualitative adherence using a grid measuring the reproducibility of the exercises proposed.

A linear mixed model was used to compare the primary endpoint between groups 6 months after randomisation.

Results: Of the 110 patients included, 71 completed the study. There was no significant difference between the two groups in terms of adherence score. However, a significant decrease in the pain score was observed in the GE at 6 months, whereas the pain score in the GC remained stable. We also observed a difference between the two groups with regard to physical tests (Ito, Sorensen, etc.) and the qualitative adherence score in favour of the GE.

Discussion: The rehabilitation programme was beneficial for both groups. Although we did not observe improved adherence by the GE at 6 months, long-term use of the application may have a positive impact on pain, physical capacity and the correct performance of physical exercises (qualitative compliance).

Key words: low back pain, adherence, physical activity

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**Parallel sessions**

**Translational research**

**Identification of bacterial lipopeptides as key players in irritable bowel syndrome**

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Objectives: Clinical studies have revealed that adverse events early in life contribute to the development of irritable bowel syndrome (IBS) in adulthood. The aim of our study was to investigate the relationship between prenatal stress (PS), gut microbiota and visceral hypersensitivity, with a focus on GABA-containing bacterial lipopeptides.

Methods: We developed a mouse model of MS and assessed visceral hypersensitivity to colorectal distension, colonic inflammation, barrier function and taxonomy of the gut microbiota in adult offspring. We quantified the production of GABA-containing lipopeptides by mass spectrometry in a specific strain of SP-diminished bacteria, in the colon of SP mice and in the faeces of IBS patients and healthy volunteers. Finally, we assessed their effect on the visceral hypersensitivity induced by MS.

Results: Prenatally stressed mice of both sexes showed visceral hypersensitivity, no overt inflammation of the colon and no barrier dysfunction, but dysbiosis of the intestinal microbiota. The dysbiosis was characterised by a reduction in the abundance of Ligilactobacillus murinus in both sexes. The abundance of this bacterium was inversely correlated with visceral hypersensitivity to colorectal distension in mice. In anaerobic culture, this bacterium produced several GABA-containing lipopeptides, including C14AsnGABA. In the colon of SP mice, the concentration of GABA-containing lipopeptide was reduced. Intracolic treatment with C14AsnGABA inhibited visceral hypersensitivity to colorectal distension in SP mice. The concentration of C16LeuGABA, a GABA-containing lipopeptide that inhibits the activation of sensory neurons, was decreased in the faeces of IBS patients compared with healthy volunteers.

Conclusion : Prenatal stress has an impact on the composition of the intestinal microbiota and its metabolic function in adulthood. The reduced capacity of the intestinal microbiota to produce GABA lipopeptides could be one of the mechanisms linking prenatal stress and visceral hypersensitivity in adulthood.

**Parallel sessions**

**Translational research**

**Inhibitory interneurons with differential plasticity at their connections regulate the excitation/inhibition balance in spinal networks**

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The dorsal horn of the spinal cord is a fundamental centre for processing nociceptive information before it is transferred to supraspinal centres. In the spinal networks, control of the gain of nociceptive information involves balances between excitatory and inhibitory activities. Primary afferent fibres carry nociceptive information into the spinal networks in the form of trains of action potentials, the frequency of which encodes the intensity of the nociceptive stimuli. The processing of such frequency-encoded information involves a specific phenomenon: short-term synaptic plasticity. Using ex vivo electrophysiological recordings on acute slices of adult mice, we explore the role of short-term synaptic plasticity at the connections of inhibitory interneurons. Our results indicate that inhibitory interneurons exhibit different frequency-dependent plasticity depending on whether their connections contact excitatory interneurons (inhibitory connections) or other inhibitory interneurons (disinhibitory connections). Furthermore, recent results indicate that this differential plasticity is altered under conditions of peripheral inflammation, and differs between males and females and according to the phases of the estrous cycle. These differential plasticities could represent a control of the gain of nociceptive information by the spinal networks, and changes in these plasticities according to physiological state or sex could contribute to the differences in sensitivity observed in these different states.

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Cathenaut L, Leonardon B, Kuster R, Inquimbert P, Schlichter R & Hugel S. Inhibitory interneurons with differential plasticities at their connections tune excitatory/inhibitory balance in the spinal nociceptive system. Pain (2022). 163(5):e675-e688.

**Parallel sessions**

**Translational research**

**Differences in cytokine levels between patients with episodic and chronic migraine: a systematic review of the literature and meta-analysis**

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Introduction. The pathophysiology of migraine remains uncertain; however, numerous studies support the hypothesis that neuroinflammation plays a key role (1). Several studies have analysed peripheral blood cytokine levels in migraine patients; however, these are heterogeneous and provide conflicting results (2,3). We therefore wish to clarify what is currently known about the role of cytokines in migraine and its chronicisation.

Methods. We conducted a systematic review of the PubMed literature using the search algorithm: ("Migraine Disorders") AND (("Chemokines") OR ("Cytokines") OR ("Interleukins")) and screened references for additional publications. We excluded from our analysis animal studies, studies involving fewer than 10 migraine sufferers, reviews, letters and case reports, and publications not written in French or English.

Results. We identified 234 publications, to which 15 more were added after reviewing the references and 51 were selected. Tumor Necrosis Factor-alpha (TNF-a), interleukin-6 (IL-6) and interleukin-1 beta (IL-1b) were the 3 most studied cytokines. In peripheral blood, IL-6 levels were generally higher in migraine patients than in controls. There was no difference in cytokine levels in migraine patients with aura vs. without aura, or in migraine patients in attack vs. not in attack. However, IL-6 levels were higher in patients with chronic versus episodic migraine. The final conclusions of this work will be drawn once other types of biological samples have been analysed and a meta-analysis has been carried out.

Conclusion. Our review of the literature suggests that IL-6 may be involved in the chronicisation of migraine rather than its onset.

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**Parallel sessions**

**Translational research**

**Establishment of proof of concept in favour of the GPER receptor as a new therapeutic target in the management of iatrogenic pain associated with breast cancer**

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Triple-negative breast cancer (TNBC) is an aggressive form of breast cancer that particularly affects pre-menopausal women, with a high risk of metastasis, particularly to bone. Treatment options are limited, necessitating the use of heavy chemotherapy such as paclitaxel, which induces chemotherapy-induced peripheral neuropathic pain in 80% of patients. When such pain appears, the dose of chemotherapy is often reduced or the treatment stopped, representing a real loss of opportunity for the patient.

Recently, studies concerning the GPER (G protein-coupled estrogen receptor) have highlighted an important role in the processes of pain and tumour growth [1-5]. The aim of this study was to explore the anti-tumour and analgesic action of MJ01032, a GPER inverse agonist.

In a mouse model of paclitaxel-induced neuropathic pain, MJ01032 showed GPER-dependent analgesic effects. In murine CSTN cells (4T1-luc2), MJ01032 demonstrated an antiproliferative action. Isobologram analysis of the combination of MJ01032 and paclitaxel showed a synergistic antiproliferative action between these two compounds. In vivo, in a TNBC model induced by orthotopic inoculation of 4T1-Luc2 cells into the mammary fat of Balb/c mice, MJ01032 reduced tumour size and attenuated the pain associated with chronic paclitaxel treatment.

This study suggests that the use of MJ01032, in addition to paclitaxel, could increase its antitumour effect while reducing the associated neuropathic pain, thereby improving the therapeutic results and quality of life of patients with TNBC.

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**Parallel sessions**

**Translational research**

**Prevention of residual neuropathic pain by periradicular application of platelet- and fibrin-enriched plasma (PRF) during disc herniation surgery (NeuroPRF clinical protocol)**

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The prevalence of post-surgical lumbar neuropathic radiculopathy is approximately 30%. Poor response to the recommended treatments for neuropathic pain, namely antidepressants and/or gabapentinoids, requires the development of new techniques to prevent chronic pain. One such well-tolerated technique is the administration of autologous plasma enriched in platelets and fibrin (PRF). This approach is largely used in regenerative medicine owing to the anti-inflammatory and analgesic properties of PRF. It could also be an interesting adjuvant to surgery, as it reduces neurogenic inflammation and promotes nerve recovery, thereby reducing the incidence of residual postoperative chronic pain. The aim of the present study is to evaluate the benefit of periradicular intraoperative application of PRF on the residual postsurgical neuropathic pain after disc herniation surgery.

A randomized, prospective, interventional, controlled, single-blind study with evaluation by a blind outcome assessor will be performed in Strasbourg University Hospital. We will compare a control group undergoing conventional surgery to an experimental group undergoing surgery and periradicular administration of PRF (30 patients in each arm). The primary outcome is the intensity of postoperative neuropathic radicular pain, measured by a visual analog scale (VAS) at 6 months post-surgery. The secondary outcomes are the characteristics of neuropathic pain (NPSI), the quality of life (SF-12 and PGIC), the presence of anxiety/depression symptoms (HAD), and the consumption of analgesics. We will also carry out transcriptomic analysis of a panel of pro- and anti-inflammatory cytokines in blood samples, before surgery and at 6 months follow-up. These gene expression results will be correlated with clinical data, in particular, with the apparition of postoperative neuropathic pain.

This study is the first randomized controlled trial to assess the efficacy of PRF in the prevention of neuropathic pain following surgery for herniated disc. This study addresses not only a clinical question but will also provide information on the physiopathological mechanisms of neuropathic pain.

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**Parallel sessions**

**Pain and violence, the violence of pain: how to spot it and react for the good of patients and healthcare teams?**

**When violence becomes pain: Clinical vignettes-Adolescent/young adult and Child**

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The management of chronic pain in children and adolescents, whether in a consultation in a Chronic Pain unit or hospitalisation for chronic pain in an SMR, may be accompanied by the revelation of violence suffered. This is one of the paths taken by our chronic pain patients: from "physical" pain to the expression of "psychological" suffering. In the authors' experience and in the context of their practice of chronic pain medicine, disclosures of violence have become more frequent since the victims' voices have been freed up (impact of the media, social networks and the many books and films on the subject) and since the "covid years".

How can we best support these revelations, without adding violence to violence through our questions? What should we do? How can we listen to what the child or adolescent has to say? In this day and age, are these words "easier" to say because we are more willing to hear them?

How can we resist the patient's initial request to maintain confidentiality and not be tempted by the argument of "maintaining the therapeutic alliance"? How do you remind them of the law, which applies to everyone, patients and carers alike?

Through two clinical vignettes dealing with chronic pain combined with disclosures of violence suffered during childhood, the first by a minor patient in consultation, the second by a patient who had just reached adulthood in a pain hospital in SMR, the authors will detail their path and their thoughts leading to the drafting of worrying information and the impact on pain symptoms.

**Parallel sessions**

**Pain and violence, the violence of pain: how to spot it and react for the good of patients and healthcare teams?**

**Dealing with violence: Risks and measures to preserve the humanity of carers**

C. Goldner 1

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When the physical, psychological and relational pain of patients and their families causes violence. How are these situations experienced by carers? What impact do they have on team dynamics? On other patients? What measures can be put in place to deal with these situations? What resources can be mobilised? How can the day-to-day experience of carers be transformed so that they can continue to practise their profession while preserving their humanity? How can monthly supervision by a psychologist from outside the team be beneficial?

The prevalence of domestic violence, particularly among people receiving pain management consultations, has risen sharply in recent years. To date, no study has provided precise data on this subject. However, feedback from carers at a paediatric pain centre points to a significant change in their clinical practice, often accompanied by distress. Vicarious trauma prowls around like an octopus, requiring great agility, both individually and collectively, to escape its tentacles.

In this complex context, the professionals took the initiative of setting up a team supervision system. This intervention, which began two years ago, provides a safe space for the multidisciplinary team to talk, reflect and receive support.

We will present how these situations of violence are experienced by carers, the consequences of vicarious trauma, and possible intervention strategies. We will also highlight the importance of a reflective approach in preserving the well-being of teams while improving patient care.

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**Parallel sessions**

**Overview of pain management worldwide and in France / humanitarian actions**

**Cancer pain management in Africa: an overview and research into limiting factors**

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The prevalence of pain is particularly high in cancer patients, with 2 out of 3 patients suffering from moderate to severe pain in the advanced stages of their disease. What's more, according to the WHO, 83% of the world's population (5.5 billion people) has inadequate access to treatment for moderate to severe pain and little or no access to controlled medicines. While North America, Oceania and Western and Central Europe account for 95.7% of opioid analgesic consumption (with the inherent problems of abuse and diversion), 75% of the world's population, mainly in low-income countries, has limited or no access to pain relief, and this situation is particularly critical in Africa. This glaring disparity makes pain relief and access to care a real ethical issue. A number of potential factors have been identified that could slow down the use of analgesics for cancer pain, such as: overly restrictive legislation, lack of training for healthcare professionals, fear of dependence or diversion, inadequate distribution networks, and cultural and religious attitudes. However, there is currently no data available to assess the respective weight of each of these factors in a given country or geographical area. This is important information, which will enable us to target the priority measures that need to be put in place to improve the treatment of cancer pain, particularly with opioids, and this will be the focus of this communication, which will provide new, accurate data.

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**Parallel sessions**

**Overview of pain management worldwide and in France / humanitarian actions**

**Humanitarian action (DSF)**

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Douleurs Sans Frontières (DSF) is a French international solidarity NGO founded in 1996 and recognised as being of public utility since 2003. Its main mission is to promote and develop actions aimed at the prevention, diagnosis, treatment and management of pain, suffering and end-of-life symptoms in vulnerable populations.

Medical action

DSF favours a long-term approach, focusing on capacity building and support for institutional and civil society healthcare players. The organisation develops patient-centred healthcare strategies, improving access, management and quality of care. DSF focuses on various forms of pain, including chronic pain and psychological and emotional suffering.

Programmes by country

France

DSF runs awareness-raising projects on chronic pain using forum theatre.

Armenia

DSF has been training child and adolescent professionals in the medical, psychological and social care of children with developmental disorders since 2001. It organises home visits for families of children with severe developmental disorders.

Cambodia

DSF has been providing palliative care at home for patients with cancer and other chronic illnesses since 1996.

Haiti

Active since 2010, DSF helped set up the Pain Unit at the Haitian State University Hospital in 2011. The organisation also carries out training, awareness-raising and study activities with institutional players and associations.

Madagascar

Established in 2009, DSF is recognised for its expertise in the management of physical and psychological pain. The organisation maintains a relationship of trust with hospital and institutional stakeholders.

Mozambique

Established in 1996, DSF has developed programmes to improve the management of pain and symptoms at the end of life.

Approach and strategy

DSF emphasises a multidisciplinary approach and builds partnerships with local players to ensure the sustainability of the actions undertaken. The organisation is striving to strengthen coordination and consultation between the players involved, taking the view that pain management cannot be effective and sustainable without a collective dynamic.

DSF's strategic framework incorporates advocacy as a cross-cutting strategy within four main areas: preserving human dignity, strengthening community resilience, ensuring the transfer of health skills and promoting an improved care pathway.

In conclusion, DSF is continuing its efforts to relieve the pain of the world's most vulnerable populations.

**Parallel sessions**

**Pain management around the world and in France / humanitarian actions**

**The place of cancer pain in chronic pain structures**

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The management of cancer pain is a public health issue, as the life expectancy of cancer patients continues to rise and the incidence of the disease increases. These needs are currently only partially covered. Based on the results of the national survey carried out at the instigation of the SFETD's cancer pain commission, we are attempting to assess the current role of pain facilities in this area of care, and to suggest avenues for future reflection.

**Parallel sessions**

**Teaching pain: where do we stand?**

**FST pain survey: our students respond**

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Pain medicine is taught in the second cycle, but currently only for a limited number of hours. Since the start of the 2019 academic year, the third cycle of medical studies has allowed interns to choose to do Transversal Specialised Training in Pain Medicine. The FSTs created as part of the reform of the 3rd cycle have replaced certain former Diplôme d'Etudes Spécialisées Complémentaires (DESC). This one-year course enables residents to acquire knowledge and skills in pain medicine. The Collège des Enseignants de Médecine de la douleur (College of Pain Medicine Teachers) has organised the theoretical teaching at national level. Practical training takes place over 2 semesters in departments that treat patients with pain.

With 5 graduating classes of students having enrolled in the FST, this session will provide an opportunity to take stock of the first few years in which this course has been introduced.

**Parallel sessions**

**Teaching pain: where do we stand?**

**Implementation of virtual reality in pain teaching**

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This presentation explores pedagogical innovation and the role of virtual reality (VR) in health teaching, with particular reference to pain. In the context of medical education reforms, where the increase in student numbers contrasts with stability in the number of professionals, medical pedagogy is evolving, with an emphasis on skills development, OSCEs (Objective Structured Clinical Examinations), and the assessment of know-how through simulation. Active learning, proven to increase student performance, is at the heart of this approach.

Initially focused on procedural learning, healthcare simulation has now expanded to include interpersonal and interpersonal skills. Simulation techniques, such as high-fidelity mannequins, role-playing and now virtual reality, help to improve the training and skills of students while ensuring patient safety.

Virtual reality is distinguished by its 360-degree immersive capability, allowing learners to move around and interact with complex environments using headsets, haptic gloves and controllers. VR encompasses several types, including augmented reality and mixed reality, and offers a realistic experience that generates emotions and sensations close to real clinical situations.

The benefits of VR are many: it allows you to create a wide variety of professional environments, to repeat actions at your own pace, and to practise safely without external judgement. What's more, it's ideal for complex, dangerous or rare situations, and encourages remote collaboration, eliminating geographical boundaries to share best practice.

Finally, this presentation will discuss the scientific evidence demonstrating the effectiveness of VR in medical education compared to other simulation methods and will detail practical strategies for integrating VR into medical schools to enhance teaching and training. It will draw on specific examples from the teaching of pain management.

**Parallel sessions**

**Teaching pain: where do we stand?**

**Pain role-play simulation**

F. Laroche 1

1 Aphp - Paris (France)

Objective Structured Clinical Education (OSCE) was proposed in 1975 as a method of objective and standardised assessment of student performance in simulated environments using standardised grids by trained examiners (Harden et al 1975, Khan et al AMEE Guide no. 81. Part I, 2013).

They have been used during medical studies since the recent reform of the 2nd cycle. They enable a combined assessment of knowledge, skills and attitudes. The aim is to assess a student's competence by judging his or her performance in a planned and structured way, using clinical situations. The OSCE enables students to be confronted with future practical clinical situations, to supplement written assessments and to identify students in difficulty.

We will describe them and see how they are conceived, used and have become an important part of the grading of students at the end of the 6th year of medicine.

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**Parallel sessions**

**Pain and rare diseases**

**Pain and Charcot-Marie-Tooth disease**

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Charcot-Marie-Tooth disease (CMT) is one of the most common hereditary neuropathies, with a worldwide prevalence of around 1 in 2,500. It is characterised by axonal degeneration due to genetic mutations, affecting both the motor and sensory nerves. The different types of CMT are classified according to three criteria: the part of the nerve affected (myelin or axon), the mode of genetic transmission and the genetic anomaly involved. The most common is CMT1A.

Patients generally present with progressive muscle atrophy associated with weakness and loss of sensation in the extremities. Among the symptoms reported, pain is common, with a high prevalence of neuropathic pain, as well as musculoskeletal and mechanical pain.

Neuropathic pain in CMT: Neuropathic pain, resulting from nerve damage, is a major symptom in CMT. It often manifests as burning sensations, electric shocks and paresthesias. It is often localised in the lower limbs, particularly the feet and legs, but also the hands. This pain is common in CMT type 1A, linked to damage to Aδ nerve fibres. Patients also report allodynia and hyperalgesia.

Musculoskeletal and mechanical pain: In addition to neuropathic pain, CMT patients often suffer from musculoskeletal pain, due to muscle atrophy and joint deformities such as sunken feet. This pain is often caused by mechanical overload or poor posture, and manifests as cramps, muscle pain and joint pain. Foot deformities can lead to chronic pain due to poor distribution of body weight.

Pain management in CMT: The treatment of pain in CMT is complex and multidimensional. Neuropathic pain is managed by general and local treatments in accordance with recommendations.

Surgical treatment may be proposed for musculoskeletal pain, particularly for joint deformities.

Rehabilitation and physiotherapy are essential in patient care

Conclusion: Pain management in CMT must take account of neuropathic, musculoskeletal and mechanical pain. A multidisciplinary approach is needed to offer patients effective relief and improve their quality of life.

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**Parallel sessions**

**Pain and rare diseases**

**Erythermalgia**

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Erythromelalgia (EM) is a rare paroxysmal acrosyndrome (incidence of less than 2/100,000 per year), involving painful attacks of the extremities with redness and increased local heat. Clinically, there are three main types of ME:

Primary ME attacks beginning in childhood, possibly associated with a mutation in the SCN9A gene coding for the sodium channel nav 1.7 . These attacks are characterised by being aggravated by exertion or heat, and relieved by cold and elevation of the limbs.

Primary ME beginning after the age of 20, considered to be idiopathic, associated with microcirculatory dysfunction and/or neuropathic damage to small-calibre sensory fibres.

Secondary ME associated with myeloproliferative syndromes (essential thrombocythemia, polycythemia, etc.), medication or other pathologies for which treatment may or may not relieve the ME.

Management of ME includes correcting triggering factors, limiting iatrogenic factors, trying local treatments, aspirin, conventional neuropathic pain treatments, and even trying sodium channel blockers such as mexiletine and funapide.

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**Parallel sessions**

**Pain and rare diseases**

**Unmet needs of patients with hypertrophic syndromes: COSY-SHS study**

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Context :

Hypertrophic syndromes, grouped together under the term PROS (PIK3CA-Related Overgrowth Syndromes), are characterised by abnormal cell and tissue growth in certain parts of the body. Little known until their etiological identification in 2012, these rare genetic syndromes cause numerous symptoms, often painful and disabling [1]. Patients suffer in particular from chronic pain linked to lymphatic malformations and thrombosis, as well as post-operative pain. Pain-relieving and anti-inflammatory treatments, such as Lovenox, codeine and Tramadol for the most severe cases, can be offered. However, there is still a lack of knowledge about how to optimise their management. Recent therapeutic advances, notably through compassionate treatments and clinical trials, offer hope of improving patients' quality of life.

Objectives:

To identify the unmet needs of patients with PROS syndromes in terms of social inclusion, access to care and carrying out daily activities. A secondary objective is to identify the determinants of these needs, the day-to-day difficulties faced by patients and their expectations, particularly with regard to pain management and possible therapeutic solutions.

Materials and methods :

The study was carried out by a multidisciplinary team (health professionals, researchers in the humanities and social sciences) and patient associations. Focus groups were held with patients of all ages (6-10 years; 11-17 years; adults), family carers and medico-social professionals. We have chosen for this paper to focus strictly on the focus group conducted with adults suffering from CLOVES syndrome, carried out in May 2024 by videoconference.

Preliminary results:

According to the 8 adults who took part in the focus group, pain proved to be a central element in the trajectory of the disease. The participants emphasised that the therapeutic trials had made them aware of the years of pain that preceded taking the treatment. Some patients have been able to reduce their use of powerful painkillers in favour of lighter treatments such as paracetamol. For those who do not benefit from treatment, pain is perceived as an indicator of bodily limits. Whether it increases or decreases, pain is a permanent disruption affecting both family and professional life.

Conclusion:

This study sheds light on how pain is experienced by patients with PROS syndromes and the means used to relieve it. A better understanding of this dimension is crucial to improving their care and quality of life.

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**Parallel sessions**

**Young talent - Hopes in research**

**Modelling temporal summation and conditioned pain modulation in people with and without chronic pain: a new step towards better pain management**

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Introduction: Temporal summation (ST) and conditioned pain modulation (CPM) are mechanisms that respectively tend to accentuate [1,2] or inhibit [1,3] the perception of pain in humans. Together, they form a pain modulation profile, specific to each individual [4], which appears to be deficient in populations with persistent pain [5]. Identifying this profile could provide valuable information on how to treat these patients more effectively [6,7]. However, measuring these mechanisms remains time-consuming and expensive. The aim of this study was to develop and validate a model for estimating ST and CPM using readily available clinical measures.

Method: A cohort of pain-free volunteers (n=347) and a cohort of chronic pain patients (n=108) were subjected to dynamic quantitative sensory testing to assess temporal summation and CPM. ST was induced by a continuous (2 min.) warm pain of moderate intensity. CPM was estimated using the pressure pain threshold (CPM-PPT) and continuous warm tonic stimulation (CPM-HPS) as test stimuli, and a cold water bath as a conditioning stimulus. Independent variables included demographic (age, sex), psychological (pain catastrophisation, anxiety and depression) and physiological (blood pressure, weight, height, body mass index and serum levels of catecholamines, endocannabinoids and sex hormones) measures. A LASSO-type penalty regression method with cross-validation was used to identify the independent variables to be included in the model, and to quantify and explain the proportion of variance in ST and CPM.

Results: The prediction models performed better for the patient cohort than for the pain-free volunteer cohort. For ST, a model including diastolic blood pressure and serum serotonin and epinephrine concentrations as the main factors explained around 40% of the variance. For CPM, the CPM-HPS model was the most effective and included diastolic pressure, pain catastrophisation and sex as the main variables, explaining around 35% of the variance. The CPM-PPT model did not perform sufficiently well.

Conclusion: This study demonstrates that ST and CPM can be estimated - for populations suffering from pain - using simple measures that are readily available in a clinical context. However, the prediction error of these models remains high, which limits their clinical use for the time being.

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**Parallel sessions**

**Young talent - Hopes in research**

**Impact of adversity on the aetiology and management of chronic pain by hypnosis in patients treated in pain facilities**

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Although the links between adverse childhood experiences and anxiety and chronic pain in adulthood are already of clinical concern and appear regularly in the literature, a recent review reminds us that although a person who has had such experiences has twice the risk of developing chronic pain in adulthood, these links remain unclear (1).

Chronic pain affects a third of French people every day. Of these patients, 2 out of 3 are not relieved by their treatments, and 1 out of 2 will experience a significantly altered quality of life (2).

In the light of these findings, our study aims to

-(Prevention) to gain a better understanding of the life trajectory of CETD patients, by studying the data collected using a set of scales and questionnaires to examine their life history and antecedents, their experience of pain, their psychological state and their cognitive performance.

-(Therapeutic) to offer each patient 2 approaches, one focusing on pain, the other on adversity, in order to compare their respective effectiveness (on pain experience and quality of life) and their complementarity according to the proposed order. The two proposals follow a similar organisation and sequence.

Each treatment proposal includes hypnosis as a therapeutic tool because its application already exists both in the field of pain (and CD) and in the management of trauma, enabling us to make informed use of it. What's more, it has already been studied through the prism of both clinical psychology and neuroscience. It will therefore be interesting in the long term to study whether we find the effects and limitations mentioned in the literature, and whether our proposal will lead to new avenues for maximising its use.

In this presentation, we will briefly outline our progress since the preliminary study and the collaborative work that led to the construction of our protocol. We will then present the results already obtained and the state of progress of this work, before concluding with the programme and the developments envisaged.

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**Parallel sessions**

**Young talent - Hopes in research**

**Post-operative pain chronicity after knee arthroplasty: an exploratory study of BDNF kinetics: Knee-BDNF**

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Chronic post-operative pain (CPOP) occurs in around 30% of patients after total knee replacement (1). Identifying profiles at risk of PCOD could enable personalised anaesthetic and post-operative management, thereby reducing the use of opioids and encouraging early mobilisation (2). This is a priority area for research in anaesthesia, and the identification of a biomarker would be useful (3).

The mechanism of PCOD is recognised as a specific entity, not just inflammation or isolated nerve damage, but a combination of both (4). The intensity of pain after an incision is influenced by two main factors: the nociceptive influx generated by the incision and the mechanisms of peripheral and central nerve sensitisation, which modulate pain perception (5).

Clinically, sensitisation is manifested by several phenomena: pain amplification in response to repetitive stimuli (wind-up), more intense pain extending beyond the area of primary injury (secondary and tertiary hyperalgesia), and the appearance of pain provoked by non-painful stimuli (allodynia) (6). These mechanisms resemble those observed in the long-term potentiation of the hippocampus, supported in particular by a key role for neurotrophins such as BDNF (Brain-Derived Neurotrophic Factor) (7).

BDNF is involved in brain homeostasis, neuronal survival, plasticity and cognitive function, and plays a crucial role in nervous system repair processes(8). Studies have shown that alterations in serum BDNF could be a biomarker of interest for certain central nervous system disorders such as depression (9). The study of blood BDNF could therefore offer a potential biomarker for PCOD (10).

The aim of the Knee-BDNF study is to analyse the post-operative kinetics of BDNF and to determine whether its variations are linked to the development of PCOD or to pre-existing risk factors. The primary endpoint is the significant increase in serum BDNF levels at 3 months post-operatively in the chronic pain group compared with pain-free patients. Secondary endpoints such as pain will also be assessed, as will validated tools specific to algology for each of the dimensions of chronic pain (BPI, HAD, WOMAC, SF12, etc.).

For the 200 patients, the study includes an inclusion visit (target patient: first total knee replacement) and three follow-up visits (post-operative 48 hours, 3 months and 6 months) during which the clinical and biological investigations specified in the protocol will be carried out.

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**Parallel sessions**

**Young talent - Hopes in research**

**Planaria as a replacement model for studying nociception**

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Planaria are a class of small aquatic flatworms. Unlike their plathelminth cousins (cestodes, trematodes and monogeneans), they are not parasitic and live mainly in freshwater. Planaria are well known to developmental biologists, who have been studying their incredible regenerative capacities, which have been described for several centuries [1]. However, regeneration is not their only strong point. In fact, the planarian nervous system has a set of physiological characteristics similar to those of vertebrates: multipolar neurons with a single axon, a majority of chemical synapses, developed dendritic spines, a large proportion of neurotransmitters in common, etc [1]. So, although they are phylogenetically more distant from mammals than other invertebrate models, such as nematodes or insects, planaria are particularly interesting to study because of these homologies. Over the last century, they have been progressively used for pharmacological, (eco)toxicological and behavioural studies, giving us access to a vast amount of data on their reactions in the presence of chemical agents [2]. More recently, their reactions have been further clarified: rather than a simple visual cue, we now know that they are highly reproducible and well characterised. Thanks to these last two factors, planaria quickly found its place in the study of nociception. Indeed, it has since been demonstrated that the expression of certain nociceptors such as TRP ion channels in planaria is necessary for the production of nociceptive reactions, typically present when a nociceptive stimulus (heat, irritants, acidity of water, abrasive substrate, etc) is present. In addition, multiple anti-nociceptive agents are capable of modulating these reactions, such as opioids (morphine, DAMGO), or anti-inflammatories (meloxicam, acetaminophen)[1,3]. Thus, in the context of the 3Rs, planaria are a promising model for the fundamental study of nociception and could constitute a replacement model in the early stages of screening for new analgesic molecules. As well as being a potentially effective replacement model, the use of planaria benefits from the great flexibility represented by the study of invertebrates: rapid reproduction in large quantities, easy handling and low maintenance costs.

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**Parallel sessions**

**Young talent - Hopes in research**

**Treatment of diabetic neuropathic pain: differential involvement of the 5-HT6 receptor and the mTOR pathway depending on gender.**

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Chronic neuropathic pain is a major complication of diabetes, with no less than 20.3% of diabetic patients (type 1 and type 2 diabetes) in France suffering from chronic neuropathic pain. Given the increase in the number of diabetic patients worldwide (an estimated 783 million by 2045), the impact of pain on quality of life and the poor efficacy of standard treatments, new therapeutic strategies are expected. The 5-HT6 receptor has recently emerged as a promising target for treating neuropathic pain and associated cognitive deficits. Data previously obtained in male diabetic rats showed that blocking the constitutive activity of the 5-HT6 receptor (using inverse agonists), inhibiting the mTOR signalling pathway (using rapamycin) and disrupting the interaction between the 5-HT6 receptor and mTOR (using a peptide mimetic, Tat-VEPE) improved pain behaviour and cognitive performance. To increase the relevance of this finding and explore pharmacodynamic differences between males and females, we evaluated the effect of 5-HT6 receptor inverse agonists, rapamycin and a peptide mimetic (Tat-VEPE) on mechanical hyperalgesia and comorbid cognitive deficits in streptozotocin (STZ)-induced diabetic rats. Full (PZ-1388, PZ-1386, SB258585) and partial (PZ-1179) inverse agonists, injected intraperitoneally, reduced mechanical hyperalgesia in females, as did rapamycin and Tat-VEPE injected intrathecally. In females, the amplitude and duration of the analgesic effect of the compounds (with the exception of Tat-VEPE) were weaker than in males, whereas PZ-1386, SB258585, rapamycin and Tat-VEPE had the same efficacy on cognitive impairment as previously observed in males. These results suggest that the 5-HT6 receptor signalling pathways involved in pain are differently sensitive to pharmacological agents depending on gender, and encourage further work to compare the downstream effectors of the 5-HT6 receptor and the pharmacokinetic properties of compounds in the two sexes in order to better understand the differential effects on diabetic neuropathic pain.

**Parallel sessions**

**Young talent - Hopes in research**

**Cortical mechanisms of interactions between pain sensitisation and attention deficit disorder with or without hyperactivity (ADHD)**

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Attention deficit disorder with or without hyperactivity (ADHD) is a common neurodevelopmental disorder affecting 8% of children and 6% of adolescents worldwide [1]. Characterised by symptoms of inattention, hyperactivity and impulsivity, it is generally associated with cognitive, emotional and behavioural deficits. Clinical studies suggest that pain awareness develops in ADHD sufferers [2,3,4,5]. However, the mechanisms and neural circuits involved in these interactions remain unknown. Our team has previously validated a mouse model of ADHD obtained by injecting 6-hydroxydopamine into one of the lateral ventricles five days after birth [6]. This model developed marked sensitisation to thermal and mechanical stimuli, suggesting that ADHD conditions increase nociception [7]. Using a combination of approaches, we have also demonstrated hyperactivity of neurons in the anterior cingulate cortex (ACC), which modifies the ACC-posterior insula (PI) circuit and the spinal networks underlying pain sensitisation [7]. We hypothesise that neuroinflammatory mechanisms are at the root of the functional alterations in the ACC and the comorbidity between ADHD and pain. Using immunofluorescence, we demonstrated changes in the morphology of microglia and astrocytes, indicating their activation. Using qRT-PCR, we identified changes in the expression of inflammatory markers in the cingulate and insular cortex. In addition, the use of mass spectrometry and high-throughput phosphoproteomics approaches enabled us to detect a deregulation in the activity of kinases and signalling pathways under ADHD conditions. Taken together, our results confirm the involvement of neuroinflammatory mechanisms in brain regions that process both attentional processes and pain perception. The identification of mechanisms common to these two neuropsychiatric disorders, involving neuronal circuits and inflammatory signalling pathways, is essential in order to improve treatments.

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**Parallel sessions**

**Young talent - Hopes in research**

**The effect of prenatal stress on development and functions of nociceptors**

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Nociceptors are specialized neurons located in the dorsal root ganglia (DRG), responsible for transmitting pain signals from organs to the central nervous system. They are classified into subtypes: Non-Peptidergic nociceptors (NP), Peptidergic nociceptors (PEP), and non-nociceptive neurons called c-low-threshold mechanoreceptors (cLTMRs). These subtypes develop from precursors between embryonic days (E) 11 and E13, achieving transcriptomic maturity by E13 to post-birth. As we previously demonstarated that prenatal stress (PS) induces mechanical hypersensitivity, we hypothesized that PS disrupts the transcriptomic development of nociceptors, contributing to mechanical hypersensitivity observed in offspring.

PS was induced in pregnant mice using restraint stress under bright light from E13 to E18. Mechanical sensitivity in 8-week-old mice was assessed using Von Frey tests. DRGs were isolated from control (CT) and PS mice for bulk RNA sequencing. Immunohistochemistry staining identified major nociceptor populations in 8-week-old DRGs. Single-cell RNA sequencing (scRNAseq) on sorted nociceptors from CT and PS offspring provided further insights on transcriptomic impacts.

PS offspring showed pronounced mechanical hypersensitivity compared to CT offspring. RNA sequencing revealed 300 differentially expressed genes, including Trpv1 (PEP), Th (cLTMR), and Mrgprd (NP). A dysregulation of the main populations of nociceptors in PS offspring has been confirmed by immunohistochemistry. scRNAseq indicated cLTMRs as the primary affected population.

Our results show that PS impacts cLTMRs development at the transcriptomic, proteic, and single-cell levels. This impairment is associated with a mechanical hypersensitivity and behavioral disorders.

**Parallel sessions**

**Implanted neurostimulation: Refractory peripheral neuropathic pain in a patient with cancer pathology**

**Use of neurostimulation for neuropathic pain in cancer patients**

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A working group from the SFETD "neurostimulation implanted in neuropathic pain" commission has been commissioned to consider this indication in cancer patients. In order to evaluate practices, a questionnaire was sent to centres implanting neurostimulation in France. The aim of this questionnaire is to gather information on the practices of centres implanting spinal cord stimulation in cancer patients, for pain that is either sequelae or independent of the cancer.

As of 11 September 2024, 30 responses had been received to this questionnaire.

Spinal cord stimulation in patients with cancer-related neuropathic pain:

Among the responder centres, a slight majority (53%) had already implanted spinal cord stimulation in patients suffering from neuropathic pain sequelae of cancer. However, this still represents a minority of the patients implanted in these centres.

The aetiologies selected are mainly refractory neuropathic pain following chemotherapy, cancer surgery and radiotherapy. The majority of candidate patients (87.5%) are implanted when they are in remission, compared with 12.5% of patients undergoing treatment.

Spinal cord stimulation in cancer patients suffering from neuropathic pain (independent of cancer):

Among the responder centres (26), half (50%) had already implanted spinal cord stimulation in cancer patients suffering from neuropathic pain (independent of the cancer). Implantation has mainly taken place (78.6%) in patients in remission, compared with 21.4% in patients undergoing treatment.

Discussion:

Generally speaking, these patients were referred to the implanting centres by algologists working in SDCs, algologists working in oncology departments, oncology physicians and radiotherapy physicians.

The main obstacles identified were as follows:

Patients with little or no referral to a Chronic Pain Facility (CPF)

Lack of knowledge of neuromodulation techniques on the part of doctors providing oncological follow-up for these patients

Space available in SDCs to receive these patients (consideration to be given to creating dedicated channels for this indication).

The general condition of these patients and their prognosis are important factors in the decision to implant. The files of these patients are discussed at the RCP SDC and Implant Centre and generally go through a test phase before final implantation.

It might be worth considering making this neuromodulation technique better known to oncologists, chemotherapists and radiotherapists, so that these patients can be optimally referred to SDCs and/or implant centres.

**Parallel sessions**

**Implanted neurostimulation: Refractory peripheral neuropathic pain in a patient with cancer pathology**

**The role of CLF in the cancer patient pathway**

MR D 1

1 Ch Lyon - Lyon

The implantation of a stimulation for analgesic purposes (NSI) is part of a systematic patient pathway, pre- and post-operatively, with multidisciplinary management involving chronic pain structures and the implanting centre (see recommendation of the SFETD neuromodulation commission).

Caring for a patient with a cancerous pathology has its own specificities and requires a number of points of vigilance, from assessment to follow-up, including the surgical procedure.

It is essential that the project is coordinated and drawn up in conjunction with the patient's referring oncology team. The indication is validated collegially at the Multidisciplinary Consultation Meeting (RCP).

NSI is a technique that should be discussed as part of the surgical treatment armoury, which also includes intrathecal analgesia (ITP) and lesional techniques. The main current indications are refractory peripheral neuropathic pain following cancer treatment in patients in remission or with only mildly progressive disease, and neuropathic pain independent of cancer disease.

**Parallel sessions**

**Implanted neurostimulation: Refractory peripheral neuropathic pain in a patient with cancer pathology**

**The psychologist's view**

A.M. Giner 1

1 Speaker - Lyon

We would like to explore the role of the psychologist in a neuromodulation programme.

The psychologist's role involves working closely with a multi-disciplinary care team, in which it will be necessary to communicate the psychic temporality of a single subject confronted with chronic pain and the related medical and neurosurgical issues. It should be noted that psychic temporality is not always in line with medical time.

The quality of the network between the various care providers is an issue that deserves to be addressed.

Identifying and respecting the need for time specific to each sufferer is necessary in order to contain the sufferer's anxieties and to support the patient's ability to adapt to and appropriate the implanted neurostimulator device.

We will also discuss the specific nature of patients suffering from cancer-related pain, which can be diagnosed by the medical profession, and those suffering from chronic pain for any other reason.

Through comparative elements, we will look at the subjective experience of pain according to its origin. It seems essential to understand the function(s) of pain in the subject's psychological economy, a real imprint on the skin and the psyche.

When people come to talk about their pain, it can serve as a gateway to the medical and social professions, to communicate the traumatic expression of a psycho-corporal experience.

To speak of persistent pain as an event, a history, a relationship, or as a stigma of existence, also refers to a self-engendering spiral in which fatigue and an anxiety-depression syndrome, common in this clinic, are added.

Pain, as an intrinsically subjective phenomenon, whether of cancerous origin or not, represents a real narcissistic wound, confronting the subject with the problem of mourning (often initiated in the aftermath of the cancer diagnosis with the many losses and renunciations that can result from it).

The sufferer will then be able to subjectively question the meaning of this existential ordeal, from which may also emerge a genuine questioning of identity.

Taking into account the psychic life of patients in pain allows the care team to design a care system that is as close as possible to the needs of each individual.

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**Parallel sessions**

**Pain in women of all ages**

**Pudendal neuropathy in elderly women**

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Neurogenic perineal pain in elderly women has a number of characteristics in terms of symptoms, progression and treatment.

Distal pudendal canal involvement (Alcock's canal syndrome) is often associated (or favoured in the context of a "double crush syndrome") with proximal radiculo-medullary involvement (narrow and/or constricted lumbar canal). It is also almost always associated with diffuse perineal neuropathy (pudendal stretch neuropathy induced by obstetric history or a long history of constipation), sometimes combined with polyneuropathy of other origin, frequently observed in this age group (diabetes, dysglobulinemia, cancer, drug iatrogenesis).

This means that although electrophysiological tests are most often impaired, their specificity in demonstrating the elective neurogenic damage responsible for the pain symptoms is more questionable, as the distal conduction block that indicates tunnelling compression is masked or rather drowned out by the diffuse perineal denervation that is almost inevitable at this age.

Pelvic MRI centred on the sacral plexuses and lumbosacral MRI are systematically performed to exclude associated aetiologies or those directly responsible for chronic pain.

The diagnostic block test (bitroncular scanoguided infiltration of the pudendal nerves) is essential to try to identify the aetiopathogenesis of the disorders.

Treatment is rarely surgical, given the neurological co-morbidities that can adversely affect the outcome of pudendal nerve transposition neurolysis, and as a rule calls on the multimodal resources of specialist algology centres.

**Parallel sessions**

**Pain in women of all ages**

**Infiltrations for chronic pelvic-perineal pain State of play in 2024**

T. Riant 1

1 Hôpital Du Confluent - Nantes (France)

Chronic pelvic pain is usually complex, multifactorial, disabling and impotent.

This complexity makes it difficult to understand and dismantle. The existence of known or presumed focal lesions is usually associated with phenomena of nodisciplasticity of the entire nociception system.

Careful and well-managed infiltrations remain a formidable diagnostic tool, making it possible to establish a personalised therapeutic strategy. There is little evidence that they can be used in isolation. On the other hand, using infiltrations as a tool within a more holistic approach seems reasonable.

In recent years, new infiltration targets have appeared: interfacial spaces[i],[ii] block under the erectors,

New imaging techniques[iii] or rather new ways of using imaging, particularly ultrasound, for example in the field of coccygodynia.

New techniques and products are being used, such as pulsed radiofrequency[iv],[v] cryotherapy[vi], dextrose[vii] and botox[viii].

All these new treatments have yet to be fully validated, but in an area where there are few effective treatments, the benefit/risk balance appears to be favourable.

It is likely that the role of infiltrations will evolve in the years to come towards new indications (lumbago, endometriosis[ix], painful bladder[x], vestibulodynia, inappropriate genital arousal syndrome, test prior to root neuromodulation, etc.), new targets (lumbar sympathetic system, dorsal spinal ganglion, roots), new methods (pulsed radiofrequency with or without local anaesthetics, repetition of procedures, new products, etc.).

Finally, and perhaps most importantly, it is to be hoped that the future will provide us with answers about the mechanism of action of infiltrations, not so much locally (qs) as about the effect of local action on nociception (modulation of local and central nodisciplasticity) and pain [xi] (the end result of stimulation of the nociceptor system).

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**Parallel sessions**

**Pain in women of all ages**

**Dysmenorrhoea: changing the paradigm**

E. Bautrant 1

1 Aix-En-Provence - Aix-En-Provence

Definition and prevalence :

Dysmenorrhoea, or menstrual pain, is present at levels of variable intensity, which we can classify from 0 to 3 according to the Andersch and Millson scale (tab1). While level 0 corresponds to painless periods with no change in daily activity, level 3, or "severe" dysmenorrhoea, corresponds to very severe pain, VAS >5, with a host of associated somatic symptoms (nausea, vomiting, asthenia, headaches, diarrhoea), a weak effect from analgesics and a significant deterioration in quality of life with absence from school and work.

The frequency of dysmenorrhoea, taken as a whole and taking all levels together, is very high, around 80 to 90% (1), and that of severe dysmenorrhoea, as defined by Andersch and Milsom's Level 3, has a prevalence of around 15 to 20%, which is considerable (2).

Severe dysmenorrhoea and hypersensitivity:

Severe dysmenorrhoea is the main symptom of endometriosis. When it is detected, it is classically referred to as secondary dysmenorrhoea.

However, analysis of the files of our patients, whom we treat or operate on for endometriosis, reveals that, in the vast majority of cases, they began with severe dysmenorrhoea from their first menstrual period.

This dysmenorrhoea is immediately and brutally severe, even though the endometriosis is not yet present at the time of the first menstrual period.

We now know that girls with severe primary dysmenorrhoea are pelvic hypersensitised.

In fact, we have a large body of scientific work and evidence published over the last fifteen years, with a number of recent publications (3-12), confirming this pelvic hypersensitivity.

Severe primary dysmenorrhoea therefore corresponds to nociplastic pain, in the context of central sensitisation. At this stage, the investigations are negative and the pain is of a non-lesional uterine type.

The failure to recognise severe primary dysmenorrhoea in young girls as a genuine pathology, and the absence of appropriate treatment, lead to repeated bombardments of painful impulses to the centres and thus to worsening of central pelvic hypersensitivity.

This worsening leads to the onset of comorbidities and, above all, the possible development of endometriosis.

In this sense, many authors consider severe primary dysmenorrhoea to be a precursor of endometriosis and chronic pelvic pain (13).

Severe dysmenorrhoea and endometriosis :

Hypercontractility of the uterine myometrium is another fundamental aspect linking endometriosis and severe dysmenorrhoea.

Numerous publications over the last twenty years have demonstrated that severe dysmenorrhoea is accompanied by uterine hypercontractility, notably thanks to cine-MRI studies (14-16).

This hypercontractility obviously plays an important role in the pain mechanisms of severe dysmenorrhoea.

But it is its association with hyperpressure in the uterine cavity that can explain the spread of endometrial foci into the myometrium, the vascularisation, the peritoneum and the subperitoneal spaces.

Thus, through uterine hypercontractility and hyperpressure in the uterine cavity, severe dysmenorrhoea could indeed represent a precursor of endometriosis.

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**Parallel sessions**

**From chronicity in children to chronicity in adults, what treatment is needed?**

**What is chronic pain in AJA?**

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When adolescents' chronic pain persists into adulthood, treatment may require a medical transition between paediatrics and adult services. This is often a difficult period for young adults, who are torn between their desire to become independent and their dependence on their parents and carers as a result of their illness. This transition is accompanied by an upheaval in the relationship with the care system. It marks the transformation of family care centred on the child and coordinated by the paediatrics department into individual, autonomous care spread across different adult departments, with different rules and practices from those of the paediatrics department. In paediatrics, appointments are usually organised by the department, which calls back if the appointment is missed, whereas in adult departments, appointments are made by the patient him/herself, who is not called back if the appointment is missed. In paediatric consultations, parents accompany their teenagers, whereas in adult consultations, young adults usually come alone. There are also other issues at stake for the young person: independence, financial and social emancipation, the start of professional life, etc.... Thus, the brutality of this medical transition is accompanied by a loss of reference points and a risk of a breakdown in care and worsening of the disease. The transition for a chronically ill patient is a long medical, psychological, family, social and professional process that needs to be prepared, organised and structured. It depends on the maturity of the young patient, and should preferably be considered during a stable period. There are no regulations specifying the age at which this transition should take place. Paediatric medical recommendations define the medical and social expectations of care for rare diseases and oncology. There are various mechanisms in place to support the transition of patients suffering from rare or chronic diseases, or to support the oncological management of young adults with cancer, opening up a specific and necessary area for reflection in the field of chronic pain medicine.

**Parallel sessions**

**From chronicity in children to chronicity in adults, what treatment is needed?**

**What are the transitions from one world to another?**

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1 Trousseau Hospital - Paris (France)

Adolescence is a transition in itself, so when should we think about the transition from paediatrics to adulthood for our young patients?

And what kind of adult world are we talking about? For which teenager?

But we can also wonder about the meaning of the transition for young patients, insofar as paediatric pain, even chronic pain, is not necessarily long-lasting and may disappear in adulthood.

The aim of this presentation is to address these different issues, by identifying the various possible transitions and how they are experienced by patients, families and also the carers themselves, who sometimes have difficulty thinking about this transition, which raises questions about each person's ability to cope with separation.

**Parallel sessions**

**From chronicity in children to chronicity in adults, what treatment is needed?**

**From child to adult, what's new, Doc?**

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1 Ghu Paris Psychiatrie Et Neurosciences - Paris (France)

Caring for a chronic pain patient requires comprehensive, multidisciplinary support that is tailored to the patient's needs and carefully considered, combining drug and non-drug treatments. We need to take into account the patient's context, environment and plans... But how do we do this when the patient himself is changing? How can we work together to deal with the physical, psychological and behavioural changes they are experiencing?

In this talk, we invite you to think about this transition together and to reflect on the particular points to consider: can the chronic teenager or young adult simply be a child who has grown up, or an adult in the making?

After addressing the specific issues relating to the patient during this "AJA period", we will consider the issues relating to the chronic pain structures that care for them and the solutions that can be devised to ensure the best possible transition from childhood to adulthood for a chronic pain patient.

From the particularities of the period of life to the emerging pathologies during this same period, we will reflect together on what could and should be put in place.

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**Pain without borders**

**Douleurs sans frontières: an international NGO working with vulnerable pain sufferers**

**Presentation of the history and current activities of DSF**

A. Serrie 1

1 Dsf - Neuilly Sur Seine

Douleurs Sans Frontières has been developing and refining its interventions for almost 28 years. The projects are carried out in a variety of contexts, which has enabled DSF to strengthen its expertise. Indeed, there is no single way to intervene. DSF adapts its approach to the specific context and constraints of each field. This flexibility enriches its actions and expertise. DSF has developed a cross-disciplinary, holistic approach that includes healthcare professionals and patients, with a focus on ethics, quality of care through a welcoming, caring, multi-disciplinary approach, communication with patients and their families, and coordination between healthcare services for a more appropriate care pathway. DSF is working to make healthcare more humane.

In the early days, Douleurs Soins Frontières focused on the pain caused by amputations and trauma caused by anti-personnel mines, leading the teams to work in Angola, Cambodia and Mozambique. Subsequently, the specialities covered expanded to include the care required for chronic illnesses (AIDS, cancer, etc.), post-operative pain, pain caused by burns, malnutrition, and pathologies requiring palliative care. Douleurs Soins Frontières is also committed to developing programmes to deal with the moral and psychological suffering of vulnerable populations.

This is how DSF established its expertise: pain management, palliative care, psychological and psychosocial care, and the transmission of knowledge and know-how.

The national and international teams continue to work to expand and deploy these skills. In recent years, initiatives have focused more specifically on women's health and children, and projects now systematically include integrated activities combining medical and psychosocial care, because interdisciplinarity is essential.

**Pain without borders**

**Douleurs sans frontières: an international NGO working with vulnerable pain sufferers**

A.S. Serrie 1, M.T. De Kergariou 2, L.C. Caron 3, S.Z. Zimmers 4

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Douleurs Sans Frontières (DSF) is an international solidarity NGO set up in 1996 by French doctors and recognised as being of public interest in 2003.

It works to prevent, diagnose, treat and care for the physical and psychological pain of the most disadvantaged and vulnerable populations.

With a presence in five countries (Armenia, Cambodia, Haiti, Madagascar and Mozambique), DSF develops projects by providing its expertise in pain management, palliative care, psychological and psychosocial support, and is particularly involved in the training and support of local healthcare professionals. The projects are carried out in agreement with the local authorities and in collaboration with civil society organisations and other partners in order to ensure the sustainability of the initiatives.

Together with the executive management of the HUEH, DSF has contributed to the creation of a pain management service (Pain Unit) - which it has been supporting for over 10 years - at the centre of an institutionalisation process aimed at making the DU autonomous as an outpatient department in its own right. The UD cares for hundreds of patients suffering from musculoskeletal, neuropathic and cancer-related pain. It is developing a culture of integrated, patient-centred, multidisciplinary care (medical and psychological) within the hospital.

However, the chronic socio-political instability amplified by the current security crisis is forcing DSF to redefine its positioning. The violence is preventing access to basic services, and hospitals are closing or reducing their crucial services due to a shortage of staff, medicines and other health inputs, making the most vulnerable people even more vulnerable and generating a phenomenon of internal displacement currently estimated at 578,074 people by the International Organisation for Migration. In addition, the closure of the HUEH by the Village de Dieu gang in February 2024 has prompted a search for new strategies for deploying algology nurses to meet the needs of patients in pain.

Based on the example of the Haitian mission, this presentation aims to :

- Illustrate the challenges of building a Pain Unit in a transcultural context

- To characterise the particularities of the pain patients encountered

- To present the specific methods of psychological support for patients facing situations with a high traumatic potential.

**Abstracts selected as "coup de coeur" oral communications**

**CO\_01 - An Updated Review on The Central Mechanism of Action of Paracetamol (Acetaminophen): Experimental Evidence and Potential Clinical impact**

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Summary

An Updated Review on The Central Mechanism of Action of Paracetamol (Acetaminophen): Experimental Evidence and Potential Clinical impact

Introduction & aim: Paracetamol remains the recommended first-line option for mild-to-moderate acute pain in general population and particularly in vulnerable populations. Despite its wide use, debate exists regarding the analgesic mechanism of action (MoA) of paracetamol. The aim is to clarify this MoA.

Method: A bibliographic literature search was performed on Medline via PubMed to collect relevant articles from their inception to May 2022. The following keywords were employed during the literature search: (paracetamol[MeSH Terms]) OR (acetaminophen[MeSH Terms])) AND (AM404). The online bibliographic search was complemented by a manual screening of the relevant references.

Results: A growing body of evidence challenged the notion that paracetamol exerts its analgesic effect through cyclooxygenase (COX)-dependent inhibitory effect. It is now more evident that paracetamol analgesia has multiple pathways and is mediated by the formation of the bioactive AM404 metabolite in the central nervous system (CNS). AM404 is a potent activator of TRPV1, a major contributor to neuronal response to pain in the brain and dorsal horn. In the periaqueductal grey, the bioactive metabolite AM404 activated the TRPV1 channel-mGlu5 receptor-PLC-DAGL-CB1 receptor signaling cascade. The present article provides a comprehensive literature review of the centrally located, COX-independent, analgesic MoA of paracetamol and relates how the current experimental evidence can be translated into clinical practice. The evidence discussed in this review established paracetamol as a central, COX-independent, antinociceptive medication that has a distinct MoA from non-steroidal anti-inflammatory drugs (NSAIDs) and a more tolerable safety profile. With the establishment of the central MoA of paracetamol, we believe that paracetamol remains the preferred first-line option for mild-to-moderate acute pain for healthy adults, children, and patients with health concerns. However, safety concerns remain with the high dose of paracetamol due to the NAPQI-mediated liver necrosis.

Conclusion: Centrally acting paracetamol/p-aminophenol derivatives could potentiate the analgesic effect of paracetamol without increasing the risk of hepatoxicity. Moreover, the specific central MoA of paracetamol allows its combination with other analgesics, including NSAIDs, with a different MoA. Future experiments to better explain the central actions of paracetamol could pave the way for discovering new central analgesics with a better benefit-to-risk ratio.

**CO\_02 - Can we isolate the brain regions modulating the experience of pain through emotions and cognitive activity?**

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Summary

Numerous neuroimaging studies have identified the areas of the brain whose activity is associated with a modulation of pain perception. These modulations may be linked to attention/distraction tasks, meditation, the performance of cognitively difficult tasks or to the creation of strong emotional situations by listening to or visualising pleasant or unpleasant elements. The aim of this study is to identify a common cerebral network underlying the increase (hyperalgesia) or decrease (hypoalgesia) in the pain experienced as a result of the cognitive and emotional context. To this end, we undertook a review of the literature in this field, followed by a machine-learning analysis of a large dataset.

Methods

A search of reviews and meta-analyses with keywords relating to pain and cognitive and/or affective modulation (Cochrane, PubMed, and Web of Science) revealed 135 original studies, 35 of which provided standardised coordinates (MNI) of brain regions significantly activated during hypoalgesia or hyperalgesia tasks (888 subjects). Next, an approach based on machine learning (Multivariate Pattern Analysis -MVPA) was used to develop a possible 'brain signature' linked to the modulation of pain perception in healthy subjects. This analysis was applied to a retrospective dataset comprising fMRI images of 88 individuals who had received nociceptive stimuli of constant intensity, the subjective intensity of which was modulated during cognitive and emotional tasks. The cerebral haemodynamic response related to subjective pain ratings (VAS) was estimated for each stimulation across the different studies, and the images derived from the individual statistical analysis were used to train a 'Ridge' regression algorithm to predict pain ratings.

Results

Analysis of the literature showed recurrent involvement (6 studies out of 35) of the middle and anterior insula, middle and anterior cingulate cortex, basal ganglia and orbitofrontal cortex, during both hyperalgesia and hypoalgesia. An initial 'predictive' model based on individual data from 36 subjects showed that the regions best able to predict pain modulation were located in regions partly corresponding to the previous ones (middle cingulate cortex) but also partly dissociated, such as the thalamus and supplementary motor area (Spearman's Rho = 0.167, p<0.001).

Conclusions

These preliminary results suggest that the regions most statistically activated during affective-cognitive manipulations of pain are not necessarily those that determine the change in subjective perception at the individual level. The possibility that less haemodynamically salient regions may have an impact on the modulation of pain experience is intriguing and needs to be confirmed by prospective studies on independent datasets.

**CO\_03 - Les Jeux de Maux, a storytelling training programme**

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Summary

The links between chronic pain and emotional elements are well described and more or less easily identified and accepted by patients and families. A process is often necessary to open up the space for discussion, to bring to light the links, secrets, difficulties and traumas, and to replace the pain with words.

The time spent listening and the psycho-corporal care offered by our pain structures, both individually and in groups, enables patients and their families to play an active role in the therapeutic project and often leads to significant improvement. But we needed and wanted to enrich our therapeutic arsenal, to broaden the proposals made to patients.

Our two teams have been trained in storytelling, with the main aim of setting up workshops for patients and, secondarily, opening up the field of imagination and possibilities for ourselves. This pilot project was supported by the Apicil and Kanthari foundations (1). Twelve training sessions were held in each team (15 professionals from the Trousseau pain centre: secretaries, psychologists, doctors, interns, nurses and managers) and 8 professionals from the LCD network (doctors, nurse, administrative director and independent professionals: psychomotor therapist, relaxation therapist and doctors). The trainers, Charlotte Cotton and Vincent Chiu (2), who set up the social organisation Propolis, had already worked with populations around the world using the transformative power of words and art to tackle the wounds inflicted by silence and taboo subjects.

Storytelling uses narrative psychology and storytelling. Few care experiences have been published, and none in pain (3,4,5). Stories were created specifically for pain patients during this pilot project and used by members of our teams with the first groups of patients (adolescents, parents, adults). The principle is to tell the beginning of a story and the patients finish it, integrating facts and events internally and weaving them together to give meaning. What the patient chooses to include and how they do it is very useful to carers, therapists and patients. Imagining, telling and discussing stories of personal experience can:

1) to help the person overcome the challenges they may face in real life (specifically if the patient suffers from chronic pain) 2) to offer the person ways of looking at and living their life differently.

This tool of storytelling and free association of ideas, used in groups and individually, is a wonderful springboard for expression, and we are working on the assumption that it will be a new tool for reducing pain and helping patients to break out of their isolation. Feedback from trainees and the first patients has been very positive. The training has empowered the teams. A first collection of stories has been published (6).

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6. Les jeux de maux. Edition Heptade

**CO\_04 - Chronic pain in primary care: a pool of trained doctors?**

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Summary

Introduction :

The purpose of the "Pain and palliative care" complementary specialised diploma (DESC) was to provide specific training in pain management and support at the end of life (1). According to the recommendations of the French National Authority for Health (HALDE) on the care of patients suffering from chronic pain, a large proportion of patients are managed by their general practitioner in primary care. We wanted to find out what doctors who had received this specialist training thought about the development of pain medicine in primary care (2).

Materials and methods :

We carried out a cross-sectional study by questionnaire in October 2023. Former DESC students were contacted by e-mail. They were questioned about socio-demographic criteria, their current mode of practice and their feelings about the obstacles and needs to the development of chronic pain management in primary care.

Results :

A total of 69 of the 380 doctors (18.2%) questioned responded. The majority (n=61, 88%) had completed a Diplôme d'Études Spécialisées (DES) in General Medicine. At the end of 2023, 7 (10%) were practising exclusively in their original DES, 23 (33%) were practising exclusively in palliative care, 8 (12%) were practising exclusively in pain structures and 22 (32%) had a mixed activity. Concerning the interest in developing an algology activity in primary care, 37.7% of doctors were in favour. The main obstacles to an activity dedicated to the management of pain in primary care were: the lack of financial revaluation, and the absence of a network or multidisciplinary team. In terms of what could help them develop a dedicated activity, the need for psychologist sessions to be reimbursed by the Caisse Nationale d'Assurance Maladie was highlighted, as was the creation of specific quotations for algology procedures, particularly for long and complex consultations.

Discussions :

This study highlights the existence of a pool of doctors trained and competent in pain management, but who are not really able to play a role in the care of these patients in primary care, partly due to a lack of financial revaluation and a lack of team and network structures in the regions (4). The DESC has trained a majority of GPs, most of whom practice in primary care. As more and more young GPs are setting up in coordinated care structures, it makes sense to use coordinated practice to encourage the management of chronic pain in primary care (3).

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**CO\_05 - Feasibility of a proposal for empowering non-drug interventions for the long-term management of chronic pain: a pragmatic non-randomised controlled trial**

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Summary

Introduction Comprehensive, multimodal management of chronic pain involves empowering patients and developing non-drug interventions [1,2]. Of these, one patient in three uses complementary approaches [3]. Today, it is still necessary to assess the benefit-risk balance in order to integrate them into care pathways [4,5]. The aim of our study is to assess the feasibility of proposing empowering non-drug interventions as part of the care pathway for these patients.

Methods: We conducted a quasi-experimental, non-randomised, controlled study. The control group (HCL) received treatment in accordance with the recommendations. The intervention group (CHUGA) also benefited from a systematic proposal of non-drug interventions (workshops), aimed at empowerment, with motivational follow-up, chosen by shared medical decision from 5 with decision support sheets (mindfulness meditation, qigong, self-hypnosis, physical activity, slackline). The workshops were held in groups of 4 to 8 patients, once or twice a week for 6 to 8 weeks. They were co-constructed and semi-standardised. Patients over the age of majority with stable chronic pain and an average pain VAS of more than 4/10 were included. The assessment criteria were collected at 3 (post-workshop) and 6 months (autonomisation). The primary endpoint was the response rate at 6 months, defined as a reduction greater than or equal to 30% in the pain VAS. A 5:1 ratio for calculating the number of subjects was used to assess the feasibility of each workshop. The primary endpoint was analysed in complete cases, followed by sensitivity analyses.

Results We recruited 154 patients (125 intervention group, 29 control group), between December 2019 and February 2023 (154 analysed). The response rate was 13.0% (3/23) in the control group and 26.7% (28/105) in the intervention group (RR=2.04; IC95%: [0.68; 6.15]; NNTB=7; p=0.28). There was an improvement at 3 months in pain (-0.84/10; CI95%: [-1.51; -0.17]; p=0.02) and perceived health (EQ5D) (+12.0/100; CI95%: [2.5; 21.5]; p=0.01). No adverse events were observed in 91.0% of patients (111/122). An increase in post-session pain or anxiety was observed in 4.9% (6/122) and 1.6% (2/122) of patients respectively. There was no difference between the groups in terms of changes in the use of healthcare (conventional or not).

Conclusion: Our results suggest the feasibility of the intervention and a favourable benefit-risk balance. Real-life studies could confirm these findings.

ClinicalTrials.gov identifier: NCT04176341

CPP : Île-de-France VI Groupe Hospitalier Pitié-Salpêtrière (25/09/2019)

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**CO\_06 - Can data collected perioperatively by a telemonitoring application predict the incidence of chronic pain after total knee replacement?**

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Summary

Introduction: Nearly a quarter of patients undergoing total knee replacement (TKR) develop chronic pain. Identifying patients at risk could help optimise pain management during the perioperative period. Recurrent collection of pain data is difficult in clinics. The use of a telemonitoring application can facilitate this collection. The aim of this study is 1) to describe the incidence of moderate to severe pain at 3 months postoperatively, 2) to identify risk factors for severe postoperative pain.

Material and methods: 623 patients undergoing PTG surgery (40 services, 2018 to 2022) were included in this study. They used an application for the recurrent collection of data on pre- and postoperative pain, risk factors for chronic pain and analgesic intake. Pain was assessed using a visual analogue scale (from 0 to 100) on the application. Patients were divided into two groups: those with pain greater than 40/100 and/or using level 2 or 3 painkillers (D+), and those who did not meet these conditions at three months post-operatively (D-). The differences between the pre- and postoperative parameters of the two groups were studied using appropriate statistical tests.

Results: The pain-free group (D-) represented 542 patients (87%). The pain group (D+) represented 81 patients (13%). 68 patients had pain greater than 40/100 three months after the operation. 19 patients were taking level 2 or 3 painkillers.

The presence of comorbidities, increased sensitivity and greater preoperative rest pain were significantly greater in the D+ group. The trajectory of postoperative pain was greater in group D+ (Week 1 D+ :53 D- :38, Week 2 D+ :47, D- : 32, Week 6 D+ : 45, D- :24). The correlation between pain at 6 weeks and 3 months was 80%. The KOOS pain subscore at 3 months was significantly lower in the D+ group (median D+ 55, 41-61, median D- 75, 60-85).

Discussion: The daily collection of pain intensity using the monitoring application enabled us to observe the higher pain trajectory of the pain group. The percentage of patients with severe to moderate pain changed little between 6 weeks and three months post-operatively. By observing the characteristics of peri-operative pain, it is possible to identify patients who will progress to chronic pain. Preventive and targeted pain management measures are needed for the first few weeks postoperatively. Prospective studies are needed to confirm the effectiveness of monitoring systems in preventing chronic pain.

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**Selected abstracts in an E-poster**

**SPC\_01.1 - Post-hoc analysis of PROGRESS: evaluation of the safety of atogepant in patients with chronic migraine and cardiovascular risk factors**

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Summary

Background/Rationale and Objective: Migraine is associated with cardiovascular disease (CVD) and cardiovascular risk factors (CRFs). The aim of this study is to evaluate the safety of atogepant in PROGRESS participants with chronic migraine (CM) and CVD.

Design/Methods: PROGRESS (NCT03855137) was a 12-week, international, randomised, double-blind, placebo-controlled, phase 3 study that included participants (18-80 years) with CD (≥15 headache days per month for 3 months prior to selection; ≥15 headache days [≥8 migraine days] during the 4-week selection period) of ≥1 year. Participants treated with atogepant 30mg twice daily, 60mg once/day or placebo were stratified according to the number of FRCVs at inclusion: 0, 1 or ≥2. FRCVs included age (male ≥45; female ≥55), smoking, Body Mass Index (BMI) ≥25 kg/m2, hypertension, diabetes, dyslipidaemia, sleep apnoea, concomitant CVD, antidiabetic medication, history of stroke, myocardial infarction, transient ischaemic attack or peripheral arterial disease. Emerging adverse events related to cardiovascular treatment (AE-CV) were evaluated.

Results: Of 773 participants, 518 (1 missing) included pooled data from the atogepant groups (0 FRCV: 110 [21.2%]; 1 FRCV: 146 [28.2%]; ≥2 FR-CV: 261 [50.4%]) and 255 from the placebo group (0 FRCV: 47 [18.4%]; 1 FR-CV: 92 [36.1%]; ≥2 FRCV: 116 [45.5%]). The majority of participants had ≥2 FRCV versus 0 or 1 FRCV. At inclusion, participants with ≥2 FRCVs had higher mean age, BMI and monthly headache days than those with 0 or 1 FRCVs. The most common FRCVs were dyslipidaemia (47.6%), BMI ≥25 kg/m2 (43.1%) and hypertension (40.9%). AE-CVs were infrequent in participants with ≥2 FRCVs (placebo: 3/116 [2.6%]; atoepant pooled data: 9/261 [3.4%]), and none were serious. Treatment-related AE-CVs included palpitations (n=2) and elevated blood pressure (n=1) in the pooled atogepant group (30mg twice/day) and flushing (n=1) in the placebo group. Palpitations led to discontinuation (assessed as unrelated to treatment) in the pooled atogepant group.

Conclusion: This post-hoc analysis demonstrates that CV-AEs are rare in participants with CD treated with atogepant, even with FRCV. AE-CVs were not serious. The majority were unrelated to treatment and only one led to treatment discontinuation.

**SPC\_01.2 - How can social affiliation and vicarious experience play decisive roles in the adoption and maintenance of an active lifestyle for people living with chronic pain?**

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Summary

How can social affiliation and vicarious experience play decisive roles in the adoption and maintenance of an active lifestyle for people living with chronic pain?

Introduction: The benefits of an active lifestyle are well recognised, even in a population suffering from chronic pain. However, it can be difficult to stay motivated to be active when pain is a major part of daily life. The Versant AKOR 2024 project involves forming a group of participants living with chronic pain and being followed at the Centre d'expertise en gestion de la douleur chronique at the Centre hospitalier universitaire de Sherbrooke, who will complete, in the form of a collective challenge, the same number of kilometres covered by the adventurers during the six months of the expedition. Objective: To study how participants' motivation to engage in physical activity is transformed by this intervention model based on social affiliation and vicarious experience, and the impact of such a project on the adoption of an active lifestyle and on the re-evaluation of the place occupied by pain in participants' lives. Methodology Longitudinal, qualitative research-intervention lasting one year, with repeated sampling in order to document changes in the phenomenon studied over time. We will administer questionnaires, conduct individual interviews and observe group meetings. Thanks to a grant for a work placement abroad (France), we will be taking part in a research project inspired by the Versant AKOR project in October 2024, involving a pain clinic (Centre hospitalier Bretagne Sud), the University of Rennes and a skipper from the Vendée Globe 2024, for a French project starting in October 2024, following on from the Canadian project. This will enable us to compare the data collected over a shorter intervention with participants also living with chronic pain in a different living environment. Results: As a first Versant AKOR project took place under similar conditions in 2021, we will be able to present the results of this first experiment and explain the elements observed that are more specific to the 2024 edition. This study could contribute (1) From a scientific point of view, to a better understanding of the role of social affiliation and vicarious experience in motivating people living with chronic pain to engage in physical activity;(2) On a professional level, to propose an intervention model based on social affiliation and vicarious experience with the aim of increasing physical activity among people living with chronic pain; (3) For the communities, to make the sports and health communities aware of the role of social affiliation on motivation for physical activity, and of the opportunities for partnerships.

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**SPC\_01.3 - Optimising drug treatments for multimorphic cancer pain: a pragmatic approach for patients with renal failure**

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Summary

The specificities of multimorphic pain in cancer patients require an interdisciplinary, multimodal, dynamic and personalised approach. Numerous national and international recommendations on drug strategies have recently been updated [1-4]. However, they do not take into account a regularly associated co-morbidity: chronic renal failure. We have combined our experience as clinical pharmacists and pain physicians working in chronic pain facilities specialising in oncology, with an analysis of the available literature on the use of opioid and antineuropatic analgesics in patients with renal failure. We offer an exhaustive summary of each opioid and antineuropathic analgesic compound, with its dosage adjustment according to the patient's renal clearance, its methods of use, and the strategic choice of compounds to use. The aim is to provide healthcare teams with the pragmatic tools they need to optimise and secure the management of patients with renal failure suffering from multimorphic cancer pain.

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**SPC\_01.4 - Epidemiology of primary headache in a population of patients with post-traumatic stress disorder (PTSD)**

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Summary

Introduction: PTSD is a common psychiatric disorder in the general population. It is frequently associated with psychiatric and somatic pathologies, including headaches [1, 2].

Objectives: To determine the frequency and characteristics of headache in a population of patients diagnosed with PTSD.

Methods: In a population consulting for evaluation of psychotrauma, DSM-5 criteria were used to make the diagnosis of PTSD. The ICHD-3 diagnostic criteria were used to diagnose headache in this population. Anxiety and depression levels were assessed using the HAD scale.

Results: 302 patients with PTSD were included in the study (84% women and 16% men, age: 42±14 years). 77% of this population had a primary headache. The prevalence of different primary headache disorders among these pain patients was: episodic migraine (EM) 33%, chronic migraine (CM) 6%, episodic tension-type headache (ETH) 47% and chronic tension-type headache (CTH) 14%. Chronic headaches were more frequently associated with childhood trauma (MC 74%, CTC 93%); the main childhood traumas were single or repeated sexual assaults (45%) and repeated physical violence (51%). With regard to episodic headaches, the prevalence did not differ between migraine sufferers who had experienced trauma in childhood (51%) or in adulthood (49%); episodic tension headaches were more prevalent when the trauma had occurred in adulthood (81%). ADH-anxiety did not differ between episodic and chronic headaches (12±2.5 vs 12.4±2.9; p>0.05). The same was true for HAD-depression (12.5±2.6 vs 14.2±3; p=0.12). 62% of headache sufferers stated that they had already received treatment for their PTSD, and 42% had already consulted a headache specialist.

Discussion and Conclusions: Primary headaches are more frequent in our population of patients with PTSD than in the general population [3, 4, 5]. The prevalence of all primary headaches is increased, particularly in chronic forms. Childhood trauma is a major risk factor for the chronicisation of primary headaches, which should be investigated in the headache consultation in order to propose specific treatment.

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**SPC\_01.5 - Characteristics of chronic pain patients admitted to emergency departments for pain in relation to their usual pain**

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Summary

Introduction

Thirty to 40% of patients admitted to emergency departments have chronic pain (CP) [1, 2]. A proportion of these patients (30-50%) come for their usual pain [2, 3]. This raises important questions as to how they should be managed in this context, which seems at first sight to be unsuitable [3, 4]. But there is very little information about these patients.

The aim of this study was to describe the main characteristics of these DC patients whose reason for going to emergency was their usual pain (proportion and nature of their chronic pain).

Method

This was an observational, prospective, multicentre study carried out in 8 emergency departments in 2022 over a period of 1 month in each centre.

All patients aged 18 and over with chronic pain admitted to emergency care between 9 a.m. and 7 p.m. Monday to Friday were included.

Chronic pain was either already known, monitored or treated, or met the definition of pain that persists or recurs for more than 3 months.

The primary endpoint was the proportion of patients whose main reason for going to A&E was pain related to chronic pain, compared with the total number of A&E patients with CD. The variables examined also included demographic, clinical and socio-economic parameters, the severity of CD (measured with CPGS) and the patient's level of catastrophising (PCS).

Ethics

CPP Sud-Est: 22.00111.000090

Results

267 patients were included, of whom 264 could be analysed. The mean age was 58 years (21) with 59% women. Pain related to usual pain as the main reason for admission concerned 107 patients, i.e. 40.5% [CI 95%: 34.6 ;46.4]. The average pain intensity was 6 (2.9) on the numerical scale. Factors associated with the risk of admission for pain in relation to usual pain in multivariate analysis were male gender (OR = 2.9 [CI95%:1.5;4.6]), catastrophism measured with PCS (OR=2.7 [1.4;5.2]) and two or more emergency admissions in the previous 12 months (OR=2.0 [CI95%:1.4;5.2]). Age and severity of CD did not appear to be risk factors.

Conclusion: In emergency departments, 40% of patients with chronic pain are admitted because of their usual pain. The factors associated with this risk are male gender, catastrophism and previous emergency admissions.

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**SPC\_02.1 - Effect of opioid exposure on frailty: 5-year follow-up of subjects included in the MAPT trial**

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Summary

Introduction: Frailty in the elderly is a reversible, multifactorial condition that can lead to loss of autonomy, worsening of health and even death [1]. Opioid analgesics increase the risk of adverse events in the elderly (falls, confusion, etc.), and are thought to increase the risk of frailty [2-3]. As a corollary, pain is closely linked to frailty, making it difficult to assess the role of opioids, which could contribute to frailty independently of a pain phenomenon [4-6]. The aim of our study was to investigate the effect of opioid exposure on the incidence and severity of frailty.

Material & method: We used data from the MAPT trial on people aged over 70 living at home, followed prospectively for 5 years. We used a 32-item frailty index (FI), with a definition threshold of frailty ≥ 0.25. Cox models with time-dependent variables were used to study the incidence of frailty. Longitudinal mixed models were used to analyse the severity of frailty. These models included chronic pain (CP), longitudinal opioid exposure and the CP-opioid interaction. Confounding factors and significant interactions were included in these models.

Results: Of the 1637 individuals included, 339 (21%) were defined as frail at inclusion with a median FI of 0.30 [0.27-0.35]; 587 subjects (36%) reported pain at inclusion, and 458 were considered to have chronic pain (CP). During the 5 years of follow-up, 235 subjects (14%) were exposed at least once to opioids, mainly tramadol (6%) and dextropropoxyphene (3%). Opioid exposure was significantly associated with the incidence of frailty (HRadj=4.46, CI95% [2.01-9.90], p<0.001), independently of the presence of CD and taking into account interactions with CD, antidepressants and gabapentinoids. A secondary analysis stratified by sex found equivalent results. Opioid exposure was significantly associated with the severity of frailty over time (badj=0.02, CI95% [0.01-0.04], p=0.007), independently of the presence of CD and taking into account interactions with CD and antidepressants.

Conclusions: These results confirm that opioids increase the risk of frailty and its severity over time, independently of the presence of CD. Studies with an exhaustive collection of pain symptoms are needed to verify the independence of the effect of opioids from potential acute pain, as well as the reversible or non-reversible nature of the frailty potentially induced by opioids.

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**SPC\_02.2 - Creating playful pharmaceutical discussions about opioids in post-operative care: how was it done?**

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Summary

The use of opioid analgesics has increased considerably in France in recent years. This consumption of morphine is accompanied by harmful consequences such as an increase in accidental hospitalisations due to overdose (+168% in 2017) [1]. Our aim is to set up pharmaceutical discussions for surgical patients for whom opioids have been prescribed on discharge from hospital. In this way, we hope to make the administration of opioids safer and limit the occurrence of overdoses and addictive behaviours.

Initially, a review of the literature and recommendations from learned societies was carried out. Two preliminary studies were carried out in collaboration with the Comité de Lutte contre la Douleur (Pain Control Committee). These identified the prescribing habits of surgeons and anaesthetists and highlighted the educational needs of patients. The results of these studies enabled us to draw up a skills reference framework and create appropriate teaching tools.

The skills framework comprises 6 skills broken down into 16 learning objectives. Various teaching aids have been created to facilitate an individual interview lasting a maximum of one hour. In the form of a game of snakes and ladders, the interview is divided into six stages (four compulsory and two optional). For each stage, the patient is given a fun, interactive tool. The first stage focuses on self-management of opioids, with patients completing an opioid plan using their discharge prescription. The aim is to make patients aware of dose intervals and maximum daily doses. The second stage, dealing with adverse reactions, takes the form of Barrow cards. The patient is put into a situation and has to choose the actions to be taken if an adverse reaction occurs. The third stage, dealing with overdoses, consists of presenting the patient with a board containing various symptoms and asking them to identify those associated with an overdose. Finally, the theme of addiction is presented in the form of True/False cards to deconstruct certain beliefs. For the optional stages ("assessing pain" and "relieving pain without medication"), patients are given informative flyers. At the end of the interview, the patient completes a satisfaction questionnaire.

The content of these interviews was presented to all the surgical teams. Analysis of patient satisfaction and needs within the hospital will enable us to develop this pharmaceutical intervention further. Finally, patients will be telephoned after hospitalisation to assess the impact of the interviews on their post-operative quality of life.

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**SPC\_02.3 - Tour de France of "pain" stays in paediatric RMS: a survey by the SFETD paediatric commission.**

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Summary

Paediatric Chronic Pain Structures (pCCS) offer hospitalisation in Medical and Rehabilitation Services (MRS) for chronic pain. These hospitalisations are often prompted by school drop-out and its corollary, social exclusion. In the literature, so-called intensive and interdisciplinary treatments have been the subject of publications on their effectiveness (1,2). Around 100 SMRs offer paediatric care in France. But which RMS have set up hospitalisations for chronic pain? What are these facilities? To answer these two questions, the SFETD paediatric committee has launched a survey of 50 paediatric RMSs in France in order to take stock of this care offer.

Method: A Google Forms questionnaire was sent to doctors practising in paediatric general medical services in France. The initial question was the existence of stays for chronic pain. If the answer was positive, the questionnaire then focused on the patient's pathway (address, pre-admission, hospitalisation criteria, length of stay, assessment and follow-up); the patients (age, pathologies); and the conditions of the stay (professionals, type of stay and department, protocols, dedicated beds, number of patients, family work, schooling).

Main results: 34 physicians practising in SMRs responded. All treated chronic pain (CP) patients. They mainly practised in PRM departments and saw patients aged 0 to 18, referred by second- or third-level doctors, who mainly presented with musculoskeletal pain. Formal pre-admission procedures exist for 80% of SMRs. School drop-out is not a necessary criterion. The main contraindication is lack of motivation. In 51% of SMRs, waiting times were between 1 and 3 months. In 68% of SMRs there was no formal protocol and in 82% there were no dedicated beds. The teams are multi-professional and work with families. Integrated schooling exists in 91% of SMRs. Lengths of stay vary (10 days to 1 year). The expertise of the SMRs varies; only 2 SMRs have admitted more than 100 DC patients in the last 5 years.

Discussion: these results show that there are SMRs offering stays for children and adolescents with chronic pain. The admission procedures and criteria are relatively identical. However, the length of stays varies and there are few formalised protocols. The Paediatrics Committee is therefore planning to set up a specific working group and to draw up a best practice guide.

Conclusion: There are stays for children and adolescents with chronic pain in SMRs in France. The heterogeneity of practices argues in favour of producing a guide to good practice.

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**SPC\_02.4 - Setting up "opioid" pharmaceutical interviews: what do our patients need?**

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Summary

In recent years, opioid consumption has increased considerably in France [1]. This increased use of morphine is inevitably accompanied by risks of overdose and addictive behaviour. The pharmaceutical team would like to offer patients who have undergone surgery and are discharged home with a prescription for opioids, therapeutic education on discharge from hospital. In order to target the essential skills and take account of our patients' literacy levels, a study of their educational needs was carried out.

Semi-structured interviews were conducted by the pharmaceutical team with surgical inpatients, using a questionnaire. The 18-item questionnaire covered three main themes: history and experience of pain, knowledge of analgesics and expectations/motivation for future interviews. The results were entered into an Excel® spreadsheet and analysed. The entire project was carried out in collaboration with the Comité de Lutte contre la Douleur team.

The interviews with 20 patients lasted an average of 30 minutes. Of these, 70% (n=14) had already received opioids prior to hospitalisation, and 33% (n=7) reported adverse effects (the most common being drowsiness and nausea). The term "opioids" was known by 70% (n=14) of patients and associated with morphine, Lamaline® or tramadol. Only 40% (n=8) of patients were able to name 3 different analgesics without error. In the event of pain occurring at home, 65% (n=13) would take one of the painkillers prescribed on discharge, and in the event of adverse effects, 25% (n=5) of patients planned to stop taking the drug. Patients wanted more information on the following topics: how to take painkillers (n=13), side effects (n=17), relieving pain without medication (n=8) and overdosing (n=6). Finally, patients gave a score of 8.7/10 to the usefulness of these future discussions.

These interviews enabled us to draw up a set of relevant skills and target four educational safety objectives. Fun educational tools have been developed to enable patients to manage their painkillers independently, learn about their side effects, know how to react in the event of overdose and avoid addiction to opioids. Patients will also be offered two optional workshops on pain assessment and non-drug alternatives for pain relief. This study has confirmed the relevance of offering these pharmaceutical talks on discharge from hospital.

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**SPC\_02.5 - Postoperative pain in the home: a challenge for the private nurse?**

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Summary

With the shift to ambulatory care, private practice nurses are increasingly called upon to care for post-operative patients, including patients in pain. Identifying and relieving pain is a real public health issue, and is both a fundamental right of patients and a responsibility for healthcare professionals. The authors wanted to ask independent nurses about the challenge of managing postoperative pain in patients returning home up to a week after their operation.

The aim was to gather information on the experiences and perceptions of private practice nurses in terms of postoperative pain management. A prospective survey was carried out among 338 private practice nurses throughout France from 13 to 21 June 2022.

The results showed that self-employed nurses were experienced professionals, and that the majority of them practised without a medical presence within their structure. They frequently come into contact with painful post-operative patients, and although they are trained in pain assessment, they seem to need more support in managing painful patients, for whom they are the first point of contact. From their reactions, it appears that they are also interested in training on the subject of pain.

According to the nurses interviewed, it is vital to improve communication and collaboration between the hospital and home care in order to ensure optimal management of postoperative pain. A great deal is already being done in this area from a general point of view. However, when it comes to pain management, it would appear that those working in the community still need support if they are to feel at ease and be able to provide efficient patient care. In addition, there is a lack of recognition of the value of pain management, in terms of scoring, which does not allow the competence of private practice nurses in this area to be recognised.

The development of specific training for homecare nurses and the creation of pain management protocols adapted to this context, as well as the strengthening of the link between the city and the hospital, are some of the proposals emanating from the responses received.

**SPC\_03.1 - Efficacy, safety and tolerability of OnabotulinumtoxinA for the treatment of chronic migraine in patients over-medicated to crisis treatments: Analysis of the PREEMPT and COMPEL studies**

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Summary

Objective: To evaluate the efficacy, safety and tolerability of OnabotulinumtoxinA (OnabotA) in patients treated for chronic migraine (CM) with or without overuse of seizure treatments (STC).

Methods: Analysis of data from patients with CD treated with OnabotA with or without CTS in COMPEL, a phase 4, single-arm study (NCT01516892) and PREEMPT, a phase 3, placebo-controlled (PBO) study (NCT00156910, NCT00168428). According to the ICHD, CTS was defined as taking seizure medication ≥2 times/week at any week during the screening phase. Patients received OnabotA every 12 weeks for 108 weeks (COMPEL) and 56 weeks (PREEMPT). In PREEMPT, placebo patients received OnabotA from week 24. Efficacy was assessed by the mean number of headache days (HMD), the Headache Impact Test (HIT-6) score and the MSQ (Restrictive Function Domain) score. Tolerability and safety were reported through the collection of adverse events (AEs).

Results: CTS was reported in 65% (n=904/1384) of PREEMPT patients (OnabotA: n=445, PBO: 459) and 64% (n=456/715) of COMPEL patients (CTS: n=456, no MSC: n=259). In PREEMPT, OnabotA reduced JCMs (vs. placebo) at week 24 in patients with CTS (mean: -8.2 vs. -6.2, P<0.001) and without (-8.8 vs. -7.3, P=0.019). OnabotA reduced moderate/severe JCM in patients with SMC MO (P<0.001) and without (P=0.008). Severe impact (HIT-6) was reported in fewer patients with CTS versus placebo at S24 (P<0.001) and without CTS (P=0.027). The MSQ score was improved versus PBO at S24 (P<0.001) and without (P<0.001). In COMPEL, improvements did not differ between patients with and without CTS: JCM (mean: -10.6 vs -11.0, P=0.397), moderate/severe JCM (P=0.573) and HIT-6 score (P=0.644) at S108. AEs were similar in frequency between patients with CTS (27%) and without (26%) and were consistent with the safety profile of OnabotA in CD.

Conclusion: In this post-hoc analysis, patients with CD and CTS treated with OnabotA responded similarly to those without CTS, with a similar safety profile.

**SPC\_03.2 - Optimising the management of osteoporosis after identification of patients treated with non-neoplastic vertebroplasty: Strasbourg experience Analysis and follow-up methods.**

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Summary

Only 7.3% of severe osteoporotic fractures are treated, despite the increase in mortality. This was observed after cementoplasty for the analgesic treatment of acute hyperalgesic vertebral fractures.

The aim of this collaborative approach was to create synchronisation between interventional radiology and the rheumatology Bone Pathway in order to improve early anti-osteoporosis management in the first 3 months of patients treated with vertebroplasty, by identifying untreated osteoporotic patients.

This alliance and co-construction, with several meetings with the Interventional Imaging Department, have enabled us to

1. a specific Parcours Os letter will be given to each patient before the cementoplasty procedure for an osteoporotic vertebral fracture in order to raise awareness among patients, who will be able to mention the word osteoporosis during the procedure and understand that this is a disease to be treated in addition to vertebroplasty.

2. every week, their nurse sends us a list of patients with non-tumour cementoplasties, enabling us to study the files

Results: From 09/2022 to 09/2023, 147 patients with cementoplasty for non-neoplastic vertebral fractures were referred to us by the Interventional Imaging team. All the files were analysed by a rheumatologist and then contacted by our coordinating nurse (5 could not be contacted). Fifty-three patients were already under the care of a rheumatologist on an outpatient basis and were not seen. Forty-two were seen at a consultation dedicated to osteoporosis, where they were assessed and treatment instituted. For patients living far away in Alsace, or with significant disabilities, a friendly partnership with the private and hospital rheumatologists in Sélestat, Saverne and Mulhouse enabled them to be successfully treated nearby.

For patients who could not be contacted, an explanatory letter was sent to GPs with treatment suggestions.

In addition, many patients and carers have contacted us directly, with our contact details appearing on the letter they received.

Discussion and conclusion

For osteoporosis, the Cochrane meta-analysis of 2018 and the American Task Force of 2019 conclude that the routine use of vertebroplasty is not supported by scientific evidence, but that it should be considered early in severe forms, especially if the vertebral fracture is located at the thoracolumbar hinge, in cases of intense spinal pain caused by a recent vertebral fracture with hospitalisation and prolonged bed rest. It must be combined with early specific treatment of this osteoporosis in order to avoid recurrences (x 5 in the first year). This alliance and co-construction with the Interventional Imaging Department has facilitated the diagnosis of OP and the initiation of anti-osteoporosis treatment before 3 months for more than 2/3 of patients after cementoplasty, encouraging us to promote the spread of this approach.

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**SPC\_03.3 - Pain doctor in general practice: a link in the care pathway?**

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Summary

Background: In France, chronic pain medicine is mainly practised in public and private care institutions, because of the way they are funded and the need for multidisciplinary teamwork, which is easier in institutions. It is very rarely practised in private practice. The agreement with the French health insurance scheme [1] does not provide for pain consultations to be rated, as this is a long and complex procedure, and there are very few pain resource nurses working in private practice, given the lack of dedicated procedures [2]. The 2023 HAS recommendations on the path taken by chronic pain patients [3] make no mention of the existence of these rare "town algologists", who are not officially listed, level 2 being direct recourse to the SDC (consultations and centres for the assessment and treatment of chronic pain).

Method: In this article, we analyse the case of a general practitioner who set up a private practice in algology during his first three years, within a group practice with psychiatrists and psychologists. We look at the profile of the patients referred and the referring doctors, how the multidisciplinary approach was put in place, the network set up between town and hospital, and the links with the referring and regional pain structures, particularly in terms of multidisciplinary consultation meetings, the use of specific techniques such as capsaicin patches, Ketamine or botulinum toxin, and the integration of patients into hospital therapeutic education programmes. We examine the economic model chosen to ensure the sustainability of the activity. Finally, we analyse the main pitfalls and limitations of this type of practice.

Results: (Tables in progress)

Conclusion: Chronic pain consultations in non-institutional private practices are a way of providing a first level of flexible and responsive care, anchored in the healthcare network. There is still not enough multi-disciplinary expertise and the economic model is tricky, so setting up a multi-professional health centre seems the most appropriate. This activity needs to be recognised by the health insurance scheme, the HAS, learned societies and the medical association to enable it to develop and be better integrated, which would relieve the pressure on pain centres as a possible level 1 referral link.

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**SPC\_03.4 - A care pathway for children in pain**

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Summary

Before the first consultation appointment, we have always sent families a questionnaire so that we can understand the situation better and adapt the timeframe and the professional(s) who will see the family. Often the doctors' letters were not very informative. In these complex situations of chronic pain, private doctors and paediatricians can feel powerless and refer patients quickly to a pain consultation or after lengthy assessments, after which they sometimes remain outside the patient's care pathway once they have been referred. Some have insufficient knowledge of paediatric pain structures, how they work and their therapeutic projects.

Since the COVID epidemic, we have seen a major increase in requests for consultations, leading to waiting times of up to 9 months in 2023.

Patient questionnaires are used to identify a level of care:

level 1: need for a one-off specialist opinion (for example, to make or confirm a diagnosis of migraine in a child who has not dropped out of school and has no major co-morbidity)

-level 2: need for specialist advice and coordinated care but local and family resources can be identified (e.g. recurrent or chronic pain without too many absences from school and with a family that has the resources for independent care).

level 3: need for a multi-professional team (all complex situations, significant school absenteeism, interactions with individual or family emotional elements, long-standing pain, drug abuse, etc.).

To improve the care pathway for these children and teenagers, and have:

- completed the family questionnaire

- created a questionnaire for private practitioners, with simple questions to help them describe the type of pain, how long it has been present, its location, their diagnostic hypotheses and their needs in relation to the patient

- identified a network of professionals trained in children's pain in private practice

- systematically readmitted the child to the nearest hospital if a consultation or a local professional could be located and if these levels of care seemed appropriate to the situation described

- referred "simple" situations that could benefit from a specialist paediatric consultation on site (without a prescription) to the LCD (Lutte contre la Douleur) network, followed by contact with the general practitioner for prescription and follow-up.

- initiated initial consultations with Advanced Practice Nurses

This process, all these tools and the results observed will be described. This work of sorting out requests for consultations and liaising with a network of professionals, which also enables occasional advice to be given in a multi-professional centre if necessary, and ongoing exchanges, is very time-consuming and poorly valued, but it is essential for an appropriate and optimal care pathway.

Our discussions took place at the same time as the work of the HAS (1), which we will also take into account in the future.

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**SPC\_03.5 - Prevalence of irritable bowel syndrome in patients treated in chronic pain facilities**

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Summary

Background: Irritable bowel syndrome is a frequent cause of consultation and epidemiological studies in gastroenterology. It is estimated that these characteristic digestive disorders affect between 5% and 10% of individuals in the general population, with a major impact on their quality of life [1,2,3]. Ethnicity, gender, stress and anxiety seem to influence this prevalence [1,4,5]. On the other hand, there is no data for patients followed up in the Chronic Pain Structure. We were therefore interested in screening our patients for this condition.

Method: This is a descriptive cross-sectional quantitative study including patients treated at the Centre de Traitement de la Douleur (Pain Treatment Centre) of the Centre Hospitalier de Luxembourg, from March to August 2024. As part of the consultations scheduled in our department, a multidisciplinary team consisting of a doctor, a nurse and a dietician, administered a questionnaire to the patients followed up. We sought to assess the prevalence of irritable bowel syndrome by looking for the Rome IV criteria, and to compare its impact with that of the initial reason for treatment in the department, supplemented by anthropometric measurements and the level of physical activity.

Results: After 2 months of data collection, 115 patients have already been included. We hope to include a total of 300 to 350 patients to present our results.

Objectives and outlook: Although it is not often a reason for initial consultation in our facilities, our initial results seem to confirm an increased prevalence of irritable bowel syndrome in chronic pain patients compared with the general population. We believe it is important to raise awareness of this condition among carers and to encourage pain centres to develop their own management programmes for this syndrome, taking advantage of their multimodal, multi-professional culture.

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**SPC\_04.1 - Interventional management of facial pain: A retrospective case series**

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Summary

Interventional management of facial pain: A retrospective case series

Trigeminal neuralgia is most commonly due to vascular compression of the trigeminal nerve (tic douloureux) and is potentially amenable to surgical intervention [1]. Atypical facial pain can result from other aetiologies involving the trigeminal nerve, including infection, injury, autoimmune, iatrogenic and idiopathic disease, and can be more difficult to treat if the patient does not respond to drug therapy [2].

We present a case series of 20 patients with atypical trigeminal neuralgia who had inadequate pain relief with drug treatment. Patients presented with pain in various distributions of the trigeminal nerve, 75% with unilateral pain and 25% with bilateral pain. Approximately half (n = 11) of the patients reported triggering events, including post-surgical, traumatic or post-infectious aetiologies, while the remainder (n = 9) had no identifiable triggering aetiology. Patients underwent infraorbital, supraorbital, supratrochlear, zygomaticotemporal or trigeminal nerve blocks under ultrasound, depending on the distribution of pain. For nerve blocks, 40 to 80 mg of methylprednisolone and 1 to 3 ml of 2% lidocaine were used [4] [5] [6]. Most patients were treated with a trigeminal nerve block performed in the pterygopalatine fossa under ultrasound [7]. Although the efficacy and duration of relief varied between patients, on average they experienced an 80% improvement in their pain over a 3-month period, leading to a significant improvement in their quality of life [8]. The results suggest that interventional techniques such as ultrasound-guided nerve blocks are an option for significant pain relief in patients with severe facial pain that is not adequately relieved by medication or is unsuitable for surgery, but may require relatively frequent repetition of these procedures.

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**SPC\_04.2 - The beneficial effects of music therapy on pain and anxiety in children undergoing paediatric dialysis: an integrative approach.**

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Summary

Through various interventions at Montpellier University Hospital, in partnership with the paediatric algology team, we set out to explore the positive effects of music therapy on pain and anxiety in children undergoing paediatric dialysis [1][3]. Focusing on an integrative approach, we examine how music therapy can improve the overall well-being of young patients facing complex medical challenges including iterative pain care in the context of chronic illness [4].

We discuss the physiological and neuropsychological mechanisms underlying these beneficial effects, highlighting the influence of music therapy on physiological responses to stress as well as on executive functions such as attention, planning and inhibition[3].

Through concrete examples and case studies, we can illustrate how music therapy can offer a space of relief and comfort to children on paediatric dialysis, helping them to cope with pain and anxiety in a holistic way. Finally, we explore the practical implications of these findings for healthcare professionals and suggest avenues for the wider integration of music therapy into paediatric care.[4]

The aim of this poster is to raise awareness of the importance of music therapy as a complementary tool in the care of children undergoing paediatric dialysis, while highlighting its many benefits for their emotional and psychological well-being.

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**SPC\_04.3 - Setting up and feasibility of therapy groups based on acceptance and commitment therapy (ACT) for patients with endometriosis and chronic pelvic-perineal pain: a multi-professional and multi-disciplinary experiment.**

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Summary

Introduction: Acceptance and Commitment Therapy (ACT) is part of the 3rd wave of behavioural and cognitive therapies (CBT)[1]. Its aim is to modify the subject's relationship with his or her symptoms, and to improve psychological flexibility. Therapeutic work focuses on six areas (Hexaflex): cognitive defusion and acceptance of emotions and sensations (openness to experience), contact with the present moment and the observing self (present moment), clarification of values and action towards values (committed action). ACT has been shown to be beneficial in cases of chronic pain, reducing depression, anxiety and catastrophising, and improving acceptance of pain, psychological flexibility and functioning [2,3]. Few studies have been carried out on patients with endometriosis [4,5]. Aims: to set up an ACT-based group therapy programme for patients with endometriosis and chronic pelvic pain. The initial aim was to assess the practical feasibility of this programme. Methods: The programme comprises 12 workshops, with psycho-education (chronic pain, pelvic anatomy and endometriosis, nutrition, physical activity), and ACT/TCC therapy: thoughts and emotions (acceptance and defusion), fighting against...or moving towards oneself, values and resources, how to put myself into action (committed action), I observe and I welcome (present moment, openness to experience), accompanying someone who is suffering, and sexuality (with partners). Each session includes exercises in sessions, metaphors and prescriptions for tasks between workshops. The team includes the programme's promoter (Dr Berkelmans, ACT therapist), the department's psychologists trained in CBT and currently undergoing ACT training, the gynaecologists and sexologist (anatomy, sexuality), an algology nurse and an algology rehabilitation doctor (Dr Menet). These are small groups of 4 to 5 patients, guaranteeing each one a place to talk. Each patient is seen in an individual consultation beforehand to assess her eligibility, and 1 month after the end of the programme (Dr Berkelmans). Eligible patients were those with cognitive meltdown and significant avoidance and struggle behaviours. Patients with severe psychiatric illnesses or who did not wish to work in a group were excluded. Results: Our experience confirms the feasibility of a group ACT therapy programme for these patients. The patients seen for the time being 1 month later retained their learning and continued to do exercises at home. The limitation is the difficulty of including patients, due to scheduling conflicts. The originality of this programme lies in its multi-disciplinary, multi-professional and integrative dimension. The future objective is to evaluate this programme using specific questionnaires, before, 1 month after and 6 months after.

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**SPC\_04.4 - Return of chronic pain patients who have benefited from an adapted physical activity programme as part of sport on prescription**

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Summary

Introduction: According to Walsh et al [1], one in three people will experience an episode of chronic pain in their lifetime. This pain has multiple repercussions on the patient's life and is often the cause of a decline in quality of life (family, social and professional impact) [2,3]. More and more non-medicinal solutions are being proposed (acupuncture, hypnosis, relaxation, physical activity, TENS, psychotherapy, mesotherapy, etc.). Among these, physical activity occupies an important place as it has been recognised as a first-line treatment [4]. Since the 2016 law on the modernisation of the healthcare system, supplemented by the law of 2 March 2022 aimed at democratising sport, adapted physical activity (APA) can be prescribed by a general practitioner or specialist in the context of a chronic pathology, a risk factor or a loss of autonomy. Methodology: We were therefore interested in the impact that an APA programme could have on chronic pain patients. This single-centre retrospective study was conducted in a hospital sports medicine department, recognised as a Maison Sport Santé and a Centre Prescri'forme (Ile-de-France sports and health programme). It was based on a self-assessment by pain patients who had received PAA sessions on medical prescription. An online form was sent to them by email. 109 patients responded. Results: The intensity of the pain felt before starting APA was assessed mainly with a numerical rating of 7/10. Most patients completed more than 10 sessions. Post-programme, 80% of patients noted a reduction in their pain. Among them, some felt that their pain had first increased and then decreased. In terms of medication, more than half the patients (54%) reduced their intake of painkillers. Using the Clinical Global Impression of Change (CGIC) score, patients stated that their state of health had improved slightly (44%), strongly (37%) or very strongly (13%). In addition, APA had a positive impact on: physical fitness, general mood, social interaction, self-confidence and self-esteem, stress and anxiety, sleep, attention and concentration - all parameters that can influence the perception of chronic pain [3]. Conclusion: According to J.A. Markenson [3], "effective therapy (for chronic pain) should aim not only to reduce or eliminate the cause of the pain, but also to rehabilitate the patient physically, socially and psychologically". Adapted physical activity is fully in line with this recommendation and should, wherever possible, be systematically introduced into the care of chronic pain patients.

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**SPC\_04.5 - Benefits of an adapted activity workshop for patients attending a Pain Assessment and Treatment Centre**

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Summary

Introduction

Physical activity not only reduces the intensity of pain1, but also improves many aspects of quality of life. This is an essential element in the management of chronic pain, but few patients are motivated to take up this offer, which is customary in chronic pain consultations.

Objectives

The aim of this study is to demonstrate the interest and feasibility of introducing an adapted physical activity (APA) workshop for patients being monitored for chronic pain, particularly those suffering from rheumatological diseases.

Methods

Patients undergoing treatment for chronic pain at the Centres d'Études et Traitement de la Douleur at the Cochin (Paris) and Saint Antoine (Paris) hospitals will be offered a cycle of 5 one-hour sessions of adapted physical activity. Pain intensity and quality of life will be assessed before and after the end of the cycle. Patient satisfaction will be monitored. At 3 months from the end of the APA cycle, the patients' commitment to and use of physical activity will be recorded. The programme will also be adapted to patients' needs and physical abilities.

Results

At this stage, the first groups are undergoing the ABS cycle, and the results will be available in November 2024.

A standardised programme with the possibility of individualisation will be defined, to be developed in other chronic pain structures, for patients suffering from rheumatological diseases but also more widely for all chronic pain patients.

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**Selected E poster abstracts**

**PO\_01 - Long-term safety, tolerability and efficacy of atogepant as a preventive treatment for migraine: interim analysis of the 156-week, open-label, long-term tolerability extension of a multicentre phase 3 study**

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Summary

Objective: To evaluate the long-term safety and efficacy of atogepant as a preventive treatment for migraine.

Rationale: Atogepant is an oral calcitonin gene-related peptide receptor antagonist approved for the preventive treatment of migraine. ELEVATE and PROGRESS were phase 3, randomised, double-blind, placebo-controlled trials evaluating atogepant for the preventive treatment of episodic migraine (EM) in participants with an inadequate response to 2 to 4 classes of conventional oral preventive therapy (ELEVATE), and for the preventive treatment of chronic migraine (CM) (PROGRESS).

Method: This interim analysis (September 14, 2023) of the 156-week, open-label, long-term safety extension study evaluated atogepant 60 mg once daily as a preventive treatment for ME or CD in participants who completed ELEVATE or PROGRESS, respectively. The long-term safety, tolerability and efficacy of atogepant in participants who completed week 48 or discontinued treatment prematurely were evaluated. Efficacy was assessed during the first 48 weeks.

Results: The population in this interim safety analysis comprised 595 participants (ELEVATE, n=270; PROGRESS, n=325). The mean duration of exposure to atogepant was 496.5 days. Treatment-related adverse events (AEs) occurred in 79.0% of participants; most were mild to moderate and not related to atogepant. The most common AEs (≥5%) were COVID-19 (28.7%), nasopharyngitis (10.9%) and constipation (8.2%). One death was attributed to asphyxia due to a house fire. Other serious AEs occurred in 5.5% of participants and were not related to atogepant. AEs leading to discontinuation occurred in 5.9% of patients. ALAT/ASAT levels ≥3 x normal values were observed in 2 participants; none met Hy's law. The least squares mean change in monthly migraine days from baseline was -5.5 (ELEVATE) and -10.9 (PROGRESS) at weeks 13-16 and was maintained for 48 weeks. Similar results were observed for the number of monthly headache days, as well as for the use of crisis treatments.

Conclusion: The overall safety results were consistent with the known safety profile of atogepant. No new safety signals were identified. The improvement in efficacy was maintained for 48 weeks.

**PO\_02 - Effectiveness of ethosuximide on abdominal pain associated with irritable bowel syndrome**

N. Kerckhove 1, C. Melchior 2, M. Chambaz 3, F. Zerbib 4, F. Mion 5, S. Roman 5, F. Goutorbe 6, B. Coffin 7, H. Duboc 7, T. Piche 8, B. Pereira 1, C. Duale 1, M. Dapoigny 1, J. Scanzi 1

1 Chu Clermont-Ferrand - Clermont Ferrand (France), 2 Chu Rouen - Rouen (France), 3 Chu Rennes - Rennes (France), 4 Chu Bordeaux - Bordeaux (France), 5 Hospices Civils Lyon - Lyon (France), 6 Ch Cote Basque - Bayonne (France), 7 Ap-Hp Louis Mourier - Paris (France), 8 Chu Nice - Nice (France)

Summary

Introduction

Irritable bowel syndrome (IBS) is characterised by a combination of chronic abdominal pain and intestinal transit disorders in the absence of any identifiable organic disease. It is the leading cause of consultation in gastroenterology, with an estimated prevalence of 10-15% in industrialised countries. Its chronicity has a profound impact on patients' quality of life, and results in considerable healthcare costs. Current medical treatments are not very effective, making it a public health problem. Recent studies have shown a pronociceptive role for T-type channels in abdominal pain. The aim of this study (IBSET) was therefore to assess the therapeutic potential of ethosuximide, an anti-epileptic and T-type channel inhibitor, on the intensity of abdominal pain in patients suffering from IBS.

Methods

The IBSET study is a randomised, controlled, parallel, double-blind, multicentre proof-of-concept study. It is the first clinical trial to evaluate the efficacy and safety of ethosuximide in IBS-related abdominal pain. All adults suffering from IBS and reporting abdominal pain (intensity ≥4/10) for at least 3 months were included in the study. It was planned to include 170 patients to receive either ethosuximide or placebo for 12 weeks. The primary endpoint was the responder rate (pain reduction ≥30% associated with a subject global assessment score of relief ≥4/5).

Main results and conclusion

161 patients were included and 124 randomised (64 ethosuximide and 60 placebo, ITT population) between 2018 and 2022. Among the 2 groups, 28 patients completed their treatment in the ethosuximide group (44%, 18 discharges for AEs and 18 for major deviations) versus 41 in the placebo group (68%, 12 discharges for AEs and 7 for major deviations), which represents our PP population. The ITT analysis showed no statistical difference in responder rates between the 2 groups (23.4% for ethosuximide and 16.7% for placebo, p=0.47). The PP analysis showed a statistical and clinical difference between the 2 groups with a higher responder rate in the ethosuximide arm (55.6%) compared to placebo (24.4, p=0.019).

In conclusion, given the lack of efficacy superior to placebo (ITT analysis), ethosuximide is not recommended as first-line treatment for pain associated with IBS. Nevertheless, in the absence of a recommended pain treatment for IBS, ethosuximide remains an interesting therapeutic alternative, particularly for patients who tolerate it (PP analysis with an nnt of 3.2). Our study also highlights the clinical interest in developing more specific T-type channel antagonists to improve tolerance.

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**PO\_03 - Chronic pain is a risk factor for the onset of Alzheimer's disease: a national cohort study using administrative data (SNDS)**

N. Kerckhove 1, C. Melchior 2, M. Chambaz 3, F. Zerbib 4, F. Mion 5, S. Roman 5, F. Goutorbe 6, B. Coffin 7, H. Duboc 7, T. Piche 8, B. Pereira 1, C. Duale 1, M. Dapoigny 1, J. Scanzi 1

1 Chu Clermont-Ferrand - Clermont Ferrand (France), 2 Chu Rouen - Rouen (France), 3 Chu Rennes - Rennes (France), 4 Chu Bordeaux - Bordeaux (France), 5 Hospices Civils Lyon - Lyon (France), 6 Ch Cote Basque - Bayonne (France), 7 Ap-Hp Louis Mourier - Paris (France), 8 Chu Nice - Nice (France)

Summary

Introduction

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**PO\_04 - Tele-expertise, a tool to help manage chronic pain patients in general practice: Scoping review**

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Summary

Objectives: We conducted a scoping study to evaluate tele-expertise as a tool for the management of chronic pain patients in general practice. The aim was to review the existing literature on this application of telemedicine, and to assess the advantages and disadvantages when it is implemented.

Material and method: This scoping study looked at all articles published between January 2010 and December 2022. It queried several search engines (Pubmed, Science direct, Cochrane, Web of Science, Google scholar) as well as the bibliographies of articles selected according to PRISMA-Scr criteria.

Results: A total of 14 references were included (8 quantitative studies [1-8], 3 qualitative studies [9-11] and 3 mixed-methodology studies [12-14]). Three distinct applications of tele-expertise were evaluated: remote case discussions with telementoring, requests for advice via telephone consultations, and requests for advice via a secure web platform. The main advantages highlighted were an overall improvement in GPs' knowledge of chronic pain, better management of sometimes complex situations, and improved communication between algologists and general practitioners, thereby optimising patient care. Limits to use depend on how the system is implemented: potential loss of revenue, problems of connectivity and accessibility to platforms.

Conclusion: The management of chronic pain is now one of the major public health issues. Although few studies are available on tele-expertise in chronic pain, the methods of application are vast and the results are encouraging. Studies on patient perceptions and economic analyses are still needed.

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**PO\_05 - Value of a topical magistral preparation of 10% amitriptyline in localised peripheral neuropathic pain**

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Summary

CONTEXT AND OBJECTIVES

The management of neuropathic pain remains difficult and warrants a range of therapeutic approaches [1]. A summary of French recommendations published in 2020 [2] suggests 3 lines of treatment. Oral pharmacological treatments can often be a source of undesirable effects, which become apparent before the recommended therapeutic doses have been reached [3]. In this context, the advantage of topical treatments is obvious. Lidocaine in 1st line and capsaicin in 2nd line have their place.

The aim of our observation was to position amitriptyline as a 10% magistral preparation in the topical treatment of localised peripheral neuropathic pain in patients already receiving the first 2 lines of treatment according to the 2020 recommendations.

Amitriptyline is a tricyclic antidepressant with proven systemic efficacy in the treatment of neuropathic pain. Locally, it has membrane-stabilising properties by inhibiting sodium channels in primary afferents [4].

MATERIALS AND METHOD

Open-label, prospective, pre/post treatment, non-comparative, uncontrolled observational study.

Patients with localised peripheral neuropathic pain, with positive DN4, already receiving 1st and 2nd lines of treatment according to the 2020 French recommendations

Statistical analysis of self-questionnaires: NPSI, SF12, and pain assessment (EN): before topical treatment, and after 1 month.

Apply a dab of 10% amitriptyline cream twice a day to the painful areas.

RESULTS

32 patients included, with a median age of 60 (range 29 to 88)

- average drop in NE of 2 points

- All NPSI items improved by an average of 33.7%: a minimum of 14% for electric shocks, and a maximum of 60% for the duration of pain.

- SF12: very slight improvement in quality of life, mental state and vitality.

- absence of side effects linked to systemic absorption.

CONCLUSION

Our observational study evaluating the value of topical treatment with a magistral preparation of 10% amitriptyline for localised peripheral neuropathic pain showed significant benefits in a small number of patients in terms of the EN, SF12 and, above all, NPSI scales, and an advantage in avoiding systemic adverse effects associated with oral administration. Our conclusions are consistent with those of other authors [5]. Effectiveness depends in particular on diffusion out of the bases in magistral preparations and penetration into the skin [6], as well as on the analgesic placebo effect which activates the same brain areas as drug substances (a patient expecting a positive result attenuates his perception of pain) [7].

This treatment would benefit from a wider observational analysis, and possibly integration into a dedicated multi-professional and multimodal therapeutic project.

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**PO\_06 - Benefits of transcutaneous electrical nerve stimulation (TENS) in hyperalgesic hereditary palmoplantar keratoderma (HPK)**

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Summary

CONTEXT AND OBJECTIVES

The management of neuropathic pain remains difficult and warrants a range of therapeutic approaches [1]. A summary of French recommendations published in 2020 [2] suggests 3 lines of treatment. Oral pharmacological treatments can often be a source of undesirable effects, which become apparent before the recommended therapeutic doses have been reached [3]. In this context, the advantage of topical treatments is obvious. Lidocaine in 1st line and capsaicin in 2nd line have their place.

The aim of our observation was to position amitriptyline as a 10% magistral preparation in the topical treatment of localised peripheral neuropathic pain in patients already receiving the first 2 lines of treatment according to the 2020 recommendations.

Amitriptyline is a tricyclic antidepressant with proven systemic efficacy in the treatment of neuropathic pain. Locally, it has membrane-stabilising properties by inhibiting sodium channels in primary afferents [4].

MATERIALS AND METHOD

Open observational study, prospective, pre/post treatment, non-comparative, non-controlled.

Patients with localised peripheral neuropathic pain, with positive DN 4, already receiving 1st and 2nd lines of treatment according to French recommendations in 2020

Statistical analysis of self-questionnaires: NPSI, SF12, and pain assessment (EN): before topical treatment, and after 1 month.

Apply a dab of 10% amitriptyline cream twice a day to the painful areas.

RESULTS

32 patients included, with a median age of 60 (range 29 to 88)

- average drop in NE of 2 points

- All NPSI items improved by an average of 33.7%: a minimum of 14% for electric shocks, and a maximum of 60% for the duration of pain.

- SF12: very slight improvement in quality of life, mental state and vitality.

- absence of side effects linked to systemic absorption.

CONCLUSION

Our observational study evaluating the value of topical treatment with a magistral preparation of 10% amitriptyline for localised peripheral neuropathic pain showed significant benefits in a small number of patients in terms of the EN, SF12 and, above all, NPSI scales, and an advantage in avoiding systemic adverse effects associated with oral administration. Our conclusions are consistent with those of other authors [5]. Effectiveness depends in particular on diffusion out of the bases in magistral preparations and penetration into the skin [6], as well as on the analgesic placebo effect which activates the same brain areas as drug substances (a patient expecting a positive result attenuates his perception of pain) [7].

This treatment would benefit from a wider observational analysis, and possibly integration into a dedicated multi-professional and multimodal therapeutic project.

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**PO\_07 - Place of locoregional analgesia in the prevention of chronic postoperative pain in carcinological breast surgery.**

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Summary

Introduction: Chronic post-surgical pain is a complex entity with an overall incidence of between 20 and 50%. Its assessment and treatment remain generally unsatisfactory. A multidisciplinary preventive strategy, involving a multimodal analgesia approach, is currently the "gold standard" for the management of such pain. The aim of this study was to evaluate the impact of ultrasound-guided spinal erector block, integrated into a multimodal analgesia protocol, on the prevention of chronic post-operative pain in carcinological breast surgery. Patients and methods: Over 150 patients were randomised into two groups (multimodal analgesia group including spinal erector block: ALR+ and conventional analgesia group: ALR-) and followed up until the sixth postoperative month. Various aspects of chronic pain were assessed, in particular incidence, severity and neuropathy. Results: After a recruitment and follow-up period, 153 patients (71 patients in the ALR+ group, 82% in the ALR- group) were analysed at three and six months respectively. The incidence of chronic pain after total mastectomy with lymph node dissection was 33.1% at month 3 and 27.3% at month 6. For all patients with chronic pain, the prevalence of neuropathic pain was estimated at 41.3% at the third month and 33.5% at the sixth month. The frequency of the neuropathic component decreased over time in both groups, but improved more rapidly and more markedly in the ALR+ group. Overall patient satisfaction with management of acute postoperative pain was significantly higher in the ALR+ group (85%). Conclusion: The erector spinae block, as part of a multimodal analgesia approach, appears to have a favourable impact on preventing chronicisation of postoperative pain, on improving intensity scores and on the neuropathic component of pain in breast cancer surgery. Similarly, better control of acute pain was confirmed by a high level of patient satisfaction. Key words: chronic post-surgical pain, spinal erector block, multimodal analgesia, neuropathic pain, breast surgery.

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**PO\_08 - Prevalence of chronic pain in people with dementia: National cohort study using administrative health data (SNDS)**

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Summary

Objective: Alzheimer's disease or a related dementia disturbs the perception of pain and reduces the ability to report it, leading to its underestimation by practitioners and suboptimal medical management. The aim of this study was to estimate the prevalence of all types of chronic pain in people with dementia.

Method: Nationwide cross-sectional study based on administrative health data (SNDS) from French residents living in a community or retirement home. All people with dementia (treated with cholinesterase inhibitors or memantine, or with a long-term diagnosis/illness associated with dementia) aged over 40 were included and matched with a control sample without dementia.

The capture-recapture method was used to estimate the prevalence of chronic pain. People treated with analgesic medication for ≥6 consecutive months or with a medical diagnosis of chronic pain (ICD-10 codes) or referred to a pain treatment centre were considered as suffering from chronic pain.

Results: A total of 48,288 people were included, of whom 16,096 had dementia and 32,192 did not. The estimated prevalence of chronic pain in people with dementia was 57.7% to 57.9%, and slightly higher than in the sample without dementia (49.9% to 50.4%, p<0.001). Older age and female gender were also associated with a higher prevalence of chronic pain.

Conclusion: The prevalence of chronic pain in people with dementia is at least equal to or higher than in people without dementia. This finding should draw practitioners' attention to the need for effective assessment and management of pain in this population, which has difficulty expressing and experiencing it.

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**PO\_09 - Isometric Endurance of Trunk Muscles and Anthropometric Parameters in Chronic Common Low Back Pain: What Relationship?**

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Summary

Introduction

Data in the literature suggest a decrease in isometric endurance of the trunk muscles in chronic low back pain (CLBP). However, few studies have assessed the relationship between anthropometric parameters and spinal muscular endurance.

Methods

A descriptive, cross-sectional, controlled study conducted over a period of 8 months. Thirty women were included, divided into two groups of equal numbers: a low back pain group (LBP) and a control group (CG). The anthropometric parameters assessed were weight, height, BMI and waist circumference. Isometric endurance of the trunk muscles was assessed using the Shirado test for trunk flexors and the Sorenson test for trunk extensors.

Results

The mean age was 37+/-14 years in the GC compared with 37.27+/-13.24 years in the GE. The difference in trunk muscular endurance between the two groups was not significant. There was a negative correlation between the Sorensen test and BMI (p<0.05) in the GE. There was no correlation between BMI and the Shirado test, nor between waist circumference and trunk muscular endurance.

Conclusion

BMI appears to influence isometric endurance of trunk muscles in women with chronic low back pain.

**PO\_10 - Hôpital de mon doudou -Dolokids Hospital Couple Child CHU Grenoble**

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Summary

introduction :

In paediatrics, the prevalence of pre-operative anxiety is between 40 and 60%. The greater the anxiety, the greater the correlation with higher pain scores and postoperative behavioural problems [1,2].

Managing this anxiety during the hospital stay is not enough, and we have developed a patient pathway with the following prerogatives: less unknown = less anxiety = less pain.

Description of the action :

Today, therapeutic communication and distraction techniques are increasingly used. As a result, we are able to understand the psychological state of our patients and provide them with the best possible support throughout their treatment.

Having the opportunity to prepare with them for their hospitalisation, to anticipate how the day (and the days before and after) will unfold, the care they will receive and the people they will meet, enables the child and their parents to project themselves better. A bit like programming a computer, we have the ability to associate and anchor a positive emotional charge that is conducive to the smooth running of care on the big day.

Thanks to the Pharmavie® association, we have set up a nurse anaesthetist's consultation room as a mini operating theatre where we offer a cuddly toy, Toudou®, with which we explain and play during anaesthetic induction. We also offer other tools: film, photo book, comic strip, games booklet.

interest of the action:

Preparing for the operation through play takes on its full meaning. Using a transitional object (Toudou®), the child experiences what he or she will experience later in hospital. The child becomes an active participant in the treatment, rather than a mere spectator. They will then come back on the big day with a real role to play that they will find easier to take on.

The hôpital de mon doudou project is part of an educational approach that aims to :

Reduce stress and pain in the perioperative period.

Improving care for children and their parents to make hospitalisation easier.

To encourage a better memory trace, and thus facilitate any subsequent treatment.

Conclusion:

The "hôpital de mon doudou" project helps to ensure that the entire perioperative period runs smoothly. This educational tool is appreciated by children, families and professionals alike. It is currently being evaluated (Clinical Investigation Centre - Grenoble Alpes University Hospital).

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**PO\_11 - Evaluation of a new ANTALOC analgesic protocol at the Centre Simone Veil- CHU de Nantes for patients having an abortion under local anaesthetic**

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1 Chu Nantes - Nantes (France)

Summary

Introduction: Voluntary termination of pregnancy under local anaesthetic is a frequent procedure which can be painful. There is no consensus on the management of pain during this procedure, and analgesic protocols vary from one orthopaedic centre to another in France. Several risk factors for pain during abortion under local anaesthetic have been identified in the literature. We conducted a retrospective/prospective study to evaluate a new analgesic protocol introduced at the Centre Simone Veil at Nantes University Hospital.

Materials and methods: Retrospective/prospective study carried out at the Centre Simone Veil of the Nantes University Hospital from September to December 2022 and from May to September 2023. During the first period, the women received the old analgesic protocol in force. During the second period, the practitioners looked for the presence of factors predictive of pain during the pre-abortion consultation. Depending on these factors, the patients then received a simple or reinforced analgesic protocol. Pain was assessed during the abortion using a numerical scale from 0 to 10: maximum pain during the procedure and pain at the end of the procedure were recorded. The main objective of this study was to reduce maximum EN by 20%.

Results: 301 patients were included in this study, 146 received the old protocol and 155 the new analgesic protocol. The median age was 30 years [17.0; 42.0], with a mean term of 9 weeks' gestation. Social and medical characteristics were comparable between the two groups. The mean maximum EN was 5.4, similar in both groups. The EN at the end of the procedure was reduced by 23%. Factors predictive of pain were not found after adjustment. No immediate or delayed side-effects were observed following the introduction of the new protocol.

Conclusion : The new analgesic protocol reduced pain at the end of the procedure by 22%, but had no effect on maximum pain during the procedure. This study served as a reminder of the factors predictive of pain during LA abortions, and as an integral part of pre-abortion counselling. This has helped to improve service practices within a multidisciplinary team, with a view to optimising patient care during the abortion procedure. This study helped to clarify the importance of non-medicinal measures. A more global reflection was carried out on the evaluation of pain using a numerical scale and on the interest of questioning patient comfort.

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**PO\_12 - Pain management and opioid analgesics: Focus on the knowledge and needs of patients in chronic pain facilities in the PACA region**

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Summary

Introduction

Chronic pain requires a comprehensive, patient-centred approach. The aim is to help them gain a good understanding of themselves, their illness and the treatment methods available, so that they can acquire a degree of autonomy in managing their pain. In this sense, the education of chronic pain patients is fundamental. A survey was carried out among patients monitored by chronic pain structures in the PACA region to assess their knowledge of pain management, opioid analgesics and their needs.

Methods

The aim of the POP programme "Prevention and risk reduction of opioid-related overdoses in the PACA region" is to improve care for patients at risk of overdose and facilitate the distribution of naloxone. One of the project's priorities targets patients/users. As part of World Pain Day (week of 16 October 2023), initiatives have been set up in the 20 pain facilities in the PACA region: an assessment of patient knowledge via an anonymous self-questionnaire and the distribution of a flyer on the golden rules of opioid analgesics. For the questionnaire, patients were given a choice of pre-listed answers, with only one question in free text (undesirable effects).

Results

A total of 456 questionnaires from 8 facilities were returned. The majority of patients (79%) expected their pain to improve by 75% or more. Among patients, 68% have concerns about the use of painkillers, and a quarter of these patients do not discuss their concerns with a healthcare professional. Patients have a good knowledge of non-medicinal approaches (82%). With regard to opioid analgesics, 2/3 of patients knew that they were not routinely used to treat pain. The top 3 adverse effects (AEs) cited were dependence (24%), impaired alertness (16%) and nausea (11%). Only 38% of patients were aware of the existence of measures to prevent AEs, and only 8% were aware of the existence of ready-to-use naloxone. Almost all the patients questioned expressed a need for information about their medicines. These information needs concerned the prevention and management of AEs, as well as interactions.

Conclusion

The survey revealed that patients' expectations regarding pain relief were overestimated. Patients also expressed concerns and needs regarding opioid drugs, in particular the side effects. This survey will enable us to create communication tools tailored to their needs.

**PO\_13 - Development of a decision tree for the correct use of analgesic tools (MEOPA, virtual reality hypnosis and musiciotherapy) during pain caused by care at the Saint hélier foundation**

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Summary

Introduction: the core business of the Fondation Saint-Hélier is the rehabilitation and support of people with disabilities, whatever their age. Prevention and medical support are essential to each care programme, in order to provide the best possible care for people who are frail, elderly or disabled at some stage in their lives, by considering all available solutions. As a pioneer and a visionary, the foundation's aim is to continue to integrate new technologies into the service of quality healthcare, which is undergoing a major transformation. At the instigation of the establishment's CLUD, the Commission Médicale d'Établissement has approved the institutional use of a number of medicinal and non-medicinal analgesic tools.

Objective: the aim of this literature review is to produce a recommendation for optimising the use of 3 available tools (MEOPA, virtual reality hypnosis and music therapy) when acute pain is caused by care at the Fondation saint Hélier.

Results: No publications compiling the results of these three solutions have been found. However, there are numerous studies evaluating the efficacy of each tool in isolation [1] [2] [3]. The scientific data obtained was supplemented by all the information obtained from the professional practice evaluations carried out on the use of MEOPA and the HypnoVR headset at the Fondation Saint Hélier.

Conclusion: MEOPA, virtual reality hypnosis and music therapy have been shown to be effective in the treatment of acute pain. We have drawn up a recommendation for optimising their use when acute pain is caused by care at the Fondation Saint Hélier, taking into account the type of care provided, the patient's sensory preferences and the organisational arrangements for each of these tools.

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**PO\_14 - Kontinue**

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Summary

Ketamine is regularly used in the management of chronic pain patients.

In recent years, numerous studies have been published on ketamine for the treatment of chronic non-cancer pain with different dosages, routes of administration, infusion durations Michelet et al., 2018; Pickering et al., 2018). With controversial results.

Several studies have been carried out in France (OKAPI, KETAPAIN) to determine the practical details of use and effective doses.

With regard to routes of administration, a group of experts has identified intravenous infusion at doses of 0.5 to 0.9 mg/kg/d for four days of treatment as preferable (Voute et al.,2021).

The aim of the Kontinue study is to evaluate the efficacy of continuous infusion of ketamine combined with magnesium sulphate in the management of patients suffering from chronic pain.

Method: This was a prospective monocentric observational study based on the collection of validated self-questionnaires (EN- NPSI-HAD-SF12) carried out at the Princess Grace Hospital in Monaco. The aim was to determine the efficacy at one month of Ketamine injection by continuous intravenous infusion over 4 days at a dose of 0.5 mg/kg/day, combined with magnesium sulphate 1000 mg/day.

Data were collected on 80 patients, with the primary endpoint being improvement in EN and global impression of change (CGI-C) at day 30. Secondary endpoints were improvement in neuropathic pain (NPSI), benefit on quality of life and mood (SF12; HAD), and persistence of benefit at day 60.

The improvement in the numerical scale will be compared with 0 using a paired-series Student's t test. The secondary criteria (responder patients) will be analysed using Chi-2 tests for qualitative variables or an analysis of variance for quantitative variables after checking the conditions of application (Gaussian distribution, equality of variances). The analysis will be carried out using SAS.

Clinical Trials Registry :Clinical trial NCT06131970

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**PO\_15 - Does intraoperative monitoring of nociception reduce pain and postoperative opioid consumption? A systematic review of the literature with meta-analysis of randomised controlled trials.**

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Summary

Background: Autonomic nervous system-based monitoring of nociception has been reported to reduce intraoperative opioid consumption. However, there are still insufficient data on postoperative events. We therefore conducted a systematic review and meta-analysis to investigate the effect of intraoperative nociception monitoring on pain, opioid consumption and postoperative complications.

Methods: From 14 July to 15 August 2023, we searched the following databases, registries and grey literature: Cochrane Library, EMBASE, Google Scholar, LILACS, PubMed, Clinical Trials, abstracts presented at the ASA and ESAIC annual meetings, and previous meta-analyses. The only studies included were RCTs, of patients of all ages, under general anaesthesia, comparing autonomic nervous system-based nociception monitoring with standard treatment, who reported pain, opioid consumption or postoperative complications. The three authors independently assessed the risk of bias according to the methods described in the Cochrane Handbook for Systematic Reviews of Interventions. A meta-analysis was performed using RevMan 5.4.1 software. Continuous data are presented as mean difference or standardised mean difference and IC95%, dichotomous data are presented as relative risk and IC95%. All results were analysed using a random effects model.

Results: 34 RCTs were included, with 2559 patients in total, corresponding to the PICO criteria above. Morphine consumption in the ICU was significantly reduced in the monitoring group, mean difference -0.47 mg, IC95% (-0.64 to -0.30), as was consumption at 24 hours, mean difference -2.56 mg, IC95% (-4.01 to -1.11), although the difference was not clinically relevant. Pain in the ICU, PONV, respiratory events, acute urine retention and postoperative delirium did not show statistically significant differences.

Discussion: This study has many limitations, notably inherent in the heterogeneity of the studies included, relating to the diversity of patients, surgical procedures, type of monitoring and standard treatment administered. In conclusion, the observed difference in morphine consumption in the ICU and at 24 hours, although significant, cannot be considered clinically relevant.

Funding and registration: This study was carried out without financial support. It was registered with PROSPERO, under identifier CRD42023490440.

**PO\_16 - Analgesic thoracic epidural after thoracotomy**

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Summary

Introduction :

Pain management is an integral part of the overall quality of care of a patient undergoing surgery. The use of a locoregional analgesia technique in postoperative thoracotomy lobectomy is recommended to improve pain control and promote postoperative rehabilitation. Thoracic epidural analgesia (TPA) combined with general anaesthesia has become the "gold standard" in the management of patients undergoing major thoracic or digestive surgery.

Materials and methods:

The experience of the thoracic surgery department of the CHU/EHU of ORAN over a period of almost 20 years (2004-2024) is that nearly 1200 thoracic epidurals have been performed in patients undergoing thoracotomy who are over 16 years of age. The thoracic epidural is performed before anaesthetic induction. The puncture level is T5-T6 or T6-T7 for thoracic surgery. The space can be identified using the liquid chuck technique (loss of resistance). Pain is assessed using the simplified verbal scale (EVS). Look for side effects (nausea, vomiting, sedation, pruritus, etc.). Products used: morphine 1 mg bolus combined with 0.125% Bupivacaine in an electric syringe. This protocol must be implemented before the surgical incision.

Results :

Failure rate: 03

Success rate: 97

Patients participated actively in respiratory physiotherapy, the removal of the drains was painless, the patients were discharged from the surgical intensive care unit on the floor around d1 d2 and the catheter was removed around d5, resulting in early post-operative rehabilitation.

Discussion and conclusion :

Thoracic surgery can be a painful experience to varying degrees, depending on the type of surgery and the approach used. The use of a technique of locoregional analgesia (LRA) in postoperative lobectomy reduces the consumption of postoperative morphine, whatever the surgical approach, and limits the occurrence of chronic postoperative pain. The majority of studies produced have concerned thoracotomy surgery. Several meta-analyses, each covering more than 10 randomised studies carried out in thoracic surgery, have shown that epidural analgesia (PDA) is more effective than patient-controlled analgesia (PCA) with morphine [1,2].

Another meta-analysis reports a reduction in postoperative pneumonia and in the need for mechanical ventilation [3].

It is therefore important to target effective and safe analgesia and to rigorously assess pain using valid and reliable tools. Thoracic epidural analgesia remains the gold standard of postoperative analgesia, and the thoracic surgery department at the EHU in ORAN is the benchmark. It requires prior training of paramedical staff, who are satisfied with the results.

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**PO\_17 - Self-medication with cannabinoids in patients with chronic inflammatory bowel disease (IBD).**

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1 Editor - Nantes (France), 2 Co-Director - Nantes (France), 3 Co-Director - Nantes (France)

Summary

Crohn's disease and haemorrhagic rectocolitis are two conditions known as chronic inflammatory bowel disease (IBD). IBD causes mainly intestinal symptoms, which can be associated with chronic digestive and extra-digestive pain. To improve their quality of life and relieve their pain, patients sometimes resort to self-medication. For patients, cannabis and its derivatives appear to be an element of choice in this self-medication. This thesis is based on an anonymous epidemiological field study of cannabis self-medication by certain IBD patients via social networks. The results of the survey were analysed to determine the value of self-medication with cannabis and its derivatives in the management of patients suffering from IBD.

Our study describes the actual use of cannabinoids in a sample of 80 IBD patients in various French-speaking countries (France, Belgium and Switzerland). More than a third of the respondents to our questionnaire stated that they had already used cannabis and its derivatives in the context of their illness.

When it comes to improving the digestive symptoms of the various consumers in our study, the results vary. Only anal pain, gas and bloating seem to have been reduced.

Sleep disorders, muscle spasms and joint pain are the symptoms that appear to be best managed by cannabinoid consumption in the patients in our study.

However, 55% of users reported at least one adverse reaction linked to cannabinoid consumption.

Secondly, one of the aims of our study was to assess the impact of cannabinoid use on patients' quality of life and stress. In view of the results, many people found that cannabinoid use had a positive impact on these two variables.

In conclusion, our study enabled us to find out the opinion of a sample of French-speaking IBD sufferers on the subject of self-medication or prescription of cannabis and its derivatives as part of the management of their disease. Those who

The respondents were almost unanimous in their support for the development of cannabinoid prescribing for therapeutic purposes. On the other hand, responses were more mixed on the subject of self-medication, with some commentators highlighting the dangerous nature of self-medication.

It therefore seems important for healthcare professionals to learn more about this subject in order to promote prevention campaigns on cannabis and its derivatives tailored to the general public and to provide specific advice to each patient wishing to use this type of medication.

**PO\_18 - Different pain profiles in a monocentric cohort of children and adolescents with neuromuscular diseases**

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Summary

Introduction: Pain is a frequent problem in children and adolescents with neuromuscular disorders (1,2). Studies on this subject are few in number, are usually focused on a specific neuromuscular disease, and do not collect data from physical examinations (1-3), even though these are often abnormal (motor deficits, deformities).

Methods: We created a systematic assessment of chronic pain in neuromuscular children/adolescents (Lille Assessment of Pain In Neuromuscular children; LAPIN-children), which we used during the follow-up of our neuromuscular patients aged between 6 and 18 years. We analysed the data from these assessments retrospectively in patients with chronic pain and those without pain, excluding patients with acute pain.

Results: 181 patients with different neuromuscular diseases (Duchenne muscular dystrophy, limb-girdle muscular dystrophies, facioscapulohumeral myopathy, congenital myopathies, Steinert's disease, spinal muscular atrophy, peripheral neuropathies) were evaluated between 2022 and 2024. After excluding 11 patients with acute pain, we found 129 patients (71.3%) with chronic pain. The topography and circumstances of chronic pain were influenced by whether the patient was ambulant or non-ambulant: in ambulant patients, chronic pain predominated in the muscles of the lower limbs (thighs, calves), and was mainly observed during exercise and reduced at rest; whereas in non-ambulant patients, it mainly affected the joints (knees, hips), and was triggered by immobility and improved with mobilisation. Undernutrition was associated with chronic pain in non-ambulant patients. The topography of chronic pain was also influenced by the type of neuromuscular disease, and appeared to be associated with the clinical signs of neuromuscular disease, particularly the location of retractions. Pain with neuropathic features, fibromyalgic features or chronic widespread pain was rarely observed, with no difference in distribution between the different types of neuromuscular disease. Analgesics against nociceptive pain were at least partially effective in 70% of cases, with paracetamol being significantly more effective than certain physical measures (massage, application of cold).

Discussion: Chronic pain in children and adolescents with neuromuscular disease appears to be mainly related to excess nociception and mechanical rhythm, and secondary to the various clinical consequences of neuromuscular disease, particularly retractions. Nociceptive pain treatments, particularly paracetamol, often appear to be only partially effective.

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**PO\_19 - Buprenorphine as a strategy for withdrawal from opioid analgesics after failure of gradual withdrawal in patients suffering from chronic non-cancer pain (SEVROP study)**

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Summary

Introduction

Opioid analgesics are frequently prescribed for prolonged use (≥ 3 months) in chronic non-cancer pain, sometimes leading to physical dependence and a range of unpleasant withdrawal symptoms for patients [1]. Currently, there is no validated weaning strategy for these patients. The aim of this study is to evaluate an outpatient weaning strategy using buprenorphine for chronic pain patients who have failed to wean themselves gradually from the opioid analgesic on which they have become dependent.

Methods

All patients began the protocol by gradually reducing their initial opioid dose, according to a 6-month reduction schedule, planned until complete withdrawal. Patients who were unable to complete the withdrawal protocol were offered buprenorphine, at an initial dose of 4 mg/day, to replace their opioid analgesic. This dose could be adjusted according to the patient's tolerance of the treatment and the appearance of withdrawal symptoms in the days following the start of buprenorphine (minimum: 2 mg, maximum: 8 mg). A progressive buprenorphine withdrawal schedule was then proposed to the patient, with the aim of complete withdrawal in a maximum of 9 months. According to Fleming's statistical plan, this criterion was considered to have been met if at least 7 of the 11 patients had an opioid-free urinalysis, including buprenorphine, at the end of the study, thus validating complete withdrawal from all opioids.

Results

Of the 20 patients included in the study, 16 did not succeed in gradually weaning themselves off their opioid analgesic. Of these, 11 agreed to replace their opioid with buprenorphine. Of these, 7 succeeded in weaning themselves off buprenorphine in less than 9 months.

Conclusion

This structured outpatient buprenorphine withdrawal protocol is effective in weaning patients suffering from chronic non-cancer pain off the opioid analgesic on which they had become dependent. The results concerning tolerance, in particular the impact of weaning on pain and other comorbidities, are currently being analysed and will be presented at the congress.

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**PO\_20 - Touch massage in chronic pain**

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Summary

The clinic of chronic pain is a clinic of complexity[1].

Each intervention contributes to the construction of a multi-professional support system enabling patients to deal with their pain as effectively as possible. One of the services offered by the Douai Pain Clinic is week-long hospitalisation, during which drug treatments are introduced. Hospitalisation provides support, a safe envelope [2] that enables the patient to receive essential psychological support. After stressing the importance of the bond in supporting chronic pain sufferers. [3] [4], we propose to study the relationship that patients have with themselves through touch massage.

Touch massage sessions are offered to subjects in order to bring about bodily introspection at different levels: is the touch of another frightening? or is it the contact with the painful area? Can the body feel relaxed? How is this sensation welcomed and felt? Can it be used as an anchor for other techniques such as self-hypnosis or sophrology?

Moreover, Canguilhem G., echoing Leriche R., spoke of "health as the silence of the organs" [5], and what if subjects were to go into contact with the silence of the non-painful parts, beyond the pain, to meet this pulpit, which accompanies everyone on a daily basis, in the purest ignorance. Can the touch massage teach the subject to access these bodily sensations, to take them into consideration like a therapeutic education? [6]

In the same way, can the subject's appropriation of soothing and pleasant bodily sensations during the touch massage contribute to the work of re-encoding the memory of pain [7]?

The purpose of this poster is to study the audit feedback from subjects on the benefits of touch massage, based on a questionnaire drawn up by our working group.

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**PO\_21 - What can a self-esteem workshop do for fibromyalgia patients?**

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Summary

Introduction. Self-esteem is low or very low in fibromyalgia (FM) patients [1]. Low self-esteem increases the effects of stress on physical health [2] and reduces life expectancy [3]. Very few studies have been carried out to improve self-esteem using a dedicated workshop. We propose to study the effect of a workshop on self-esteem integrated into a therapeutic education programme (TPE) for fibromyalgia patients.

Materials and methods. Quantitative retrospective study using anonymised data from 240 patients in the pain department of the Hôpital du Haut Anjou between October 2018 and April 2022. The Rosenberg scale, reference test of self-esteem, HAD, SF12 was chosen by the service. The analysis was carried out using R software under R studio. The workshop consists of projecting 3 to 6 scenes from the 8 films developed in the consultation.

Results. Our study showed statistically significant results on the self-esteem of patients (p<0.001) attending the workshop compared with those absent, with a mean increase in the Rosenberg score from 26.7 to 29.25. The HAD (anxiety/depression), SF12 (quality of life) and Rosenberg (self-esteem) scores were lower in FM patients and significantly correlated with each other (p<0.001).

Discussion. Our study found results consistent with the literature and, according to the state of the art, is the only study of a workshop dedicated to self-esteem in FM involving such a large number of patients. Although this session alone brought about a favourable change from a statistical point of view, the ETP as a whole reinforced this effect in the context of multidisciplinary management.

Conclusion. A self-esteem workshop on FM can improve self-esteem. Given the protective role of self-esteem on physical health, it would be relevant to consider its potential in future programmes concerning health and in particular FM.

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**PO\_22 - Missions and added value of a "Chronic Pelvic Pain" RCP Experience of Médipôle LYON VILLEURBANNE**

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Summary

INTRODUCTION

Chronic pelvic pain is frequently aetiological and difficult to treat, and necessarily multidisciplinary. The latest HAS guidelines recommend regular multidisciplinary meetings with at least two somatic specialists and a psychologist or psychiatrist, all adapted to the pathology encountered (1).The multidisciplinary team at the Médipôle LYON VILLEURBANNE meets once a month and is made up of two specialised algologists, a neurosurgeon, a psychologist, a physiotherapist and an osteopath. The purpose of this communication is to describe the activity of the Lyon multidisciplinary group with these missions and to evaluate its added value.

MATERIALS AND METHODS

From January 2023 to March 2024, 60 patients with an average age of 53.3, including 46 women, initially referred either by a pain centre, an organ specialist or a general practitioner, were referred to the RCP in the presence of the patient after a consultation with an algologist from our pain consultation. The following diagnoses were made: pudendal neuralgia (23.3%), follow-up of operated pudendal neuralgia (33%), coccygodynia (11.6%), pelvic hypersensitivity syndrome (15%), ischial pain (13.3%) and other neuropathic pain (3%).The questions put to the RCP were: confirmation of the diagnosis and indication for surgery for pudendal neuralgia? additional assessment? adaptation of treatment?

RESULTS

The diagnosis and validation of surgery to release the pudendal nerve or implanted neuromodulation to relieve pain were confirmed in 64.5% of cases (rejected in 35.5%), and a change of treatment was proposed in 52% of cases, with continuation of the same treatment in 48% of cases.

DISCUSSION AND CONCLUSION

The HAS guidelines recommend regular multidisciplinary meetings for pain management, and the ARS are increasingly in favour of identifying specific areas of expertise, such as chronic pelvic pain. The added value of our multidisciplinary group, thanks to our face-to-face RCP, lies in its regulatory compliance and its benefits (diagnosis and confirmed surgical management in 64.5% of cases, and therapeutic adaptation in 52% of cases). The patient's presence at this RCP seems to us to be justified and essential.

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**PO\_23 - Implanted Neurostimulation for analgesia (NSI) and post-radiotherapy neuropathic pain**

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Summary

INTRODUCTION

Neuropathic pain in cancer is underestimated, poorly diagnosed and poorly treated. There is still insufficient use of NSI in these situations, even less than for non-cancer neuropathic pain. However, the recommendations published in 2020 [1] suggest this and make no distinction between these two situations.

We will present the case of a patient born in 1959 and describe her history.

PRESENTATION

This patient was treated for squamous cell carcinoma of the uterine cervix with brachytherapy followed by surgical excision. She was considered to be in remission and had no further follow-up. 2 months after the end of her brachytherapy, the 1st pains set in and were treated with the 3 WHO levels and Lyrica. She was only referred to our chronic pain structure (SDC) 7 years after the onset of her pain!

At the 1st consultation, she estimated her pain at 4/10 and during her daily attacks at 10/10. The NDQ4 was 4/10 and the HADS 16/42. She was taking 120mg oxycodone LP, 20-120mg oxynorm LI and 200mg pregabalin every day. The oxynorm LI disconnected her during attacks and had no analgesic action.

Over the next year, various anti-neuropathic therapies were tried without success (Cymbalta, Neurontin, TENStherapy, rTMS, etc.). This time was also needed to gain her trust. NSI was proposed and accepted. A surgical electrode was placed at the T9-T10 level.

Relief was immediate, with the disappearance of the attacks and a reduction in the intensity of the underlying pain, enabling all oral treatment to be gradually reduced and then stopped.

4 years later, she stopped her NSI of her own accord without any painful recurrence. She did not want the generator to be removed and is now monitored annually.

DISCUSSIONS

This case illustrates the inadequacy of cancer pain management and the delay in referring patients to the DCS. Patients suffering from pain caused by active cancer or sequelae of cancer are still often left without proper treatment.

There is still too little use of NSI in France for intractable neuropathic pain, and even less in cancer. Various publications argue in favour of the use of NSI for neuropathic pain in cancer [2, 3, 4, 5].

CONCLUSIONS

The SFETD's cancer pain commission and neuromodulation commission are working together on the role of NSI in neuropathic pain in active cancer and sequelae. We look forward to the conclusions of this work, and hope that it will encourage early referral to the SDC, as well as the use of NSI in such complex and intractable situations.

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**PO\_24 - Introducing non-invasive neuromodulation techniques (tDCS, tsDCS) in a chronic pain facility - What's in it for our patients?**

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Summary

The therapeutic virtues of electric currents and magnetic fields have been known to mankind for thousands of years. In the first written work on the use of electricity in the treatment of pain, the 47 AD medical prescription treatise "Compositiones medicae" by Scribonius Largus, physician to the Roman emperor Claudius, recommends "for unbearable and ancient headaches, the application of a live black torpedo to the site of the pain". Today, modern non-invasive brain stimulation devices use techniques such as repetitive transcranial magnetic stimulation (rTMS) and transcranial direct current stimulation (tDCS) to treat chronic refractory pain.

Today, we have access to numerous studies confirming the safety and efficacy of rTMS and tDCS in the treatment of chronic pain.neuromodulation techniques act on pain through different mechanisms. rTMS and tDCS may have selective indications in the treatment of pain, because of their different mechanisms of action.

We would like to share our experiences of introducing these cortical neuromodulation techniques in our CETD, the Centre d'Etude et Traitement de la Douleur (Centre for the Study and Treatment of Pain) at the Hôpital du Confluent in Nantes. What can these techniques do for our chronic pain patients? What difficulties are encountered when a new technique arrives in an already well-structured CETD, and how can we ensure that this technique is accepted by our medical and paramedical teams? What are the challenges, advantages and promises of these new pain management tools? We will try to provide some answers to these questions and share our experience with our colleagues.

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**PO\_25 - OPTYMED 2: Impact of standardised training for pharmacy teams on pain and pain management**

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Summary

Introduction: A survey of French pharmacies showed that 61% of pharmacists and 39% of pharmacy assistants stated that they had received training in pain management. [1] The aim of the OPTYMED 2 study was to evaluate the benefits of training on the knowledge of pharmacists and pharmacy assistants regarding pain and its management. [2]

Methods: OPTYMED 2 was conducted in 2 phases and included 190 healthcare professionals (HCPs), pharmacists and pharmacy assistants, randomly allocated to 2 groups. During phase 1 of the study, only group 1 received pain training, which also included "at risk" situations (misuse, pregnancy, drug interactions, co-morbidities, ....). During phase 2, the group 1 SDPs were randomly divided into 2 sub-groups according to whether they had access (group 1.1) or not (group 1.2) to post-training summary material. Participants' level of satisfaction (on a scale of 0 to 10) and impact on practice were also assessed.

Results: Phase 1 results showed a higher rate of good response in group 1 (65.2% vs 55.5%; p < 0.001) and a higher score of very good responses (>70%) (35% vs 2%; p < 0.0001). The results by subgroup also showed a higher response rate in group 1.1 than in group 1.2 (43.6% vs 11.8%). Lastly, 46% of group 1 SDPs maintained or increased their scores compared with the first assessment of "at risk" situations. The average level of satisfaction with the training content was good (7±2); 79% of doctors' representatives would recommend it to a colleague, 83% would like to retain access to the documentation and 87% considered that the training had enabled them to improve their ability to manage patients in pain in "at risk" situations.

Conclusion: OPTYMED 2 confirms the benefits of the training in terms of general knowledge of pain and improved identification of at-risk situations/patients. The benefits of this training persist over time. Ongoing training, with access to training and practical tools, is essential for improving pain management in pharmacies and ensuring that knowledge is retained over the long term.

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**PO\_26 - Multi-professional (bio-psycho-social) management of chronic pain sequelae of cancer in a pain day-care centre**

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Summary

Pain management is an essential aspect of quality of life for cancer patients. Approaching chronic pain from a bio-psycho-social model requires the collaboration of specialists and is based on an evaluative, therapeutic, multimodal and re-educational approach. Since October 2021, the Rouen CLCC has been able to provide care for chronic pain resulting from cancer in a Pain-Day Unit [1]. The role of this unit is to explain the concept of chronicity to the patient, carry out an overall assessment, and propose a care pathway tailored to each situation and a personalised therapeutic plan. This makes it possible to monitor the development of hospital services and the "ambulatory shift". This activity meets the needs of patients and professionals in a multi-professional approach.

More than 200 HDJs were carried out, an average of two per week with a constant number of staff. Pathologies included: breast cancer (50% of cases), myeloma, sarcoma and ENT cancers. A multidisciplinary assessment by the algologist, nurse, physiotherapist (80% of HDJ) and/or psychologist (almost 50% of HDJ) is used to propose a personalised treatment plan. These psychological and re-educational approaches are based on sensory-motor work (TENS, adapted physical activity), movement education and the fight against kinesiophobia. Other supportive treatments such as sophrology, hypnosis and socio-aesthetic care may also be combined. Additional professional expertise (nutrition, social assessment, PRM) may be required depending on the needs identified. The dedicated assessment time also allows for coordination with local professionals close to the patient's home (general practitioner, pharmacy, physiotherapy practice, psychologist, etc.). Family support is also possible. The aim of this multi-professional approach is to reduce pain and improve quality of life. It should not be forgotten that chronic cancer pain is multimorphic and progressive [2], requiring a global, multimodal and adaptive approach.

We plan to assess the impact of these initiatives by means of a "patient experience" questionnaire, and by looking at the number of unscheduled consultations and emergency hospital admissions for these patients. As the team expands, this activity could be developed by incorporating digital tools (e-medicine) to assess support care needs more comprehensively.

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**PO\_27 - Algie game: the escape game for overcoming pain**

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Summary

Introduction. The prevalence of chronic pain in the general population of developing countries is estimated at 18%, and is expected to increase with population growth and ageing [1]. It is therefore necessary to develop more effective pain prevention, diagnosis and management strategies because of the social, health and personal costs involved [2]. Based on a biopsychosocial model of chronic pain, the recommendations suggest combining a biomedical approach with a more global approach to chronic pain. The aim of the latter is to help patients understand and cope with their pain [3]. A high level of internal control and a feeling of personal efficacy are associated with better results in terms of pain and its impact on daily life [4,5], highlighting the importance of helping patients feel competent to cope. Therapeutic education programmes therefore offer educational interventions designed to improve understanding of the biopsychosocial nature of pain and the body's ability to adapt. Patients suffering from chronic pain learn the importance of a balance between pharmacological treatment, physical activity, complementary therapies and active coping strategies [6,7]. How do we get this message across to patients?

Method. Therapeutic education appears to be more effective when the patient is active and learns through playful means. We propose a therapeutic education programme for chronic pain patients based on solving an escape game. As a group, patients will have to solve a series of enigmas, the answers to which will convey key messages about the physiology of pain, pharmacological and non-pharmacological aids, adapting daily life, adapted physical activity, socio-professional projects and cognitive restructuring. The main aim is to help patients become active and autonomous players in the overall management of their pain. The patients targeted suffer from all types of chronic pain and are monitored at the Colmar Pain Assessment and Treatment Centre. They do not suffer from severe depression or total denial of the chronic nature of their pain, and can function in a group. The groups are made up of 6 patients, with a homogenisation of their pathologies.

Conclusion. We propose a unique and fun therapeutic education tool for chronic pain patients. Clinical studies will be necessary in the future to assess the therapeutic benefit on the various bio-psycho-social aspects of patients. In addition, this educational tool is part of a coherent, personalised education programme for each patient.

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**PO\_28 - The benefits of being in pairs: for a strong link between the soma and the psyche in patients with pain**

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Summary

In the management of chronic pain, the interplay between the psyche and the body is an unavoidable subject. Nevertheless, many patients have difficulty accepting this reality because they think that as soon as we talk about psychology, we are talking about "imaginary" pain. In fact, in the traditional organisation of medical care, "psychogenic" aetiology is only mentioned after all possibility of organic causes has been ruled out, and this does nothing to help patients understand the importance of the psychosomatic aspect of human nature. In order to address this complexity as effectively as possible, we have rethought the care pathway within our chronic pain unit, and have introduced so-called "shared" consultations as an essential step for patients emotionally affected by and/or with pain. The value of this approach is presented here in three clinical vignettes, and the therapeutic issues involved will be discussed.

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**PO\_29 - Preliminary observational study of the use of virtual reality with the Pico G3 headset using HYPNO-VR software in general practices for chronic pain and generalized anxiety-Study of 26 cases**

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1 Exercise In Town (Luxembourg)

Summary

Introduction:The impact of virtual reality with Pico G3 type immersive headsets using HYPNO-VR software on pain and procedural anxiety has been demonstrated in numerous studies (1), but its impact and place, as well as its use in outpatient clinics for chronic pain and generalised anxiety, is poorly known. I carried out a preliminary study on 26 patients to assess the potential of its use outside hospital, with a study of the impact on pain, anxiety, satisfaction index and side effects.

Method : Participation of 26 patients with either chronic pain (69%) (18 cases including 13 with low back pain (VAS>5 despite multimodal treatment) and 5 with fibromyalgia), and 8 patients with generalised anxiety (31%) (defined by a GAD-7>10), the patients received one session of HYPNOVR, twice a day for 5 days, with measurement of the impact on pain according to the VAS scale before, during and before the next session, impact on anxiety according to the GAD-7 scale, before and after all the sessions, satisfaction index of the experience on a scale from 0 to 10, and collection of side effects.

Results: 6 men (23%) and 20 women (77%) completed the sessions.According to the VAS, chronic pain group: 30% improvement during the session but only a 2.5% improvement before the next session, satisfaction index: 85%, 46.1% with asthenia, 26.9% nausea and 26.9% dizziness of which 19.2% presented the asthenia/nausea/dizziness combination, for the chronic low back pain, fibromyalgia and generalized anxiety groups we noted a 28%, 25% and 35% reduction in anxiety respectively according to the GAD-7 scale. Two observations were noted outside the initial objectives: 30.7% described an improvement in their sleep and 85% of patients found the protocol restrictive; 30.7% had to reduce to one session a day due to discomfort.

Discussion: The protocol is too short to judge the impact on chronic pain, and according to the literature, one session per day for 8 weeks seems to have a positive impact for chronic low back pain (2,3), the positive impact on anxiety is found in the short term and it is more positive in the generalized anxiety group, but with the need for a longer term evaluation. HYPNO-VR can therefore be used in general practices, preferably with one session per day, on more homogeneous cohorts of patients, and future studies should examine the impact on sleep and quality of life using appropriate scales.

A poster is available

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**PO\_30 - Prevalence of patients with pain consulting a physiotherapist in France - PHYSIODOL national epidemiological study**

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Summary

Introduction: Pain occupies a prominent place in the world of health, being the number one reason for consultation in emergency departments and one of the top three reasons for consultation in medicine. Although all physiotherapists are well aware of the central role pain plays in their care, it is interesting to note that to date no epidemiological study in France has referenced the prevalence of painful patients consulting a Masseur-Kinésithérapeute (MK).

Objective: To establish the prevalence of patients with pain consulting a Masseur-Kinésithérapeute.

Methodology: The main challenge was to quantify and characterise the proportion of pain patients seen by a physiotherapist in his or her patient base. In collaboration with several pain experts from INSERM, the human sciences for the questionnaire design, and the SFETD scientific committee, we constructed a questionnaire that was as relevant and precise as possible in view of our initial objectives. The study has been validated by the ethics committee of Claude Bernard Lyon-1 University, and we also benefit from the support of the two leading national learned societies in the field of physiotherapy and pain: the Société Française de Physiothérapie (SFP) and the research commission of the Société Française d'Étude et de Traitement de la Douleur (SFETD).

The questionnaire was distributed from January 2024 to June 2024 throughout France via the departmental councils (CDOs) and the URPSs for masseur-physiotherapists.

Results & Discussion: We will present the final results of the study, i.e. the proportion of patients with pain seen daily, the proportion of patients with pain as the 1st reason for consultation, the proportion of chronic/acute pain, the location of pain and the average intensity of pain in patients with pain.

**PO\_31 - Pain in paediatric intensive care: teamwork.**

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Summary

Introduction

In the paediatric cardiac surgery intensive care unit (PACU), the assessment and management of pain are often complicated by the young age of patients, invasive care and haemodynamic instability, all of which justify deep sedation.

We wanted to gather the views of an entire RCCP team, doctors and paramedical staff, on practices for assessing and treating children's pain in order to identify areas for reflection and improvement in our practices.

Materials & Methods

A 10-item questionnaire was drawn up jointly by an anaesthetist-reanimator working in the RCCP and a paediatrician working in the hospital's "Pain and palliative care" team, to be completed anonymously (Appendix 1). It was made available to the entire team for one month. Each question called for a numerical response between 0 and 10, and blank spaces were left for free comments.

Results

Fifty-six carers responded to the survey: 7 doctors, 43 paramedics and 6 people who did not specify their profession.

To the question "Do you find pain assessment scales easy to use", the median response from doctors was 10 [7; 10] (on a scale of "0: not at all" to "10: completely") and from paramedics 7.5 [2; 10] (p = 0.03).

To the question "Would you like to take part in training on pain management? the median response was 10 for the whole team, with no difference between doctors and paramedics.

The quality of communication within the team about children's pain was rated by the whole team at 6 [1; 10] on a scale from 0 to 10, with no significant difference between doctors and paramedics (p = 0.65).

A total of 8 paramedics (14.2% of respondents) expressed the wish to improve analgesia for removal of thoracic drains and redons, which they considered insufficient.

Conclusion

The results of the survey only show a significant difference between doctors and paramedics in terms of ease of use of pain assessment scales, subject to the low discriminatory performance of data collection by questionnaire.

We did, however, highlight a common desire for training in pain management, particularly through hypnoanalgesia, and the need to rethink analgesia for drain and redon removal, as well as communication within the team.

These results served as a basis for joint reflection on improving our practices and could be useful to other paediatric intensive care teams.

**PO\_32 - The contribution of real-life pain monitoring in the support of patients using TENS**

M.H. Huet 1, R.J. Jouvencel 1

1 Sublimed

Summary

Low back pain is a common condition affecting a large proportion of the world's population, with a significant impact on quality of life. Transcutaneous electrical neurostimulation (TENS) therapy offers a non-invasive and effective solution for pain relief. To illustrate the value of real-life data, this poster presents an analysis of the data collected over the first three months of use of a connected TENS (demographics, use of TENS, relief) in a patient suffering from low back pain, compared with the average number of low back pain patients using the connected TENS,

Discussion

The data collected by a connected TENS device available on the market shows that the patient uses the TENS device repeatedly, with positive results in terms of improved mobility and reduced pain. A rewarding discussion can take place with the patient on a number of points:

Commitment to treatment : Does the patient use the TENS regularly?

Prescription compliance: Does the patient follow the recommendations concerning the programmes, duration and frequency of use provided during therapeutic education?

Involvement in physical activity: Over the period studied, the patient showed a higher increase in the average number of steps taken per day, reflecting a significant improvement in mobility (+44% compared with +10% for the average population).

Perceived effectiveness: The patient's Session Effectiveness Index (SEI) shows positive satisfaction, with a value of 1.7 points.

Conclusion

The contribution of monitoring based on real-life data can be a valuable asset for healthcare professionals in pain assessment and treatment centres (PACT), as a tool for communication, therapeutic education and patient engagement in their therapy. This approach not only helps to optimise care protocols, but also provides a powerful means of communication between patients and healthcare professionals in CETDs.

Comparison between patient data and population average

Patient

Population average

Demographics

Indication

Low back pain

Height (cm) 155 164

Weight (kg) 63 72

age (years) 48 45

BMI (kg/m²) 26 26.7

Use and effectiveness of TENS

Total number of stimulation sessions carried out

82 78

Average stimulation time (min)

48 98

Average number of steps

4771 steps/day 3322 steps/day

Number of sessions per week

1,8 8,3

Change in mobility index

+44% +10% (standard deviation: 71%)

Session Effectiveness Index (SEI)

1,7 0,8

Most popular programmes

P6: 30 sessions, 48 minutes

P1: 20 sessions, 45 minutes

P3: 17 sessions, 47 minutes

P1: 28 sessions, 85 minutes P10: 26 sessions, 81 minutes

P6: 24 sessions, 88 minutes

**PO\_33 - Feedback from therapeutic groups combining therapeutic hypnosis and music in a paediatric Chronic Pain Clinic (SDC).**

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Summary

According to the latest international recommendations, chronic pain requires comprehensive management focused on the patient and his or her quality of life. Prescription of powerful painkillers should be kept to a minimum, in favour of non-medicinal management (1). Within the paediatric Chronic Pain Structure (SDC) at the CHI Créteil, children and adolescents consulting for chronic pain have been offered an in-depth therapeutic proposal, based on an integrative approach combining hypnosis, music and group dynamics.

Therapeutic hypnosis has been widely validated for many years and can be defined as follows: "an altered state of consciousness in which the patient is focused on a specific idea with the aim of improving their mental or physical health" [2].

Music has neurophysiological effects. According to the literature (2,3), it can have an effect on the intensity of acute and chronic pain and on morphine savings. It is used in a wide range of fields, including education, support for medical care and psychotherapeutic mediation. Some musical sequences have been composed as part of music therapy for pain management (4).

The group, for its part, mobilises physical, emotional, psychological and relational dimensions. It enables individual problems to be articulated in the context of a group dynamic, and the understanding of individual painful experiences to resonate in an intersubjective perspective (5).

In our scheme, each group is made up of 4 children of the same age group and runs for around 2 months. They meet weekly. The groups are closed and run by two clinical psychologists. Referrals are discussed on a multidisciplinary basis. The young person is offered a pre-group interview and a post-group interview (2 months later).

The originality of the system lies in the combination of several non-medicinal methods. It's not just a juxtaposition of tools, but an integrative approach.

We have observed, empirically, with children and adolescents who have benefited from this scheme :

- Better pain management (intensity, duration, regulation),

- Reduction in drug consumption,

- Reduced emotional impact associated with pain,

- Learning new tools,

- Improved self-image,

- Improved quality of life.

These promising observations still need to be confirmed in young people over time, by repeating the programme with a larger number of patients, using validated scales (for quality of life and anxiety) and quantitative measures (drug consumption, days absent from school), and evaluating overall improvements.

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**PO\_34 - The "double crush syndrome": the benefits of collaboration between neurosurgeons and algologists in pelviperineology**

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Summary

Introduction: When decided, pudendal nerve decompression surgery has a functional objective: success is defined by a reduction in pain and an improvement in sitting time (1). However, some functional failures raise the question of interrelated aetiologies. The "double crush syndrome" is the hypothesis that a peripherally compressed nerve is also likely to be compressed at a more proximal site, concomitantly and asymptomatically (2-4). In the case of the pudendal nerve, there are various sites of compression, particularly in the low lumbar spine.

The aim of our multicentre retrospective study was to assess the influence of patients' spinal status on the outcome of pudendal decompression surgery. The primary endpoint was improvement in pain, while the secondary endpoints concerned quality of life: improvement in mood, functional recovery and return to work.

Material and methods: The population included consisted of patients operated on for transgluteal decompression of the pudendal nerve whose indication had been validated by the RCP. The patients' spinal status was documented by their history and imaging. Improvements in pain, sitting time, mood and return to work 12 months after surgery are all assessed.

Patients with systemic pathologies likely to cause multiple nerve entrapments or of iatrogenic origin were excluded.

Results: 10 patients divided into two groups: 5 with successful surgery, 5 considered a failure. In the "successful" group, the average improvement was 70%, with a gain in sitting position of more than 60 minutes, with the majority of patients returning to work. Two (40%) patients had lumbar disc disease, one of whom was symptomatic. No history of spinal surgery was reported. In the "failure" group, the results were 25% relief, a 33-minute gain in sitting time, and no return to work. Four patients (80%) had disc disease centred on the last two lumbar levels, one had a herniated L5-S1 disc, and one had undergone L5-S1 lumbar surgery. All had low back pain, with two radiculalgias in addition. In both groups, mood improved in parallel with pain relief.

Discussion : A history of lumbar disease seems to be more frequently associated with surgical failure. Disc disease may be favoured by a pathological spinal morphotype (5). It therefore seems worthwhile carrying out a systematic spinal assessment in patients complaining of perineal pain, particularly when surgery is being considered. Multidisciplinary management should therefore include joint reflection and close collaboration with a rehabilitation physician.

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**PO\_35 - A digital storybook as a healthcare tool, accessible to all**

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Summary

Tales, short accounts of imaginary events, were originally intended for adults until the 17th century. Since the Age of Enlightenment, storytelling has extended its audience to children.

CHI Créteil and CHI Villeneuve Saint Georges (94) are offering an institutional "hypnosis initiation" course over three days. Over the course of the three days, carers were given a theoretical course on how to create a metaphorical tale. Some of the stories were used to create a collection of tales in the form of a digital book. This tool was validated by the CLUD and distributed institutionally via several newsletters. Thanks to the QR Code, this book can now be consulted by anyone.

At the patient's bedside, we have found that metaphorical storytelling provides an initial approach to the patient, whether a child or an adult. Storytelling is an additional tool in the relationship between carer and patient, whatever the age or reason for hospitalisation. Storytelling helps to open up a dialogue, provides a basis for communication and discussion about everyday life, and raises familiar and ordinary questions. This is an interesting approach for some patients who are prostrate with pain or stuck in an anxiety loop. The stories can also be used as hypnotic inducers by trained carers.

There are plans to include metaphorical tales with sound in the near future.

Feedback on the use of this tool could be the next stage in the work.

**PO\_36 - Impact of dance on anxiety related to chronic pain in patients with fibromyalgia syndrome**

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Summary

Background: At the Henri Duffaut Hospital in Avignon, adapted physical activity is offered to patients with fibromyalgia syndrome. Psychological factors play a role in the onset, persistence and recovery from chronic pain [1]. Since anxiety linked to chronic pain is highly prevalent in these patients [2/3], acting on it could have a positive impact on the pain syndrome. Moreover, dance is an artistic discipline that has shown significant benefits for chronic pain, particularly in terms of reducing pain levels, improving quality of life and physical function, and reducing anxiety and depression [4].

Objective: To reduce anxiety linked to chronic pain in people with fibromyalgia, thanks to an adapted dance programme based on creative interventions.

Materials and methods: For 8 weeks, 9 patients with fibromyalgia participated in a one-hour dance session per week. Each session was based on creative interventions, considered more effective than repetitive interventions [5]. The sessions followed the following guidelines: motor problem solving, expression of emotions, individual participation and interaction between participants [5].

The programme was presented to the SDC's medical and paramedical team and filmed (link: https://scanned.page/66488519565c0).

To assess the effects, patients completed the State Trait Anxiety Inventory before and after the programme. This questionnaire consists of two parts: one on situational (state) anxiety and one on general (trait) anxiety. They also completed the QIF questionnaire, which assesses the impact of fibromyalgia.

Results: After 8 weeks, a significant decrease of 12 points in the situational anxiety score was observed (p=0.061). However, there was no significant effect on general anxiety (-1.875; p=0.135). It is important to note that a significant reduction in pain was noted on the QIF questionnaire (-1; p = 0.033).

Conclusion: The adapted dance programme showed encouraging results in reducing situational anxiety and pain in patients with fibromyalgia. Although the reduction in general anxiety was not statistically significant, the other results suggest that creative interventions such as dance can have a positive impact on the management of fibromyalgia symptoms. These results encourage the integration of dance and other adapted physical activities into treatment programmes to improve patients' quality of life.

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**PO\_37 - The contribution of art therapy to the 'pain' care/study programme for adolescents with chronic pain who have dropped out of school**

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Summary

Background: The internal medicine department for adolescents at the Clinique FSEF Paris 16 has developed full hospitalisation for adolescents with chronic pain who have dropped out of school [1]. These adolescents benefit from a Care/Study project focusing on the assessment and treatment of their pain and the resumption of their schooling. This care programme, based mainly on non-medicinal methods (physiotherapy, balneotherapy, relaxation, psychological support, etc.) is accompanied by modified schooling. In 2011, the department enhanced this Care/Study project with Art-Therapy programmes run by the Association Médecins de l'Imaginaire. The diverse and varied range of non-medicinal workshops on offer means that adolescents not only benefit from the complementary nature of this multi-disciplinary approach, but can also choose the method that suits them best and, if possible, continue with it once they have left the ward.

The method:

Art therapy is a care practice based on the therapeutic use of the artistic creation process. The Art-Therapy protocol is part of the treatment plan and contributes to the conditions that encourage a return to a healthy balance. Involved, the teenagers are gently mobilised in their creative project, a different way of relating to their body and psyche. Over the weeks, in the caring environment of their peer group, despite and with the pain, they regain confidence in their ability to express themselves, feel, regulate and recharge their batteries. Art therapy helps them to move away from pain and feel better, while mobilising the many resources, adaptability and autonomy that are essential for coping with pain in adolescence.

Results: Since 2015, more than 150 patients aged between 12 and 18 have benefited from these workshops: weekly rhythm, group of 8 to 10 patients, course of 8 to 10 sessions.

Main indications: chronic tension headaches and migraines, musculoskeletal pain syndromes, chronic abdominal pain.

The benefits expected by patients are as follows: discovering new things, creating freely without pressure, taking time, letting themselves go, creating in connection with their feelings, putting down their emotions, finding peace, expressing themselves in ways other than words, paying less attention to the way others look at them.

Their personal assessments highlight their openness to new experiences, the acquisition of positive skills (relaxation, expression, adaptation and concentration), the possibility of evolving in harmony with a group and, for some, a direct effect on their pain.

The aim is for them to be able to extract themselves from their painful feelings, at least for the duration of the workshop, and above all to experience this possibility.

Conclusion:

The success of this approach, its seamless integration into the Care and Study project, and the satisfaction of patients, families, both teams and referring doctors are encouraging us to continue in this direction.

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**PO\_38 - Innovative treatment regimen combining millimetre waves and drug treatment in the management of pain associated with osteoarthritis: a real-life study.**

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Summary

Osteoarthritis, a degenerative joint disease, is one of the main causes of chronic pain, and its incidence is rising as a result of the increase in obesity and the ageing of the population. Pain and loss of mobility caused by this condition have a negative impact on quality of life [1]. In this context, pain is a complex outcome involving the three mechanisms of chronic pain: nociceptive, neuropathic and no disciplastic [2]. The management of osteoarthritis aims to relieve pain and improve joint function and quality of life. The recommended treatments combine non-medicinal and medicinal approaches and, as a last resort, surgery [3,4].

The application of millimetre waves (MMW) to a highly innervated area has neuromodulatory effects through the release of endorphins and activation of the parasympathetic system [5]. This non-invasive approach is particularly interesting for pain of nociplastic origin, which is likely to respond better to centrally than peripherally acting therapies [6]. MMOs combined with the usual medicinal treatments, paracetamol and NSAIDs, would optimise the relief of osteoarthritis symptoms.

A well-being solution combining an OMM transmitter bracelet with a support programme is available to the general public, with the aim of reducing stress and improving quality of life and sleep. The recommendations for use are to carry out three 30-minute sessions with the bracelet every day. The support provided is designed to help users get to grips with the wristband and integrate it into their daily routine, so as to encourage proper use and reap the benefits. At the start of the programme, users complete questionnaires on their quality of life, sleep and discomfort. They complete these questionnaires again, along with their impression of change (IOGC) after three months' use. In this way, users can monitor the evolution of their symptoms.

We present a retrospective study of real-life data collected from new users reporting osteoarthritis from December 2022 to January 2024. The aim is to explore changes in quality of life after three months of use, in particular the benefits of a combination of OMM and drug treatments. The primary endpoint is the distribution of users according to their ICMP score.

At three months, of the 318 users included in the study, 68.6% were still using the solution. Based on the ICMP, 80.1% of users reported an improvement in quality of life, including 27.5% in the "much improved" and "greatly improved" categories. The full results of the study are expected in June 2024.

This initial result supports those of a recent clinical trial on peripheral osteoarthritis, which showed a significant effect of this OMM therapy on pain reduction [7].

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**PO\_39 - Changes in the quality of life of fibromyalgia sufferers using a millimetre wave neuromodulation device**

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Summary

Fibromyalgia (FM) is a non-disciplinary disorder for which non-pharmacological approaches are recommended as first-line management. Exposure of the peripheral nervous system to millimetre waves (MMW) leads to the central release of endogenous opioids [1], resulting in hypoalgesia and parasympathetic effects [2]. The effectiveness of a therapy combining an OMM bracelet and coaching in improving the quality of life (QOL) of FM patients, compared with usual care, was tested in a clinical trial [3]. The results showed a significant reduction in the Fibromyalgia Impact Questionnaire (FIIQ [4]) score compared with usual care after 3 months of use. An OMM bracelet + smartphone monitoring application was marketed as part of an offer designed to improve the quality of life of people suffering from bodily discomforts (pain, stiffness, fatigue) and sleep disturbances. The majority of users were people with FM. In a retrospective study using real-life data collected by the mobile application, we studied long-term changes in the quality of life of people with FM using this product independently at home. Of the 1125 people with FM who subscribed to the offer during the study period, 388 (34.5%) were still using it 18 months after initialization. Responses to the QIF [4] showed an average reduction in scores of mM3=27.3% from the first quarter, which was maintained over time until the 18th month (mM6=25.6%, mM9=29.4%, mM12=28.3%, mM15=27.3%, mM18=27.5%). The weekly and quarterly changes in their symptoms and the use of the bracelet over time are reported. These data, confirming the results obtained in a clinical trial, are the first to report the use of an MMO emitting device in real life and its impact on the quality of life of people reporting suffering from FM and over a period rarely reported in the literature on FM. However, there are some biases, notably selection and confirmation bias, which are discussed.

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**PO\_40 - DOLCIP project**

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Summary

We would like to present the initial results of the DOLCIP project (Pain and Advice on Professional Integration), which was set up thanks to funding from the APICIL Foundation.

According to the recommendations of the French National Authority for Health (HAS), the assessment of chronic pain patients should include a biopsychosocial assessment as part of the treatment process [1]. Chronic pain impairs patients' health in all areas of life, requiring multidisciplinary medical, psychological and social care [2,3,4]. Chronic pain clinics (SDCs) are now well equipped to assess patients medically and psychologically, but social assessment is often poor because of the scarcity of dedicated social workers (social service assistants, vocational integration advisers, etc.) in SDCs. What's more, chronic pain patients often don't dare broach the subject out of modesty and/or unfamiliarity with the places or professionals who can provide them with information on social and employment rights. When certain professional, financial and social difficulties are neglected, they can become a major obstacle. These difficulties focus the patient's attention and make them unavailable for treatment. Identifying these difficulties often makes it possible to improve patient management in TCS [5]. In the absence of dedicated staff trained in socio-professional expertise within our TCS at the CHU de MONTPELLIER SAINT-ÉLOI, as in many TCSs in France, we thought it would be interesting to set up the "DOLCIP" pilot project, which was made possible thanks to funding from the Fondation APICIL.

We have asked an expert patient (followed as a patient in our SDC) to take part in this project. He has training as a social worker and has received 40 hours of training in TVE in June 2023 and attended a one-week course with the social worker at the Clermont-Ferrand SDC in November 2023 [6].

In December 2023, a group workshop was held with one of the SDC doctors on the subject of "RQTH for whom? Why? Since January 2024, when socio-professional vulnerability has been identified, the resource patient Vocational Integration Adviser has been able to see a patient individually (36 patients are currently being monitored) and/or suggest that they take part in the "RQTH for whom? (currently offered to 10 patients). On a one-to-one basis, he supports certain patients in their career development by establishing links with the various players involved in this process (France Travail, Cap Emploi, MDPH, SDC multidisciplinary team, training organisations, AGEFIPH, etc.) [7].

The aim of the DOLCIP project is to encourage patients to return to work, to enable them to look to the future despite their pain, and to encourage them to take care of their health by freeing them from insecure socio-professional prospects.

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**PO\_41 - ETP endometriosis: Method, teaching and support for patients**

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Summary

Endometriosis is a common, chronic disease affecting one in ten women of childbearing age (1). It is characterised by the development of a tissue similar to the uterine mucosa outside the uterus (2). Endometriosis impairs quality of life, due to recurrent, chronic pain (affecting around 40% of patients) (1) and the functional and psychosocial repercussions of the disease. The fact that endometriosis is still largely unrecognised, the delay in diagnosis (on average 7 years after the onset of symptoms) (3) and the impact on sexuality and fertility all play a part in patients' "endometrial lives and journeys".

In 2022, the Ministry of Health has launched a national strategy to combat this disease (4), which includes therapeutic patient education (TPE) as one of the areas to be developed.

The aim of TVE is to acquire, maintain or reinforce skills so that patients and those around them can manage their illness as well as possible (5). Making it easier for patients to access, understand, evaluate and use information improves their health literacy. It is therefore a question of empowerment (6,7), in the sense of increased autonomy, the ability to take action, to make health choices and to define a possible life plan with a long-term illness.

In this context, the team at the Limoges University Hospital Pain Centre has redirected part of its resources to building an ETP programme (8). The ETP pathway must also, and above all, be designed in pedagogical and didactic terms, with the aim of facilitating the transmission of knowledge, decision-making skills, motivation to change, etc. Designing the programme involves a number of important stages, such as identifying patients' needs, finding the right pedagogical balance between academic and lay knowledge, formalising various partnerships, training, setting up and coordinating a multi-professional team, building workshops and evaluating the programme. Our entire approach had to take into account the need to create the most facilitating space for learning, forcing us to reinvent our posture and our environment in order to improve our relationship and communication with patients (9).

The aim of this poster is to present our methodological approach to the design and implementation of an ETP programme for patients suffering from chronic pain in the context of endometriosis. While TVE is still too often a matter of habit or empiricism, and the acquisition of knowledge is often seen as an automatic consequence of teaching, we envisaged a didactic universe offering a motivational environment, based on the allosteric pedagogical model (10); a model which we felt was more conducive to the acquisition of skills and the transmission of knowledge, with the aim of improving the effectiveness and even the efficiency of the TVE programme.

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**PO\_42 - Use of MEPHENON (Methadone IV) at the Rouen CLCC: series of 11 cases**

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Summary

Introduction

Methadone, a synthetic opioid agonist, is an effective alternative to conventional opioids for the management of intractable cancer pain. [1]. There are currently few data on the use of intravenous methadone hydrochloride or Mephenon®. This treatment is used intravenously and has had a temporary authorisation for use (ATU) in France since 2018. This molecule is useful when opioid rotation is necessary or when the oral route is no longer possible [2]. We report a series of 11 cases.

Methodology

Based on IMD data, retrospective study from January 2020 to January 2024. Various epidemiological, neoplastic and drug-related parameters were studied.

Results

We identified 11 patients treated with IV methadone. There were 9 women and 2 men, with an average age of 51.4 years [28-69 years]. We observed all neoplastic pathologies (3 sarcomas, 1 melanoma, 3 cervical cancers, 2 ENT, 1 thyroid, 1 senologic). All had advanced or metastatic disease with a mean WHO stage of 2.55. Pain was mixed in more than 90% of cases. All had already received strong opioids, with an average of 2.8 opioid changes before MEPHENON was started, most of them in combination with ketamine (8/11). Four patients were switched from methadone PO to IV at an average dose of 75 mg per day. For relapses with other strong opioids (SUFENTANIL, MORPHINE, OXYCODONE), the mean OME was 437.7 mg. The mean initial dose of MEPHENON was 29.8 mg [10-60 mg] as background dose. The median length of stay on day 1 of initiation of IV methadone was 36 days [4-137 days]. Two patients were discharged home on HAH, the others died during hospitalisation. Overall, the treatment was well tolerated. No treatment was stopped because of intolerance. We did not perform ECGs in certain situations, as we accepted the double effect of the treatments. No significant difference in EN but overall improvement felt by patients and carers.

Discussion

Information is still lacking on the switch from opioids to intravenous methadone. Even if pain assessment cannot show significant efficacy, this is due to the small number of patients and retrospective data. Nevertheless, our results remain encouraging, allowing access to treatment for intractable pain, and seem to corroborate the data in the literature [3, 4, 5]. And there is currently no algorithm for these treatments.

Conclusion

IV methadone is an alternative for pain relief in the treatment of intractable cancer pain. This would require larger-scale prospective studies.

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**PO\_43 - Manual medicine-medical osteopathy in a pain structure**

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Summary

Manual Medicine-Medical Osteopathy in pain structures

Introduction

Osteopathic manual medicine (OMM) is a rich discipline in many respects, which deserves its place in the management of chronic pain patients.

Method

To find out about the possibilities for referral and knowledge of this medical speciality, we carried out an analysis of practices by sending a 10-question questionnaire to the 71 CETDs in France listed on the SFETD website.

Results

A total of 30 CETDs (42%) responded. Only 6 of them have osteopathic manual physicians (MMOs). These MMOs are called upon to treat a variety of conditions, including osteoarticular pain, musculoskeletal disorders, myofascial pain, postural disorders, low back pain, minor intervertebral disorders and body image disorders. Four CETDs have osteopaths who are not doctors. Just over 66% of centres would like to have an MMO. The main reasons for not having an MMO were financial, lack of dedicated time, lack of a trained doctor, the presence of non-physician osteopaths, an activity not considered a priority, or the use of other complementary approaches considered to have a better level of scientific evidence. Several CETDs expressed ignorance of the indications for MMOM.

Discussion

This study highlights the under-use of this medical speciality and a lack of knowledge about this practice and its indications. A review of the literature highlights the indications for MMOM in the treatment of minor intervertebral disorders (including certain cervicogenic headaches), chronic low back pain and chronic pelvic-perineal pain [1][2][3][4][5]. Fibromyalgia is not an indication for MMOM [6]. MMOM is recognised as having a positive impact on patients' quality of life, activities of daily living and mental health, as well as reducing drug consumption [1][7][8][9][10]. Our work also highlights a lack of distinction between medical and non-medical osteopathy. Firstly, a doctor's ability to establish a medical diagnosis in the face of a given situation does not reduce his or her treatment to the simple field of osteopathy. The practice of non-medical osteopathy remains heterogeneous and the law prohibits doctors from performing certain acts. Physicians are also directly liable if a patient is referred to a non-medical osteopath in the event of an accident [11]. The Inter-University Diploma should enable more MMOs to be trained in order to improve access to this practice.

Conclusion

MMOM is a discipline that can provide a response to many of the issues raised by patients suffering from chronic pain. CETDs must have access to this practice as part of their multidisciplinary approach. More extensive and scientifically sound research is needed to validate the indications.

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**PO\_44 - The Transcultural Clinic associated with the Pain Clinic: a therapeutic approach to pain management.**

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Summary

Introduction :

Pain is intimate, of course, but it is also imbued with social, cultural and relational aspects. It is the result of education. Pain cannot escape the social bond [1].

Luxembourg is a multilingual border country that welcomes people from migrant and exile backgrounds. Cultural diversity and the intermingling of cultures and care require us to develop therapeutic tools adapted to human suffering and to this diversity. This diversity is present not only in the patient population, but also in the healthcare professionals working there.

At the Centre de la douleur du Centre Hospitalier de Luxembourg, we are putting in place a transcultural approach to pain, combined with the assessment and psychotherapeutic treatment of our patients' pain.

Description :

Providing care in a transcultural situation, where patients and therapists do not belong to the same culture, means making adjustments to oneself, to the relationship with patients and to the systems on offer [2].

The clinical professional must also seek to understand himself as a person embedded in an individual history, a profession, a theory, a society and a culture; this is what is known as cultural counter-transference [3].

Any cultural system is subject to changes over time, both internal modifications and the integration of external contributions. There are as many descriptions of care systems as there are cultures [4].

This requires a certain flexibility and association of various forms of thought, including anthropology, psychoanalysis, ethnopsychiatry and ethnology, among others, in order to develop methods for thinking about and operationalising the onion-skin interactions between the collective, intersubjective and intrapsychic levels [5].

Objective:

Our transcultural clinical approach to the treatment of pain in uprooted and/or migrant patients offers a clinical framework that considers other dimensions, such as the social and family role, the way in which somatic complaints are culturally expressed, and how they can metaphorise experience. This opens up new perspectives for the well-being of the pain patient and those around them. We would like to present this approach.

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**PO\_45 - Neurology-Pain collaboration for Eptizenumab**

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Summary

Eptinezumab is a monoclonal antibody that targets calcitonin gene-related peptide (CGRP), a protein involved in mediating migraine pain [1]. By blocking the action of CGRP, eptinezumab reduces the frequency and severity of severe migraine attacks in adults with at least eight migraine days per month who have failed at least two prophylactic treatments [2-3]. However, the use of this treatment is limited in patients with a history of cardiovascular disease or fructose intolerance due to excipients present in the drug.

Eptinezumab, administered by intravenous infusion, is reserved for use in hospitals and can only be prescribed by neurologists. This method of delivering the drug requires close collaboration between the neurology and pain departments to ensure the safety and efficacy of the treatment in patients who are not necessarily under the care of the neurology department [4].

At the Centre d'Évaluation et de Traitement de la Douleur (CETD) in Nîmes, a dedicated care pathway has been set up to offer this treatment to patients who have failed conventional migraine treatments.

The process begins with the identification of patients likely to benefit from eptinezumab during a migraine consultation. Patients then undergo a multidisciplinary day hospital consultation to assess their eligibility for the treatment protocol. This consultation includes interaction with various specialists:

An algologist studies the factors leading to chronicity.

A clinical pharmacist examines current drug treatments.

An advanced practice nurse provides an assessment of the impact on quality of life.

An algologist specialising in migraines will assess the appropriateness of the treatment.

At the end of this multidisciplinary consultation, a report is presented at the monthly multidisciplinary consultation meeting in the neurology department. A neurologist specialising in migraine assessment is involved in validating the files.

If the application is accepted, the CETD will arrange for patients to receive an initial infusion of eptinezumab in the day hospital, followed by a second infusion 12 weeks after the first. Eight weeks after the second infusion, a multidisciplinary assessment consultation is held to determine the response to treatment.

The case is then discussed again at a multidisciplinary consultation meeting in the neurology department to decide whether or not to renew the treatment. Since September 2023, this procedure has enabled 10 patients to receive two quarterly infusions before being clinically reassessed.

This collaborative approach between neurology and pain services makes it possible to offer effective treatment to patients suffering from severe migraines, while guaranteeing comprehensive, personalised care [5].

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**PO\_46 - Perception, detection and management of peripartum pain by cattle farmers**

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Summary

PERCEPTIONS, DETECTION AND MANAGEMENT OF PERIPARTUM PAIN BY CATTLE FARMERS

Peripartum management is the subject of numerous studies, few of which focus specifically on pain management in cattle. Pain has a number of adverse effects on performance (milk production, immune transfer, immunity, etc.). The use of certain analgesics has been shown to be beneficial.

We carried out a survey of a sample of breeders, with the aim of taking stock of the attitudes of breeders in a given customer group to pain in the peripartum period. This study was part of an effort to raise awareness among breeders of the need to detect and manage pain in the peripartum period. The survey was carried out over the winter of 2022-2023, involving 120 breeders and providing feedback from 34 breeders.

We have highlighted a certain sensitivity among farmers to peripartum pain, which is more marked in the female population. The studies carried out on the pain associated with pregnancy, childbirth and the peripartum in general in women, alongside the studies carried out on cattle, are making it possible to gain a better understanding of the pain associated with the peripartum. Despite a certain sensitivity to pain in cattle on the part of farmers, there are still obstacles to the management of such pain. These obstacles can be overcome in part by :

- Raising awareness of the signs of pain;

- providing information on the use of analgesics in the peripartum period and their short- and long-term benefits, which breeders are demanding.

As part of this process of passing on information, information media are being produced. The first information sheets have been produced. These materials are a way of encouraging partnership between the farmer and his veterinary surgeon in the management of pain in peripartum cattle.

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**PO\_47 - Three-month efficacy of the use of a dynamic spinal traction table in the routine care of patients with chronic common low back pain**

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Summary

Introduction: Chronic low back pain (CLBP) affects the quality of life of 600 million people worldwide, resulting in costs and lost productivity. This study aims to evaluate the effectiveness of dynamic spinal traction in the treatment of chronic low back pain using a medical device called DPA Med®. This device combines two therapeutic techniques: spinal traction and belt dissociation.

Population: 18 patients with chronic low back pain followed up in general practice (10 men, 8 women, mean age 63.40, mean duration of symptoms 46 months).

Method: Retrospective multicentre study of the short-term efficacy of DPA Med®. The Oswestry disability index was used as the primary endpoint, with data collected at the start and end of treatment. The secondary objectives were to monitor the use of medicinal and non-medicinal treatments and adverse events.

Results: DPA Med® significantly improved ODI scores by 20.47% (p = 0.05, SD = 11.62) at the end of three months of treatment. We also observed a reduction in drug and non-drug consumption, and no adverse effects were reported.

Discussion/Conclusion: This study confirms the efficacy of DPA Med® dynamic spinal traction in chronic low back pain. The results suggest that this device can help improve patients' quality of life while reducing their dependence on medication. As an accessible tool in general practice, the DPA Med® offers a promising treatment option for patients with this common health problem.

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**PO\_48 - Determinants of fears and beliefs in chronic low back pain**

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Summary

Introduction

The bio-psycho-social model for the assessment and management of chronic common low back pain is widely recommended in the literature. Objective evaluation of the determinants of this approach has become possible thanks to the development of questionnaires.

The aim of our study was to assess the factors that may influence fears and beliefs in this population.

Methods

This was a cross-sectional descriptive study. A validated Arabic version of the FABQ was used to assess patients' fear and avoidance beliefs. Two sub-scores were calculated: the FABQ-W (FABQ-work) and the FABQ-AP (FABQ-physical activity). Disability was assessed by a validated Tunisian version of the ODI (OswestryDisabilityIndex).

Results

34 patients were included with a sex ratio of 0.25 and a mean age of 36.8+/-11.78 years. There was a significant positive correlation between age and FABQ sub-scores (p<0.05), a significant negative correlation between education level and FABQ sub-scores (p<0.05), and no correlation between FABQ sub-scores and duration of low back pain or between FABQ sub-scores and ODI.

Conclusion

The results of our study suggest that fear and avoidance beliefs in people with low back pain are influenced by age and educational level.

As a result, when these factors are present, particular care needs to be taken when drawing up a rehabilitation protocol.

**PO\_49 - Implanted Neurostimulation for analgesia (NSI) and post-chemotherapy neuropathic pain**

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Summary

INTRODUCTION

The prevalence of neuropathic pain (NP) in cancer varies from 20 to 40%. This pain is poorly diagnosed and poorly treated. The recommendations published in 2020 [1] suggest therapeutic stratification, including the use of NCI.

We will present 3 clinical cases and describe their history.

PRESENTATION

Mrs ER, born in 1949, has had myeloma since 2015 and is still undergoing chemotherapy. Since 2016, chemo-induced neuropathic pain (CNP) has set in. She was taken into care by our chronic pain structure (SDC) in 2018. She had systematic antineuropathic therapies and rTMS. In 2020 the NCI was fitted with a T9-T10 electrode. Her pain has decreased by more than 50% and she has reduced her treatments.

Mrs MFG, born in 1943, suffers from anti-MAG neuropathy linked to waldenstrom diagnosed in 2007. The pain was brought under control and the disease was brought under control. In 2016, a recurrence of Waldenstrom necessitated further chemotherapy. After 3 weeks, invalidating DN related to the new chemotherapy were observed. She was not referred to our SDC in 2018. She benefited from oral antineuropathy, TENS therapy and rTMS, which enabled her DN to be contained for 4 years. As the patient found all her treatments restrictive, the NCI was placed with a T9-T10 electrode. Relief was rapid and better, with a real impact on quality of life and sleep. She is continuing her chemotherapy.

Mrs MR, born in 1948, is in remission from breast cancer diagnosed in 2020. Since the end of her chemotherapy, DNC has set in. In 2021, she is cared for by our TCS. In 2022, she was offered NCI because of the failure of specific therapies. A T9-T10 electrode was inserted. In 2024, she reduced and then stopped using NCI without any recurrence of pain and had no systemic therapy.

DISCUSSIONS - CONCLUSIONS

These cases illustrate the place of CLF in the treatment of intractable and/or intractable DNC. Various publications argue in favour of CLF in cancer DN [2, 3, 4, 5, 6, 7] and French recommendations have not excluded it from their recommendations in these situations.

However, the use of CLF is still too low in France in rebellious DN and more so in cancer patients.

The SFETD is working on the role of NSI in cancer DN. We hope that the recommendations will encourage early referral to the DCS, as well as the use of NSI in such complex and intractable situations.

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**PO\_50 - Taiji and kinesiophobia in CETD**

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Summary

Taiji, a gentle physical activity (involving relaxation, postural work, improving joint mobility and balance) appears to be suitable for chronic pain patients [1] and [2], even those with motor difficulties [3].

How well do chronic pain patients treated in a CETD adhere to a Taiji therapy physical activity proposal?

101 patients were prescribed 5 taiji sessions, each lasting 1.5 hours per week, between April 2018 and April 2023 by the department's algology doctors, carried out by a doctor trained in therapeutic taiji in the form of group workshops (with a maximum of 5 patients).

Eighty per cent of the patients were women, with an average age of 52. 85 had osteoarticular or rheumatological pathologies (35 chronic low back pain, 12 fibromyalgia, 10 CRPS, 7 SPA, 7 NCB, 5 Ehler Danlos, 5 polyarticular arthrosis, 2 back pain, 1 rheumatoid arthritis, one shoulder dystocia) and 16 neurological pathologies (4 peripheral neuropathies, 2 MS, 2 myelitis sequelae, 2 pudendal neuropathies, 1 stroke, 1 intractable headache, 1 intercostal neuralgia, 2 pudendal neuralgia).

A computerised record of appointments kept was drawn up.

Results: 11 patients attended one session, 12 attended 2, 23 attended 3, 19 attended 4 and 36 attended 5.

The closer the score is to 5 (number of sessions offered), the more the objective of combating kinesiophobia is achieved.

We can consider that 23 patients had little or no adherence to the therapeutic proposal, coming for only 1 or 2 sessions.

More than 75% of patients attended at least 3 sessions and more than 50% 4, including 35% 5, and this first stage initiated a return to movement with benefits for their quality of life.

Patients were invited to resume gentle physical activity (walking) and to consult a sports and health consultant to find a suitable physical activity for them.

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**PO\_51 - Evaluation of therapeutic groups in the follow-up of chronic pain patients**

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Summary

Evaluation of therapeutic groups in the follow-up of chronic pain patients

Qualitative approach with semi-structured interviews

The chronicisation of pain is a process, which takes place in the presence of numerous personal and environmental factors (amplifying and maintaining factors). Collective therapeutic systems run by multi-professional and multi-disciplinary teams are an effective way of tackling and treating these different components in a multimodal and integrated way. It is important to set up systematic evaluations using qualitative approaches to go beyond quantitative measurement tools, which are too limited to assess the effects of this approach. Assessment often poses a number of difficulties, given the complexity of the factors involved, the fluctuating and individual nature of the symptoms and the disparity in the 'language' of the multi-professional players involved. However, regular and systematic assessments are essential, both for the patient and for the team, in order to assess progress and maintain motivation.

In this analysis, we share with you our experience of evaluating the follow-up of our patients in therapeutic groups at the Pain Assessment and Treatment Centre.

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**PO\_52 - Who are the patients referred to our chronic pain structure? Analysis of 481 requests for appointments at our centre in 2023**

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Summary

Chronic pain clinics are designed to treat patients suffering from the most complex forms of chronic pain, but unfortunately only accept 4% of those in need [1]. We wanted to find out about the characteristics of patients seeking treatment at a chronic pain centre, and analysed the 481 requests submitted to our centre over the course of a year.

The main results were as follows: 76% were women, with an average age of 47, 27.5% of whom lived in our geographical area.

Their pain had been ongoing for an average of 6 years (more than 10 years for 23% of claimants), had no obvious cause in 51.1% of cases, was linked to endometriosis in 17% of patients, fibromyalgia in 4.8%, and neuropathic pain in 4.2%. It followed surgery in 19.9% of cases, an accident in 10.9% of cases, and was related to an accident at work or an occupational disease in 6.3% of cases.

Most of the pain was localized to the spine (45.2%), the lower limb (44.4%), the pelvis (38.2%), the upper limb (31.3%), the head (24.1%) or diffuse (13.3%) and was of average intensity at 7.5/10.

The patients were being treated with opioids (33.4%), paracetamol (26.9%), physiotherapy (24.2%) and antidepressant painkillers (14%), while 15.7% were not being treated at all.

They were referred mainly by their general practitioner (42.2%), or a surgeon (11.7%), a gynaecologist (9.76%), a rheumatologist (8.1%), a neurologist (4.6%), another algologist (4.6%) or a doctor in another speciality (10.5%), who practised in our establishment in 29.9% of cases.

102 people (21.79%) had already consulted a pain doctor, and 157 (33.48%) had previously seen a psychiatrist or psychologist for their pain.

Their main expectations were to "find a solution" (17.54%), "suffer less or no more pain" (10.44%), "live better with pain" (8.98%), "understand better" (7.30%) and "return to a normal life" (7.30%).

These data, admittedly biased by their monocentric nature, enable us to establish the typical profile of patients seeking care from our TCS: a 47-year-old woman suffering from spinal pain for 6 years and ultimately receiving little treatment given the intensity of the pain (7.5/10); we can identify areas for improvement in the prevention and management of these patients suffering from chronic pain:

-Raising public awareness of how chronic pain works and its various components,

-training doctors on the use of antidepressants in chronic pain,

-information campaigns on the role of chronic pain structures and the need to contact them early.

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**PO\_53 - MUSIPEDOL: The contribution of music therapy to pain management in paediatrics at Rouen University Hospital**

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Summary

Pain in children and adolescents is a major public health issue, profoundly affecting their emotional and social well-being, as well as their family and school environment. Optimal management of chronic pain requires a comprehensive approach, incorporating both medicinal treatments and non-medicinal interventions based on the bio-psycho-social model. Among the latter, music therapy stands out for its ease of application and its potential to reduce the use of analgesic drugs [1,2,3].

Our research, a prospective, descriptive study conducted at the Centre d'Évaluation et de Traitement de la Douleur (CETD) Pédiatrique du CHU de Rouen, aims to evaluate the effectiveness of music therapy in the treatment of acute, chronic or care-related pain in children aged 0-18 years, over a 12-month period. This treatment technique was implemented via the Music Care programme and was reserved for children for whom this approach had been recommended by the referring doctors or nurses in the pain unit.

The study included 52 children aged between 3 and 17, the majority of whom were girls (75%). Most were recruited following a consultation for pain (55%), suffering mainly from chronic pain (94%) of an abdominal, neuropathic and cephalic nature. Around a third of patients also reported anxiety associated with their pain.

The results obtained with the MUSIPEDOL programme revealed a significant reduction in pain and anxiety levels. Pain scores decreased on average by 1.47, 1.6 and 1.25 for the first, second and third sessions respectively. Similarly, anxiety scores decreased by 1.57, 1.74 and 0.67 for the same sessions. However, follow-up was difficult, with only 23% of children completing the three planned sessions. Despite these obstacles, the observed efficacy remains significant, with 80% of participants declaring themselves very satisfied with this non-medicinal method of pain management.

This study highlights the importance and effectiveness of music therapy as a complement to conventional approaches to paediatric pain management, offering a valid option for improving the quality of life of young patients.

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**PO\_54 - INDUCE DIABETIC NEUROPATHIC PAIN: SURVEY CARRIED OUT IN THE PAIN UNIT EPH ARRIS**

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Summary

INTRODUCTION :

The incidence of DP is more difficult to estimate and painful diabetic neuropathy is a very frequent form of ND, the presence of which indicates chronically unbalanced diabetes.

It should be systematically investigated by questioning, as patients do not mention it spontaneously or attribute it to other aetiologies.

Studies report a prevalence of between 10% and 50%.

OBJECTIVES OF THE STUDY :

The main aim of our study was to assess the prevalence of painful neuropathy and induced neuropathy in a group of diabetic patients, based on the DN4

Materials and methods :

This is a cross-sectional study carried out at the pain unit of EPH ARRIS, during 2018 to 2019, based on patient records and files consulted during the same period.

Target population :

-Our survey involved 147 diabetic patients recruited from the pain unit consultation.

All patients consulting for pain and presenting with type 2 diabetes with or without degenerative complications and regardless of the duration of the diabetes were included.

-We excluded patients with type 1 diabetes and women with gestational diabetes.

Equipment:

the diagnostic tool used is the DN4 score and the EVA

Results

The average age of our patients was 55.46, with extremes ranging from 46 to 82.

The survey population was made up of 62.5% women and 37.5% men.

The duration of diabetes was 12.5 years, with a minimum of one year and a maximum of 40 years.

The incidence of painful diabetic neuropathy DN4 was 29.5%, in the literature (10-50%)

63% reported new onset or worsening of pain after rapid insulin intensification

70.5% of diabetics have a DN4 score of less than 4/10 and 29.5% have a score of 4/10 or more

37.5% were taking oral antidiabetic drugs, 37.5% were taking insulin, 22.5% were taking a combination of oral antidiabetic drugs and insulin and only 2.5% were taking dietary hygiene measures alone.

Most of our patients (71%) had degenerative complications related to diabetes and only 29% had no degenerative complications.

79.5% do not meet the objectives in our survey (70% according to the SFETD white paper)

Conclusions:

Neuropathic pain is often under-treated Our survey will be fully useful when it is followed up by other studies, which will make it possible to compare the data and assess the progress made in diagnosing and treating neuropathic pain, which is often under-estimated and under-diagnosed, and where the various studies show that even when diagnosed, specific neuropathic pain medications are not always used to best effect, if at all.

**PO\_55 - Review of rheumatology patients' knowledge of their analgesic treatment**

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Summary

As part of the management of chronic pain in rheumatology, a large number of analgesics are prescribed, with a major risk of misuse. It is therefore vital to optimise patients' knowledge of these treatments in order to avoid any risk of iatrogenia. The aim of this study was to take stock of patients' knowledge of their painkillers in order to assess the value of setting up targeted pharmaceutical discussions to prevent their misuse.

The patients included were admitted to rheumatology consultations and day hospitals. They presented with chronic pain and were taking tier I analgesics (paracetamol, non-steroidal anti-inflammatory drugs (NSAIDs), nefopam) and/or tier II analgesics (tramadol, opium, codeine). Patients not known to be taking any of the analgesics studied were excluded. An interview grid consisting of general questions (identification of analgesics, self-medication) and specific questions (dosage, time taken, etc.) for each analgesic was drawn up in order to establish a score. Patients were contacted by telephone beforehand to explain the study and obtain their consent. Afterwards, a pharmacy intern conducted the interviews.

Data was collected between September 2023 and February 2024. Of 103 patients contacted by telephone, 60 responded. Of these, 40 patients were included, 7 patients refused and 13 patients were excluded from the study. The average age was 55, with a sex ratio of 0.54. The most common pathologies were ankylosing spondylitis (30%) and rheumatoid arthritis (20%). 75% of patients were taking paracetamol alone or in combination, and 35% NSAIDs alone or in combination. It was therefore decided to focus solely on these drugs and their combinations, as the population was too small for the other drugs. 95% of patients knew how to identify their painkillers on their prescription; 20% said they were self-medicating (mainly ibuprofen). The rate of correct response to the specific questions was 88.7% for paracetamol, 81.2% for NSAIDs and 66.8% for their combinations. Finally, 57% of patients would like to know more about the side-effects of their painkillers and how to take them.

The study shows that rheumatology patients are relatively familiar with analgesics. Combinations of analgesics are less well understood. It would therefore be appropriate to discuss them during personalised pharmaceutical interviews with each patient. The main limitation of the study was the small number of patients, which made it impossible to interpret the data for certain analgesics. It would be interesting to extend this study to a larger cohort of patients and include other analgesics. Nevertheless, the study confirmed the value of setting up targeted pharmaceutical interviews to promote the correct use of analgesics among patients.

**PO\_56 - Analgesic efficacy of non-invasive neuromodulation techniques in chronic cancer pain: a systematic review**

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Summary

Cancer has become a major cause of chronic pain, due to the tumour itself and/or its treatment(s): surgery, radiotherapy or chemotherapy (e.g. chemo-induced peripheral neuropathy (CIPN)) [1]. The increasing prevalence of such pain and the difficulties in treating it represent a major health challenge.

This pain is mainly nociceptive, but in around 30% of patients there is a neuropathic component that is often refractory to pharmacological treatments [2]. Current recommendations now suggest an integrative therapeutic approach, including the use of cerebral neuromodulation techniques.

Non-invasive brain stimulation (NIBS) such as transcranial magnetic stimulation (TMS) or direct current stimulation (tDCS) is increasingly used in the treatment of refractory neuropathic pain, but it remains unclear whether NIBS is effective on chronic pain associated with cancer. The aim of this study is therefore to examine the efficacy of NIBS on such pain by means of a systematic review (and meta-analysis) of the existing evidence in the literature.

This review follows the PRISMA recommendations [3]. Searches were performed using keywords related to cancer, pain and non-invasive brain stimulation (i.e., TMS and tDCS) on the databases: The Cochrane, PubMed, Web of Science and Google scholar.

The primary endpoint was pain intensity. The effect was assessed using the difference of means. A methodological evaluation and the quality of the evidence were examined according to the GRADE criteria, based on those of ANAES. [4].

Eight articles (154 patients) were included in this review: three concerned tDCS and five rTMS, of which four were randomised controlled trials and four were observational studies. Seven studies targeted stimulation of the M1 primary motor cortex, while one targeted the DLPFC dorsolateral prefrontal cortex. Stimulation parameters were high frequency for five articles (≥10 HZ or 2 mA), while two studies used low frequencies and one did not specify this. Despite a variation in the number of sessions performed in the studies, ranging from 2 to 35, all reported a decrease in pain intensity, with a slight trend in favour of tDCS.

NIBS appear to have an analgesic effect in cancer-related pain. However, due to the low level of evidence of the studies and the high heterogeneity of pain conditions, randomised controlled trials on larger homogeneous populations are now required to validate these promising results.

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**PO\_57 - Epidemiological-clinical, therapeutic and developmental profiles of patients treated at the Centre for the Study and Treatment of Pain in the Department of Internal Medicine at CHNU Dalal Jamm**

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Summary

Introduction:

The management of chronic pain is a real public health issue. It cannot be managed without an in-depth assessment of the various characteristics and aetiologies of the pain. The aim of this study was to evaluate this global approach to pain management and to demonstrate the need for dedicated centres.

Patients and methods:

We conducted a descriptive cross-sectional study including patients followed at the pain study and treatment centre of the Dalal Jamm National Hospital during the period January 2021 to December 2022. Data were collected and analysed using Epi Info software version 7.2.5.0.

Results :

This study involved 247 patients in 488 consultations over 24 months. The sex ratio M/F was 0.31, with an average age of 49.6 years and extremes of 18 and 87 years. Housewives made up 29.1% of the patients, followed by health workers (18.7%). Outpatient care was provided for 223 patients, with 12 requiring hospitalisation and 2 home care. The main reasons for consultation were lumboradiculalgia (52.4%), followed by peripheral arthralgia (13.41%), headache and diffuse pain (5.3%). As comorbidity, hypertension was found in 26.5% of patients and diabetes in 10.8%. In terms of characteristics, mixed neuropathic and nociceptive pain was found in 65.6% of patients, compared with 12.1% for nondisciplinary pain and 6.8% for simple neuropathic pain. The average pain intensity at EEN was 8/10, with extremes of 2/10 and 10/10. The identified causes of pain were related to degenerative disc disease in 103 patients; 11 cases of fibromyalgia were found and 5 cases of migraine. Anxiety was present in 80% of patients, depression in 38.8%. Treatment was dominated by antiepileptics in 21.42% of cases, followed by muscle relaxants in 14.7% and morphine analgesics in 1.7%. Complementary therapies were used in 76 patients for TENS, 23 patients for physiotherapy and 6 patients for psychotherapy. In terms of changes in pain intensity during follow-up, the EEN showed an average of 1.9/10, with extremes of 0/10 and 9/10.

Conclusion:

Pain management is a major public health issue. As a result, new approaches are needed to take account of the characteristics, repercussions and origins of pain and illness, in order to provide patients with a lasting solution.

Key words: Pain, nociceptive, nociplastic, complementary therapies

Bibliography

CETD Activity Report, Internal Medicine Department, Dalal Jamm National Hospital, December 2022

**PO\_58 - Reducing post-operative pain by reducing pre-operative anxiety: effectiveness of the Music Care© medical device (Dtx/web app) on heart rate variability in the operating theatre**

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Summary

Issue: Patients may experience a state of anxiety that can compromise certain surgical procedures, in particular cataract surgery performed under local anaesthetic [1,2], which may also have an impact on post-operative pain perception [3]. Digital therapies (DTx) are increasingly used and recent publications have described their impact on pain and anxiety using music [4,5]. In addition, heart rate variability (HRV) appears to be an objective parameter for quantifying the pre-operative level of anxiety [6]. The aim of this study is to evaluate the effects of Music Care© (DTx / web app) on HRV and pre-operative anxiety prior to cataract surgery.

Method/analysis: This multicentre, randomised, single-blind, controlled clinical trial consisted of 2 arms. Patients requiring cataract surgery were randomly assigned to either the experimental arm (Music Care, web application using the "U" technique [7]) or the control arm (earmuffs without music) for 15 minutes prior to surgery. The primary endpoint was LF/HF, and the secondary endpoints were RMSSD and anxiety level (VAS).

Results/discussion: Between June 2023 and March 2024, 184 participants were included in the study, 142 of whom were randomised (71 in each arm, mean age 68.5 years, 84 women). The LF/HF indicator improved significantly (p=0.0216) in the music group, falling from 4.0 (±3.9) to 3.3 (±5.1) in 5 minutes, corresponding to a reduction of 20% compared with an increase of 11.2 (±86.2) in the control group. The level of anxiety improved significantly (p<0.0001) in the music group, dropping from 6.9 (±2.0) to 4.0 (±1.7), corresponding to a 42% reduction compared with 4% in the control group.

A positive correlation was found between the descending tempo of the musical intervention and an increase in the HF value (Spearman's coefficient= -0.15; p=0.025).

Conclusion: This study suggests that a personalised musical intervention via the Web Music Care© application can be easily integrated into the care pathway of people suffering from anxiety prior to cataract surgery. It could also help to reduce post-operative pain. These results could facilitate the incorporation of biofeedback data into personalised musical interventions and offer a potential intervention worthy of investigation in other surgical contexts.

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**PO\_59 - Qualitative evaluation of the ETP programme offered to SDC patients at the Paris Saint Joseph Hospital in Paris, focusing on the group's experience.**

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Summary

The therapeutic education programme (ETP) at the Paris Saint Joseph Hospital pain centre aims to make patients more independent and improve their quality of life by enabling them to acquire new knowledge and skills relating to their pain. It takes place in groups of 6 to 12 people (4 weekly 2.5-hour workshops).

This programme is offered to "compatible group" patients.

The effectiveness of this programme needs to be evaluated in order to justify its continued existence and funding, and to promote ongoing reflection and improvement. With this in mind, it seemed appropriate to us to question the mechanisms implemented by the workshops and the way in which they were experienced/appropriated by the patients, through a qualitative study. This patient-centred approach enables us to better understand and envision what makes sense for the patient, based on the patient's description of the phenomenon experienced, and to see whether this can be shared by other patients. The aim of the study was to understand what it was like to take part in the ETP programme and, in particular, how the group structure of six to ten people affected this experience.

The study consisted of semi-structured interviews with participants one month after the end of the programme, exploring the cognitive, behavioural and emotional dimensions of their experience of these workshops.

From December 2022 to March 2023 29 patients took part in the workshops, 22 gave their agreement and 19 met the inclusion conditions (meeting the need for a homogeneous sample: completed all 4 workshops).

The interviews were carried out with up to the sixth patient volunteer, with the sufficiency of the data collected established after analysis of the 6 interviews. These 6 participants were divided into 4 different ETP groups.

Analysis of the results has identified six thematic groupings:

- A similar route to the ETPs

- A rewarding experience

- A demanding test

- A group of resource peers

- A heterogeneous group in their approach to pain

- A spark for a paradigm shift in the experience of pain

All in all, this study highlights the advantages of the group: enriching experience, meeting resourceful peers, but also the difficulties it can cause for certain patients who do not recognise themselves in the experience of others, but who may nevertheless question it. It reinforces our belief in the possibility of continuing these ETP group workshops.

**PO\_60 - Chronic paediatric pain before and after Covid**

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Summary

Since the COVID epidemic, there has been an explosion in requests for pain consultations in our department, and the burden on patients has worsened. In the past, our team had already used tools to assess emotional factors (anxiety and depression scales), and since 2019 we have been implementing a questionnaire to identify psycho-emotional and life factors, REPERADO (1), as well as using the PPST functional impact scale (2), the HAD questionnaire, the anxiety and pain scale and the CGI score (3). We recorded the duration of consultations, how they were organised (single doctor consultation, doctor/psychologist consultation in pairs, more recent HDJ pain) and systematically questioned whether pain was aggravated by the situation linked to the COVID, as well as suspected or confirmed long COVIDs. We called "aggravated by the situation linked to the COVID" all pain linked to or increased by individual and family elements following the COVID.

In 2013, 11.3% of patients with chronic headaches had a high anxiety score and 7% a high depression score on the HAD scale. In the year following the COVID epidemic, these figures rose to 37% and 16% respectively for chronic headaches and 30% and 9.6% for all our patients. That same year, a quarter of our patients were suffering from pain related to or aggravated by the COVID situation. This figure rose to 41% in 2023.

The worsening situation has made it necessary to increase the number of consultations in pairs. The length of consultations, already longer in paediatrics than in adults, has increased still further, with almost 60% of them lasting 2 hours or more. The HDJ pain unit has enabled better multi-professional assessment. We have had to step up our RSP (Réunions de synthèse pluri-professionnelle) and RCP (Réunions de Concertation pluri-professionnelle) meetings, and organise regular meetings with child protection teams to deal with the large number of violent situations. In 2023, almost half of our patients had been exposed (witnesses or victims) to situations of violence at school, whether verbal, psychological, sexual or cyber-bullying, 27% had been exposed to violence within the family and 26% had been exposed to both violence at school and within the family circle.

In 2023, the percentage of children with a high depression score had doubled since 2020-2021; that of anxiety had increased by 30%. 53 patients required prolonged hospitalisation, mainly in centres run by the Fondation Santé des Etudiants de France or in adolescent or mental health services, and 25 others refused.

The mental health of children and adolescents is currently a major concern (HAS, HCSP, paediatric conferences), and rightly so, and the effects of these difficulties are having a major impact on paediatric pain structures. Resources are needed to deal with this.

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**PO\_61 - Effects of the Music Care© web-app on pain associated with care following application of the Qutenza® patch in patients suffering from neuropathic pain: feasibility study**

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Summary

Introduction: Peripheral neuropathies are one of the most common neurological disorders. Some of these conditions can lead to severe disability and a significant reduction in autonomy. Qutenza® is a capsaicin-based transdermal system indicated for the treatment of peripheral neuropathic pain. Its use is frequently associated with painful reactions at the application site. Among non-medicinal interventions, those based on listening to music are of interest in the management of pain. Recent publications have described the impact of digital therapies (DTx) using music on pain [1,2].

Objective: To demonstrate the feasibility and evaluate the efficacy of using the Music Care© web-app on pain-related feelings during the application of the Qutenza® patch in patients suffering from neuropathic pain.

Method: Feasibility study. This controlled, open-label clinical investigation consisted of 2 arms and took place at the Noumea CHT. Patients were seen on an outpatient basis at the Centre d'Evaluation et de Traitement de la Douleur and had to be suffering from localised neuropathic pain. At the CHT, the patches were applied using cryotherapy. In addition, each patient was offered a musical intervention session during the treatment, in addition to the standard treatment. Each patch was assigned to either the intervention group (Music Care, web application using the "U" technique [3]) or the control group (no music). The primary endpoint of the study was pain level, measured before, during and after treatment using a visual analogue scale from 0 (no pain) to 10 (maximum pain).

Results: A total of 224 patches were applied to a total of 95 patients between 2016 and 2022, of which 53 patches (23.7%) benefited from musical intervention sessions lasting 20 minutes. The number of patches varied from 1 to 8 per patient, with an average of 2.4. Almost half the patients (43.2%) had only one session. Under Music Care, a significantly greater reduction in the level of pain was observed during treatment compared with the control group (-2.3±2.2 versus -0.6±3.2, p=0.0154, Mann-Whitney-Wilcoxon test).

Conclusion: This pilot study demonstrated the feasibility and assessed the impact of the Music Care© web-app on pain related to care in patients suffering from neuropathic pain. The next step would be to conduct a randomised controlled trial to confirm these results on a larger scale. These preliminary results could be used to calculate the number of subjects required.

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**PO\_62 - Perineural administration of botulinum toxin in the treatment of neuropathic pain: a retrospective series**

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Summary

Introduction. Neuropathic pain is defined by the IASP as "pain resulting from injury or disease affecting the somatosensory system". In France, the prevalence of chronic pain is 31.7%, including 6.9% with neuropathic features. Chronic pain remains under-diagnosed in general, considerably affecting patients' quality of life and causing major socio-economic problems [1]. Current French guidelines recommend the use of antidepressant or anticonvulsant treatments as first-line therapy, although the therapeutic response is often poor and there are significant side-effects. Other therapeutic alternatives seem to be emerging, in particular botulinum toxin type A (TBA). Subcutaneous injection of TBA into the painful area improves certain neuropathic symptoms, making the toxin a recommended second-line treatment for localised neuropathic pain [2]. Among other possible routes of administration, perineural administration of TBA around the nerve trunks or plexuses involved in chronic pain symptoms has been proposed [3]. Although the mechanism of action of TBA in peripheral neuromodulation remains unclear, applying the toxin directly to the nerve structure topographically involved in peripheral neuropathic pain would appear to be an interesting strategy.

Material and method. We present a monocentric retrospective case report on a series of 21 patients with a diagnosis of peripheral neuropathic pain of post-traumatic or post-surgical origin. Each patient underwent an ultrasound-guided anaesthetic test block for diagnostic and topographical purposes. After informing the patients and obtaining their consent, we offered them a perineural injection of botulinum toxin for their neuropathic pain. The doses used ranged from 50 to 150 units in a single injection, depending on the size of the nerve. At 3 weeks post-injection, we assessed pain intensity (numerical scale) as the main criterion. Secondary endpoints were neuropathic characteristics (NPSI questionnaire) and quality of life (EQ5D3L and PGIC questionnaires).

Results. We report a significant difference with a decrease in the intensity of neuropathic pain after botulinum toxin injection (median mean -3 points), also associated with a significant difference in the NPSI score and the EQ5D3L score. In addition, more than half the patients reported a significant overall improvement (PGIC). No serious adverse events were observed.

Conclusion. Botulinum toxin administered perineurally appears to be able to provide long-lasting relief of peripheral neuropathic pain, suggesting an additional therapeutic option for chronic pain patients for whom the current therapeutic arsenal remains modest. However, further comparative clinical studies will be needed to define and validate this therapeutic approach.

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**PO\_63 - Filling intrathecal pumps in end-of-life patients at home**

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##### **Summary**

In 2020, the French National Authority for Health (HAS) (1) published a recommendation on the management of patients suffering from intractable cancer pain using intrathecal pumps (ITP). The refilling of pumps in terminally ill patients at home or in hospital units that do not provide intrathecal analgesia is one of the many obstacles to the spread of this technique.

From 2019 to 2024, our team implanted 120 intrathecal pumps for patients suffering from intractable cancer pain; of these 120 patients, 11 required filling outside our centre, including 5 at home and 6 in another hospital facility that does not perform filling (palliative care or supportive care units).

We set up a strict procedure for monitoring fillings, with weekly telephone calls to patients by our team of pain referral nurses. The filling syringe was prepared in a laminar flow hood after checking with our prescription software. The syringe was sterile packed in a refrigerated container just before leaving for the filling. The practitioner left with the refrigerated container, the programming console and a Medtronic® filling kit. Filling was carried out at home or in the hospital ward on the patient bed, under the usual aseptic conditions.

During this period, we carried out 244 fillings for these 11 patients, including 44 outside our centre (HC), which represents an average of 20 fillings per patient, including 4 outside the centre, with an average distance travelled of 45 km.

The following table summarises the key figures

|  |  |  |
| --- | --- | --- |
| patient characteristics, fill-ups and kilometres travelled | | |
| Number of patients n=11 | Average | Standard deviation |
| Age (year) | 65 | 14,5 |
| PIT duration (months) | 10,6 | 16 |
| Driveway distance (Km) | 45 | 41,6 |
| number of fills | 20,3 | 22,1 |
| Number of HC fill-ups | 3,7 | 3,1 |

We did not observe any cases of infection during home or out-of-centre fillings.

As a reminder, the CCAM (2) coding (QZMP004) stipulates that when the filling or reprogramming procedure is carried out at the patient's home, it authorises reimbursement of the mileage costs incurred.

This small study shows how feasible this practice is on a day-to-day basis, and above all the need for training and support for palliative and supportive care centres, as well as the involvement of hospital at home (HAD) on a large scale in order to guarantee access for patients suffering from intractable cancer pain throughout the Hauts de France region, as recommended by the HAS.

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2). CCAM Classification Commune des Actes Médicaux (Common Classification of Medical Acts)

**PO\_64 - Museotherapy in oncology: soothing palliative care patients**

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Summary

The World Health Organisation's report of 11 November 2019 states that art can be beneficial to both physical and mental health [1]. Art therapy is emerging as a complementary form of care for cancer patients. This paramedical discipline is defined as "the exploitation of artistic potential for therapeutic and/or humanitarian purposes" [2]. Its aim is to create a space for support "beyond words" to help patients rediscover the desire, strength and means to overcome the difficulties associated with the disease and its treatment, and to give meaning to their lives by taking account of what is happening to them.

Museum therapy, a recent paramedical approach, is a component of art therapy. It is "the use of the museum environment and its collections to promote well-being or improve the state of health of participants" [3]. Since the health crisis, the important role of museums in the development of health and well-being has been recognised, supported by neuroscience, which reveals how art sculpts and caresses our brain. Museum therapy is emerging as a complement to standard care, improving its effectiveness [4-5].

Our study, carried out over the last 3 months in a cancer ward with identified palliative care beds (Hôpital Privé Océane, Vannes), has revealed through its initial results what museum therapy can offer patients in the early or advanced palliative phase. Firstly, we will define the specific features of palliative care in terms of dealing with total pain (physical, psychological, social and spiritual), and show how museum therapy can help to relieve patients through a comprehensive, multidisciplinary and personalised approach. Secondly, we will present our method of work and investigation, the choice of scientific scales for the assessments and, in particular, the approach to total pain and self-esteem. Thirdly, we will present the most significant results of the study. Finally, we will present our conclusions, highlighting the importance of museotherapy as a therapeutic space, but also as a place for social therapy.

KEYWORDS: Museotherapy; Palliative care; Total pain; Well-being

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**PO\_65 - The role of paracetamol in pain management in children: What do we know today?**

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Summary

THE ROLE OF PARACETAMOL IN PAIN MANAGEMENT IN CHILDREN: WHAT DO WE KNOW TODAY?

Background: The choice of an appropriate treatment for the management of pain in children from birth remains a subject of debate.

Objective: The aim of this study was to provide up-to-date information on the use of paracetamol in children.

Methods :

An exhaustive literature search was carried out on the use of paracetamol in children from birth. Its efficacy and safety were analysed on the basis of various studies, meta-analyses and recommendations from learned societies.

Results: The analgesic efficacy of paracetamol at a dose of 15mg/kg/day has been demonstrated in headache/migraine, traumatic pain, ENT pathologies such as pharyngo- tonsillitis, acute otitis media, sore throat or tonsillectomy and post-operative pain after dental extraction. Given its COX-independent central antinociceptive action, paracetamol is a good alternative to non-steroidal anti-inflammatory drugs for mild to moderate acute pain. Overall, paracetamol is well tolerated in children and adverse reactions at therapeutic doses are rare.

Conclusion:

Paracetamol has demonstrated a good efficacy/safety profile from birth in the treatment of pain. It is recommended as a first-line analgesic by the various learned societies for mild to moderate pain.

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**PO\_66 - Place of locoregional analgesia in children with Ewing's sarcoma**

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Summary

Ewing's sarcoma is a rare but aggressive form of bone cancer that mainly affects children and young adults. This type of cancer develops from bone cells or soft tissue surrounding the bone, causing persistent and very intense pain. Because of its rarity, complexity, tumour location and stage, a multimodal approach is often used. The treatment of Ewing's sarcoma requires a multidisciplinary approach involving paediatricians, oncologists, orthopaedic surgeons, radiotherapists, anaesthetists and other specialists to provide the best possible outcome for patients. Perioperative pain management is particularly important due to the often aggressive nature of the disease, surgical procedures and associated treatments. Locoregional analgesia techniques, such as peripheral nerve blocks, epidural or spinal analgesia, can be used to provide more effective pain relief. We share our experience from the orthopaedic department of Constantine University Hospital in the management of children with Ewing's sacoma. The patients were admitted to the operating theatre under general anaesthetic and received only paracetamol at the end of the procedure. On discharge to the ICU, an ultrasound-guided femoral block was performed. Immediate postoperative pain was assessed in the ICU using a verbal scale after the patients were fully awake, and then using a numerical scale at H1, H4, H6, H8 and H12. The reduction in pain was very significant throughout the hospital stay, without the need for morphine administration. Peripheral blocks have a proven analgesic benefit and form part of a multimodal management of postoperative pain. They are easy-to-use analgesic techniques. As well as reducing pain, they also reduce morphine consumption and its undesirable effects, thereby speeding up patient rehabilitation.

**PO\_67 - Management of neuropathic pain in spinal cord injured patients in a multidisciplinary neurological PRM unit - Nantes University Hospital.**

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Summary

Neuropathic pain in spinal cord injured patients is the number one health problem reported by patients, ahead of spasticity and sexual problems [1]. It has a major impact on the quality of life of spinal cord injured patients, as well as on their socio-professional and family reintegration [2]. Diagnosis requires a rigorous anamnestic and clinical assessment, due to the complexity of the multi-systemic deficiencies associated with SCI. Diagnosis is made on the basis of standard clinical assessments, ISNCSCI and ISCIP, and specific, recent and validated classifications and questionnaires, including DN4, SCIPI, ISCIPBDS and NPSI. The multidisciplinary management of neuropathic pain is complex. It requires a medical assessment to look for possible irritative spurs and an overall functional assessment of the patient. It is limited in therapeutic terms by recommendations based mainly on the management of peripheral neuropathic pain, and by the lack of evidence of the efficacy of pharmacological and non-pharmacological treatments for central neuropathic pain in this population [3]. In order to optimise the management of patients with spinal cord injuries, a multidisciplinary neuropathic pain management network has been set up within the University Department of Neurological PRM at Nantes University Hospital, which is a regional and inter-regional reference centre for spinal cord injuries.

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**PO\_68 - Pelvic pain and Thoracolumbar Junction Syndrome: An exploratory review**

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Summary

Context

Chronic pelvic-perineal pain is frequently encountered in the general population and is often difficult to diagnose and treat due to its multifactorial nature involving several anatomical systems [1]. Thoracolumbar junction syndrome (TLS) is a potential cause of this pain, but its recognition is often overlooked. This syndrome is characterised by referred pain in the pelvic and perineal regions without any apparent lesion, thus complicating the clinical diagnosis [2]. The aim of this study was to explore the prevalence, symptoms, treatments and outcomes associated with pelvic pain associated with LTPJS through an exploratory systematic review.

Method

For this exploratory review, the recommendations of the PRISMA extension for scoping review were followed. The inclusion criteria included all publications dealing with pelvic-perineal pain of thoraco-lumbar origin, excluding those due to spinal cord or disco-radicular impingement origins. The databases searched included Cochrane Central Register of Controlled Trials, PubMed and Google Scholar, and the search was conducted in April 2023. Study selection, data extraction and results synthesis were carried out systematically to ensure a rigorous assessment of the available information.

Results

The results show that the prevalence of TLS in pelvic-perineal pain varies between 2.5% and 66.1%, with a notable presence in approximately 30% of consultations for pelvic-perineal pain and 66% of chronic testicular pain. The clinical symptoms of pelvic pain were varied, including acute, deep, neuropathic and pulsatile pain, triggered by specific movements. Physical treatments such as spinal manipulation, passive mobilisation and self-administered exercises showed a significant improvement in symptoms in the majority of cases studied. The duration of treatment efficacy ranged from 5 months to 3 years.

Conclusion

LTPJS is a significant cause of chronic pelvic-perineal pain that deserves increased attention in diagnosis and clinical management. Recognition and appropriate treatment of LTPS can lead to substantial improvement in symptoms for patients suffering from this complex pain. This review highlights the importance of further research to refine diagnostic and therapeutic strategies, as well as to raise awareness among clinicians of this syndrome, which is under-diagnosed but can benefit from effective management.

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**PO\_69 - Prevalence and characteristics of chronic pain in general practice in Aquitaine. Quantitative, descriptive, cross-sectional study conducted by means of observations of training doctors in real care situations by base phase interns in 2023.**

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Summary

Introduction :

Pain is a ubiquitous symptom in general medical consultations [1][2].

In France, the prevalence of pain in general medical consultations is estimated at between 36 and 43% [3][4]. Among these types of pain, chronic pain is little studied in the literature; its prevalence in France is described as between 21 and 31.7%[4][5].

Chronic pain is a major public health problem, with significant costs associated with its management and repercussions.

Method :

We conducted a real-time quantitative descriptive cross-sectional study. The data were collected by general medical interns on a level 1 placement with the practitioner, using a questionnaire. This questionnaire, completed during consultations, enabled us to determine the presence of pain and chronic pain in patients undergoing consultations, and to characterise this pain.

Results :

A total of 688 questionnaires were analysed.

Acute or chronic pain accounts for 49.2% of consultations with general practitioners. Chronic pain accounts for 23.7% of consultations with general practitioners.

60.74% of chronic pain sufferers are women. Its prevalence increases up to the age of 74. It affects the rheumatological sphere in 93.3% of cases, with joint pain in 53.4% and spinal pain in 39.9% of patients.

In terms of aetiology, musculoskeletal pain accounts for 69.7% of chronic pain. However, no aetiology was found for 17.2% of patients.

Only 3% of patients are referred to a pain centre.

Discussion:

This confirms the importance of chronic pain in general medical consultations and the stability of its prevalence over the last 20 years.

Conclusion:

Chronic pain is very common in primary care. Improvements are needed in the way it is managed, in conjunction with communication between the city and the hospital. The training of healthcare professionals also needs to be studied.

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**PO\_70 - What management strategy should be adopted for back pain in pregnant women?**

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Summary

Introduction :

Disturbing physiological changes may be the direct consequence of these back pains in pregnant women.

These pains are intensified by risk factors: stress, weight gain, sedentary lifestyle, etc. They have a direct impact on quality of life: morale, daily activities, professional activities, sleep and sexual activity. This pain sometimes persists after childbirth. Their management should not be neglected.

Aim and objectives:

What is suggested or advised to prevent or treat dorsolumbosciatalgia in pregnant women?

We carried out a multicentre, prospective survey, using a questionnaire with closed and open answers, one aimed at pregnant women and the other at healthcare professionals.

Results :

Pregnant women: we obtained 77 responses. 67.5% experienced back pain during pregnancy. In 76.6% of cases, there was no self-medication. 44.4% had consulted their midwife and 28.6% their gynaecologist. Osteopathy was used by 60.8% of women, acupuncture by 21.7%, massage by 17.4% and physiotherapy by 4%. 85.7% of women were relieved by non-drug therapies (TNM). None of the pregnant women surveyed had received any advice or guidance.

We obtained 27 responses from healthcare professionals. 36% treated with TNMs and 44% with paracetamol combined with TNMs. TNM: 34% osteopathy, 24% lumbar belt, 10% physiotherapy...

Discussion:

TNM is the primary therapy for pregnant women. In our sample, 60% of women were physically active before pregnancy.

75.8% continued their sporting activities during pregnancy.

Healthcare professionals seem convinced of the benefits of TNM. It is advisable to limit weight gain and continue appropriate physical activity during pregnancy.

Conclusion:

The management of back pain in pregnant women requires referral to professionals trained in non-medicinal therapies for appropriate and safe treatment. It is recommended that sports activities be continued in an appropriate manner.

**PO\_71 - Creating a QUTENZA® capsaicin-based spice course: from theory to practice.**

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Summary

Introduction

Skin patches containing capsaicin are an interesting therapeutic option for patients suffering from localised peripheral neuropathic pain resistant to analgesics alone. Following a benefit/risk assessment, and in view of the proven need within our establishment, a "QUTENZA" programme was set up by a multidisciplinary team led by the algologist. The aim of this work is to provide feedback on the development of this pathway within our hospital.

Method

Following a review of the literature and meetings between the pain team, the medical day hospital (MDH) and the in-house pharmacy, the supply circuit and patient pathway were defined. Each healthcare professional has received the mandatory training required by the risk management plan for capsaicin. Procedures have been drawn up describing the stages in the patient pathway and the role of each person involved. These include a checklist of the equipment required for insertion, and an operating procedure listing the steps involved in inserting/removing the device and monitoring vital signs. An information flyer for patients has been designed to ensure safe treatment.

Results

Started in January 2024, 8 healthcare professionals have been trained to apply the patch in our establishment. There are 4 main stages in the patient's journey: 1/initial medical consultation with the algologist, 2/application of the patch and its removal in the hospital, 3/telephone call from the pain nurse 10 to 15 days after application and 4/a medical consultation one and a half months after application to reassess the pain. To date, 8 patients have benefited from this treatment, with one or two patches applied in our establishment. A total of 12 patches have been applied, in a variety of locations (chest, back, breast, knee and foot). Initial feedback from patients has been very satisfactory. On a numerical scale, average pain during application was rated at 6/10.

The first applications have already enabled us to identify areas for improvement: the application of frozen ice packs, which are more effective in reducing pain than those that are only refrigerated, and the addition of single-use gowns to gloves and masks following the appearance of skin rushes and tingling sensations in the nurses who performed the application.

Concluding discussion

The creation of this "QUTENZA®" network meets a real need among our patients suffering from chronic neuropathic pain. Setting it up required multidisciplinary coordination to ensure that the risks associated with capsaicin were optimised for both patients and healthcare professionals.

**PO\_72 - Refractory post-mastectomy pain syndrome: two cases treated by spinal cord stimulation**

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Summary

Introduction

Breast cancer is the most common malignant disease affecting women worldwide. Surgery and adjuvant chemotherapy are the main curative treatments, but 25-60% of these women suffer from chronic post-surgical pain [1].

Post-mastectomy pain syndrome (PMPS) involves chronic neuropathic pain localized to the axilla, the inner arm and the anterolateral chest wall. PMDS is frequently refractory to systemic and topical analgesics. Blocks using perineural injections of LA and delayed corticosteroids [2], or even botulinum toxin or neurolytic agents (phenol), represent an effective but generally short-lived alternative.

Spinal cord neurostimulation (SCN) is a reversible, minimally invasive neuromodulation technique with recognised efficacy in the treatment of localised neuropathic pain. Its most common indications are pain of radicular origin, algodystrophy and peripheral neuropathy [3]. The treatment of PMDS with NSM has not yet been the subject of recommendations. However, it could play a central role according to an interventional management algorithm proposed by an American team [2].

Materials and methods

We present two cases of PMDS refractory to analgesics and anaesthetic blocks. Both patients suffered from neuropathic pain localised in the sensory territories of the first five intercostal nerves and the lateral cutaneous nerves of the arm. Disabling dynamic mechanical allodynia was present.

We suggested implanting spinal cord stimulation electrodes for testing purposes. After duly informing the patients, answering their questions and obtaining their consent, we implanted 8 electrodes (Boston Scientific) percutaneously, under local anaesthetic and vigorous sedation, which were positioned in the cervicothoracic epidural space.

The tests were carried out using a programme (FAST-TM Therapy) which simultaneously combined tonic stimulation and "silent" stimulation, below the threshold for the perception of paresthesia.

We assessed pain intensity (VAS), neuropathic features (NPSI) and quality of life (EQ5D5L) before, during and after the test period.

Results

The neurostimulation tests were positive, leading to the implantation of the generators on D7. FAST-TM Therapy programming was started. We report a lasting disappearance of allodynia as soon as the intraoperative tests were performed, with a significant improvement in pain scores and quality of life at 1, 3, 6 and 12 months of treatment. No adverse effects were observed.

Conclusions

NSM appears to have good analgesic efficacy in PMDS, with a significant and lasting improvement in quality of life. FAST-TM Therapy appears to be highly effective for allodynia. However, powerful comparative studies are needed to confirm this hypothesis and to define the exact role of NSM and the type of programming.

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**PO\_73 - Should a ketogenic diet be proposed for long COVID?**

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Summary

Introduction

Long COVID is a nosological entity whose clinical presentation is similar to Fibromyalgia. Recent studies suggest that the interaction between SarsCov2 and mitochondria is a key element in the pathophysiology of COVID 19 (1). The aim of this study is to characterise the metabolic profile of patients presenting with long COVID.

Materials and methods

We present a retrospective study of patients who consulted the Pain Centre between 1 April 2022 and 31 March 2024 for chronic fatigue and pain that began in the immediate aftermath of a Sars-Cov2 infection or a Covid vaccination. A full interview, clinical examination, inflammatory and metabolic work-up (Ionogram, orally induced hyperglycaemia, lipid profile, membrane fatty acid profile, urinary catecholamine assay) was carried out. A quality of life questionnaire was administered to all patients.

Results

Over the period in question, of the 21 patients who met the inclusion criteria, 14 patients consulted the pain centre for the first time, and 7 patients were already known to the pain centre. There were three children (aged 11 and two aged 17), 15 women and 2 men. BMI ranged from 17 to 46 (median 24).

Of the 13 non-diabetic patients with a complete metabolic work-up, 7 had a high Homa test (57%) and only 1 had a low test. Of the 5 patients with a normal Homa test, 3 had a pathological HPGO curve.

The standard lipid profile carried out in 11 patients was pathological in 5 cases (low HDL n=4). In 6 patients who had a membrane fatty acid profile, 4 had very low levels of eicosapentaenoic acid (EPA).

As for urinary catecholamines, adrenaline was not detectable in 8 of the 10 patients who underwent this test.

CRP was normal (<5) in 12 out of 13 patients, but CRP US was normal in only 3 out of 13 patients.

Discussion

The majority of non-diabetic patients (10 out of 13) showed signs of dysregulation of carbohydrate metabolism, either insulin resistance as revealed by an elevated Homa test or a disturbed OGTT.

Impaired carbohydrate metabolism and reduced adrenalin secretion are two factors that may explain the chronic fatigue experienced by these patients.

Mitochondrial dysfunction may explain the whole picture. In addition, the lack of fatty acids means that these patients cannot compensate for the lack of carbohydrate metabolism for energy production.

It is possible that reducing carbohydrate consumption and increasing fatty acid intake will enable the mitochondria to function better.

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**PO\_74 - Music Care® and low back pain in the elderly: a pilot study in the United States**

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Summary

Background: Low back pain is a common complaint in the elderly, causing functional disability and reduced quality of life. Non-drug interventions (NDIs) are recommended as a first-line treatment, but their evaluation in practice is often limited, both clinically and pathophysiologically.

Music Care® is a digital application dedicated to relieving pain and anxiety by listening to music, and falls into the category of NMIs. The musical sequences, specially composed for Music Care® and based on the "U" sequence technique [1], respond to algorithms whose parameters evolve over time to bring the listener to a state of relaxation and release, as would hypnosis, but with a musical induction and not by voice.

Method: A single-centre, open-label pilot study carried out in the Houston area in black patients over 65 with low back pain to assess the acceptability and impact of Music Care® on pain, both clinically and neurophysiologically.

Results: 20 patients with low back pain, including 13 women, with an average age of 71.6 years, were exposed to 2 Music Care® sessions of 20 minutes per day for 4 days, at home, via their digital tablet or telephone [2].

Acceptability of the musical intervention, measured on the TAP (Treatment Acceptability and Preference) scale from 0 to 4, was high and greater than or equal to 3 in 80% of participants. Pain levels were measured on a numerical scale from 0 to 100 over the 4 days of the study. Mean pain scores decreased significantly (p=0.002) between the first assessment on Day 1 and the last assessment on Day 4, from 46.90 (SD=21.47) to 35.70 (SD=16.57).

In parallel, cortical activity using functional near infrared spectroscopy (fNIRS) was assessed twice in each patient, after pressure on the lower back to induce pain: before the first Music Care® session, and the second time after the last listening session 4 days later [3]. A significant reduction in the haemodynamic activity of the primary motor areas and somato-sensory areas of the brain in both hemispheres was observed (n=12), suggesting that music listening sessions could act on cerebral activity and modulate the mechanisms of perception of painful stimuli.

Conclusion: In this pilot study of low-back pain patients aged over 65, the 4-day Music Care® intervention was well accepted and significantly reduced the sensation of pain. Assessment of cortical activity by fNIRS also suggests that it may modulate the perception of painful stimuli in the central nervous system.

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**PO\_75 - Pain in neurofibromatosis: place of ultrasound-guided popliteal sciatic block**

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Summary

Neurofibromatosis is a complex genetic disease often accompanied by chronic and severe pain due to the presence of neurofibromas on the nerves. Pain management in this condition represents a major challenge, requiring a variety of therapeutic approaches. Locoregional anaesthesia (LRA) is emerging as a potential option for effective pain control in these patients. We share our experience of two children, aged 12 and 10, who had neurofibromas removed from their legs. Both patients presented with very intense postoperative pain (EN at 8 and 10) that did not respond to the usual analgesics (paracetamol and NSAIDs). An echo-guided popliteal sciatic block was performed on them using bupivacaine.ALR represents a promising therapeutic option for pain management in patients with neurofibromatosis, offering benefits in terms of pain reduction and improved quality of life. However, careful risk-benefit assessment is required, and this approach needs to be integrated into a multidisciplinary framework for optimal pain management.

**PO\_76 - Music Care©, a digital musical intervention to relieve pain and anxiety: systematic review and meta-analysis**

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Summary

Background: Digital technologies and other emerging innovations are playing an increasingly important role in the healthcare arsenal of our systems [1,2]. Designed on the basis of scientific research and clinical recommendations, Music Care© is a personalised digital musical intervention application offering a catalogue of original musical sequences of varied cultural inspiration specially composed and arranged according to standardised specifications (the U-shaped sequence) [3]. The Music Care© application is used in various clinical situations to reduce anxiety and pain in people suffering from a variety of pathologies [3,4].

Objective: To identify studies evaluating the effectiveness of Music Care© in the management of pain and anxiety in various clinical contexts and to carry out a meta-analysis.

Method: Original publications, in French or English, of randomised controlled trials (RCTs) evaluating the Music Care© application were included and analysed to assess the effectiveness of a musical intervention programme in medicine. Ongoing trials were also listed.

Results: A total of 14 RCTs were included. The majority of studies involved acute or chronic pain conditions and acute anxiety. Compared with the control arm, Music Care© was effective in reducing pain and anxiety in most of the medical contexts studied, particularly in surgical settings and in people suffering from chronic pain or Alzheimer's disease. Significant improvements were also reported in cardio-respiratory function, depressive symptoms and levels of stress and burnout.

Conclusion: The available studies are methodologically heterogeneous, but they generally support the effectiveness of the Music Care© application in reducing pain, anxiety, depressive symptoms and stress and burnout symptoms in a variety of medical conditions and procedures. Standardisation of the intervention simplifies its clinical application and facilitates its rigorous evaluation, but the control conditions used in the studies are varied. Music Care© could be a useful tool that is affordable, mobile and easy to implement as adjuvant therapy in a wide range of clinical situations.

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