



# REVISTA BRASILEIRA DE ANESTESIOLOGIA

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## LETTERS TO THE EDITOR

### Change Pain Latin America – new initiative established to enhance management of patients with chronic pain in Latin America

Dear Editor,

I wish to advise you of the formation of a new scientific advisory panel, committed to enhancing the quality of life of chronic pain patients in Latin America. The panel was formed in response to the encouraging outcomes observed with the Change Pain Europe program, which aimed to identify the unmet needs of European chronic pain patients and provide best practice solutions to improve patient outcomes. The panel of regional experts is driving a pan-Latin American initiative: Change Pain Latin America (CPLA).

The CPLA Advisory Panel comprises 17 experts from Brazil, Chile, Colombia, Costa Rica, Ecuador, Mexico, Peru, Venezuela and Spain, who work across a variety of clinical pain-related specialties (Table 1). Panel members are applying their knowledge and experience to highlight and address the unmet medical needs associated with treating patients with chronic pain in Latin America and overcome obstacles to improve best practice and outcomes in this region. The inaugural meeting of the panel took place in Miami (June 28–29, 2012) where discussions focused on current treatment paradigms in Latin America and barriers to effective patient management. During this meeting, the objectives for CPLA were determined after robust discussions, and accepted with consensual agreement from the panel members (Table 2).

While suboptimal management of patients with chronic pain is a global issue, factors that contribute to this problem in Latin America include gaps in physicians' understanding and associated pain management misconceptions. Patients in Latin America often misunderstand the risks associated with analgesics, making patient education a priority. Consequently, healthcare professionals in the region have inadequate knowledge of the advantages and disadvantages of opioids, and the correct dosing of these medications, which limits appropriate prescribing. Other significant barriers include limited patient access to medications and/or pain specialists and specialist facilities, as well as restrictive government healthcare policies. All of these factors

contribute to the unmet medical needs of patients with chronic pain in Latin America.

At the second CPLA meeting in Mexico City (November 9–10, 2012), the panel unveiled several key initiatives designed to address these unmet needs. To help improve patient management, panel members are now reviewing international chronic pain guidelines to identify management strategies that are most relevant to Latin America. The next step will be to provide physicians throughout the region with clear treatment recommendations based on this research to facilitate the adoption of uniform best practice throughout the region. The first set of recommendations will focus on chronic low back pain. The unmet need for education among physicians is also being addressed via an online 'Meeting in a Box' tool comprising an up-to-date slide library and meeting organization resources for the education of groups of physicians on key issues in chronic pain at local meetings. In addition, newsletters detailing key regional issues in chronic pain management and activities planned by the CPLA panel to help address these issues, will be distributed to the wider healthcare community.

Part of the panel's efforts will focus on gaining a better understanding of the burden of chronic pain in the Latin American region. Panel members have conducted a meta-analysis of available epidemiological data, which established the prevalence of chronic lower back pain in the region and highlighted the need for more robust studies. To support this, the panel discussed a new burden of disease protocol that is designed to quantify healthcare resource consumption by chronic pain patients across Latin America. The data generated should provide consistent estimates of both the direct and indirect costs associated with this burden in all member countries, which it is hoped will inform better resource management in the area. In addition, information on prescribing and diagnosis habits among physicians in Mexico will be published in the near future. If the survey is extended to include the entire region and repeated on a yearly basis, it will allow changes in clinical practice across Latin America to be documented.

The CPLA panel will establish working groups to focus on meeting accepted consensus objectives. Practical strategies are required to break down regional-specific barriers to the effective management of patients with chronic pain. Improved training and ongoing education of healthcare

**Table 1** Change Pain Latin America Advisory Panel members.

Argelia Lara-Solares	Mexico	Anesthesiology, pain management and palliative care
José Alberto Flores Cantisani	Mexico	Anesthesiology, pain management and palliative care
César Amescua-García	Mexico	Anesthesiology, pain management and palliative care
María del Rocío Guillén Núñez	Mexico	Anesthesiology, pain management and palliative care
Aziza Jreige Iskandar	Venezuela	Physical rehabilitation
Patricia Bonilla	Venezuela	Anesthesiology, pain management and palliative care
João Batista Santos Garcia	Brazil	Anesthesiology, pain management and palliative care
Osvandré Lech Durval Campos Kraychete	Brazil Brazil	Orthopedics Anesthesiology and pain management
María Antonieta Rico	Chile	Anesthesiology, pain management and palliative care
John Jairo Hernández-Castro	Colombia	Neurosurgery, pain management and palliative care
Frantz Colimon	Colombia	Anesthesiology and pain management
Carlos Guerrero	Colombia	Anesthesiology, pain management and palliative care
William Delgado Barrera	Costa Rica	Anesthesiology
Manuel Sempértegui Gallegos	Ecuador	Anesthesiology and pain management
María Berenguel Cook	Peru	Anesthesiology, pain management and palliative care
Concepción Pérez Hernández	Spain	Anesthesiology and pain management

professionals and providers are needed to improve diagnostic and treatment decisions. This will increase appropriate prescribing of currently available analgesics and the acceptance of new analgesic technologies as they are approved across Latin America. A greater understanding of the burden of pain in Latin America is also critical moving forward. By generating robust epidemiologic and pharmaco-economic data for the region, CPLA will assist efforts to predict how the needs for analgesics will change in future. These new data and current

**Table 2** Objectives of the Change Pain Latin America Advisory Panel.

- Identify the relevant factors influencing the treatment of pain and the decision makers across Latin America
- Understand the relevant factors/reasons behind the current pain treatment paradigm
- Identify the levers that can be used to modify the situation
- Establish the link between medical practice and theory in the management of chronic pain
- Establish the real unmet needs in the treatment of chronic pain in Latin America
- Better understand the reality of chronic pain patients today
- Find consensus on the challenges in managing chronic pain from a physician's perspective
- Evaluate the need to educate to raise the awareness on best practice in the management of chronic pain
- Assess the need to enhance communication between physicians and patients as a way to improve the management of pain
- Develop solutions based on research data and experts' opinion supporting more effective and efficient pain management
- Increase knowledge and provide appropriate tools to improve pain diagnosis
- Eliminate opiophobia through education of healthcare professionals and patients on opioid treatment

evidence will also be vital in endeavors to facilitate greater dialogue with national government decision-makers, and help reshape healthcare policy leading to the best possible care for patients with chronic pain in Latin America.

To help highlight the relevant issues in Latin America, CPLA is seeking to partner with established national pain organizations across the region. A familiar approach assisted Change Pain Europe, which is endorsed by the European Federation of IASP® Chapters (EFIC), in achieving its aims.

The CPLA Advisory Panel is next scheduled to meet in May 2013, with a further meeting planned for later in 2013. Practical materials are being developed and will be disseminated at a national level. For further information about CPLA and the CPLA panel, please visit the website at [www.latamchangeinpain.com](http://www.latamchangeinpain.com).

### Conflicts of interest

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## Contraction versus contracture and centronuclear myopathy versus central part myopathy in malignant hyperthermia

Dear Editor,

We read with great interest the review article by Correia et al. "Malignant hyperthermia: clinical and molecular aspects"<sup>1</sup> (*Hipertermia maligna: aspectos moleculares e clínicos*) and would like to comment on some aspects.

In the section "Malignant hyperthermia", item "Contraction to exposure to halothane-caffeine (TCHC) Test", Correia et al. use the term "contraction" instead of the original term "contracture". The test for diagnosis of susceptibility to malignant hyperthermia (MH) is based on an abnormal contracture response after administration of caffeine/halothane, and not on the normal response of muscle contraction after electrical stimulation, which is applied throughout the test to prove viability of the muscle fragment tested. Fig. 1 shows the difference between contraction and contracture in the chart of a positive test in a patient susceptible to MH. Thus, the nomenclature should be "contracture test" in English and *teste de contratura* in Portuguese.<sup>2-4</sup>

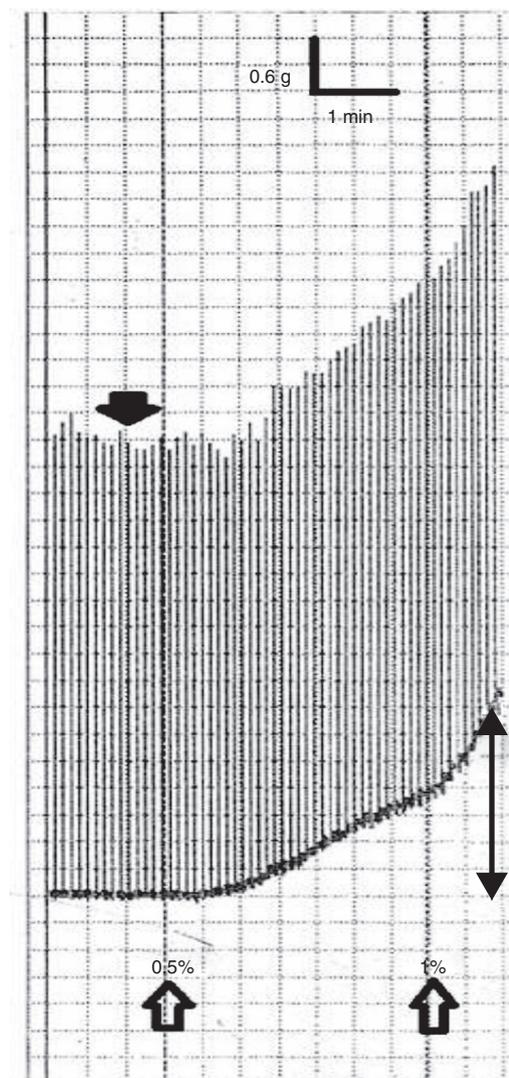
Also in this subsection, we emphasize that the cutoff levels of TCHC cited correspond to values used in the U.S. group of HM (MHAUS – [www.mhaus.org](http://www.mhaus.org)) protocol. Moreover, the protocol of the European MH Group (EMHG – [www.emhg.org](http://www.emhg.org)) differs from the U.S. one in additional aspects that were not mentioned, such as the number of fragments tested (six in the U.S. and four in the European protocol), halothane administration (single dose of 3% in the U.S. and an increasing dose from 0.5% to 3% in the European protocol) and finally the cutoff, which is 0.2 g to for halothane 2% and 0.2 g for caffeine 2 mm in the European protocol.<sup>5,6</sup>

Unlike that noted by Correia et al., in Brazil the Cedhima (Center for the Study, Diagnosis and Research for Malignant Hyperthermia), Escola Paulista de Medicina, Universidade Federal de São Paulo (UNIFESP) uses the European MH group protocol for *in vitro* muscle contracture testing (IVCT).<sup>4</sup>

In the same section "Malignant hyperthermia", item "Treatment", Correia et al. include as an indicated measure the "Replacement of anesthesia circuit by other circuit uncontaminated by anesthetic agent". It is important to emphasize here that there is no indication for this measure during the treatment of a crisis, but only in the preparation of the anesthetic machine for anesthesia in a patient with a history of HM. At the time of a MH crisis we must "disconnect the vaporizer, but with no waste of time changing the circuit or the anesthetic machine".<sup>7</sup> In "Dantrolene" item,

although Correia et al. state that the modern clinical use of dantrolene is restricted to malignant hyperthermia, this drug is still employed in the management of spasticity.<sup>8</sup>

Furthermore, the maintenance of dantrolene for 24–48 h after the initial treatment of HM crisis is important to avoid



**Figure 1** *In vitro* muscle contracture test (IVCT) in response to halothane. The two lower arrows indicate the time at which the drug was added. The upper arrow indicates the lines that correspond to muscle contractions triggered by electrical stimulation. The lateral double arrow indicates the ascension of the base line, which corresponds to an abnormal muscle contracture.