Correspondence

Addressing physician resources for chronic pain management

To the Editor:

The article by Veillette *et al.*¹ in the June/July issue of the Canadian Journal of Anesthesia draws attention to the serious problem of under funding of chronic pain management in Canada. Québec is not unique in its scarcity of multidisciplinary clinics and lengthy waiting lists. Large areas of Ontario have no access to any chronic pain specialists, let alone multidisciplinary clinics, and waiting lists have ballooned to up to two years in other provinces. In this writer's opinion, the situation will continue to deteriorate unless national and provincial strategies are undertaken promptly.

As Veillette and collaborators state, chronic pain is not rare in Canada with an overall prevalence of 29% and considerably higher in those over 60. While demand is increasing, the supply of pain specialists is dwindling. Physicians treating chronic pain are retiring/leaving practice and are not being replaced. A survey I conducted electronically in May, 2005 of 13 university-affiliated Pain Clinic Directors across Canada found that there were only 12 to 15 post-graduate trainees in Chronic Pain Management in the country and some were planning to return to their homeland after training. In the past few years, in South-western Ontario alone, three have left pain practice and three others are on the verge of retiring.

To address the impending crisis effectively will require a multi-pronged attack including the following components:

- 1) Increased education in Chronic Pain Management at the undergraduate and postgraduate level particularly in Family Medicine, Physical Medicine, Rheumatology, Neurology and Psychiatry residencies. Currently, only Anesthesiology requires mandatory training in this area, yet for the reasons outlined in the article, only a small number of certified anesthesiologists are involved in any form of chronic pain service. Family doctors will continue to provide the mainstay of treatment but are not being adequately trained or supported in the task.

- 2) Improved provincial insurance fee structure to allow physicians to spend the time necessary to deal with the needs of complex chronic pain patients.

- 3) Envelope funding from provincial Ministries

of Health to support the allied health services required in multidisciplinary pain clinics.

We cannot afford multidisciplinary care for all chronic pain patients; fortunately all do not need it. It is also possible that with greater awareness of the relationship between acute and chronic pain, relatively simple low-cost strategies could be implemented to identify and treat patients earlier who are at high risk of developing persistent pain.

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Reference

- 1 Veillette Y, Dion D, Altier N, Choinière M. The treatment of chronic pain in Québec: a study of hospital-based services offered within anesthesia departments. *Can J Anesth* 2005; 52: 600–6.

General anesthesia for a patient with alternating hemiplegia of childhood

To the Editor:

Alternating hemiplegia of childhood (AHC) is a rare neurological disorder, diagnosed clinically, usually after 18 months. It is characterised by attacks of unilateral hemiplegia, with variable duration and severity. Seizures, oculomotor disturbances and cognitive impairment, can occur. It was first described by Verret in 1971 and is a diagnosis of exclusion and of unknown etiology.¹

A pregnant 37-yr-old woman with AHC presented at 13 weeks gestation for a termination of pregnancy for severe fetal malformation. Alternating hemiplegia of childhood had been diagnosed at age 14, after an initial misdiagnosis of myasthenia gravis. Her attacks regressed during adolescence, being able to control the triggering factors, namely stress, anxiety, exertion and extremes of temperature. Two previous volatile anesthetics were followed by extreme limb weakness, and difficulty swallowing. Symptoms in both cases resolved without intervention, although the cause was unclear. A general anesthetic performed in 2000 for a Cesarean section was performed with propofol as a target controlled infusion (TCI). A modified rapid