香港疼痛學會
The Hong Kong Pain Society

Newsletter
Oct 2015

Message from the President

Dear Colleagues and Friends,

I am delighted to share with you that, with the help of the Hong Kong Pain Society, the Hong Kong Pain Foundation was successfully incorporated. A Kickoff Ceremony was held on 2 June 2015. In this issue of our newsletter, there will be a special report on this memorable event.

With the establishment of the Hong Kong Pain Foundation, there will be a delineation of work. The Hong Kong Pain Foundation will focus on providing public education as well as community support for patients suffering from pain. The Hong Kong Pain Society will concentrate our work on continued education and training of healthcare professionals with interest in pain management. The Society and Foundation will join our hands to ensure "Relief of pain as a basic human right".

I have finished my second term as the President of the Society. According to our constitutions, I have to hand over the post to my successor. I would like to thank our council members and all those who have helped in the activities of the Society. Please continue to render your support to our next council.

Best wishes,

Dr Steven Wong
President
The Hong Kong Pain Society

Announcement:

1. HKPS Annual Scientific Meeting 2015

Date: 17-18th Oct 2015
Venue: Sheraton Hong Kong Hotel & Towers.

2. The 9th AGM

Date: 17th Oct 2015
Time: 12:10
Venue: Sung Room II, 4th Floor,
Sheraton Hong Kong Hotel & Towers
AGM will be followed by an EGM for a special resolution on approval of an injection of seeding money to the Hong Kong Pain Foundation from the HKPS.

3. Newsletter article submission

HKPS newsletter serves as a platform for interaction between specialties in pain management. Members are welcomed to submit article related to clinical updates or sharing experience in managing pain in daily practices. A book coupon will be rewarded once the article is published.

For any enquiry, please contact Dr. Doris LEUNG at newsletter.painsociety@gmail.com

HKPS membership:

There are different membership plans for our society. Lifetime membership offers single payment ($3000) and saves the trouble of annual renewal ($300).

Benefits of members:

- Discounted price on HKPS conference and meeting
- Conference Grant for overseas meeting
- Quarterly newsletter

Please see details at : wwwhkpainsociety.org

Welcome of new members:

Ms. LAU Kar Woon
Mr. LAU Pak Wai
Ms. PI Sing Sui

Pediatric Pain

Dr. Kwong Ngai Shan, Consultant, Department of Paediatric, TMH

Pain is an unpleasant, highly complex and subjective experience.
It is above all a perception associated with negative feelings, very often associated with fears, anxieties and sense of difficulties. Children may have difficulty in communicating pain due to various reasons, and their pain expression and recognition may vary through different developmental stages. Appropriate pain assessment and management is important in addressing children's need and preventing pain related complication.

There had been a long history of misunderstanding and recognition of pain sensation in children until the 80's. For years, it was believed that children did not experience pain in the same way as adults, as people thought that perception of pain was dependent on high level of maturation of intra-cortical association and memories, which are not possible for infants. Evidences in 1980s changed this traditional belief when scientific studies showed that children could experience pain from week 26 of gestation and painful stimuli are conducted by both myelinated and unmyelinated fibers, and that complete myelination is not necessary for pain to be felt. Noxious stimuli have been shown to produce cortical response in preterm babies. Others confirmed that neonates exhibited behavioral, physiological, and hormonal responses to pain. Young kids can report the intensity of pain by age of 3 to 4 years.

Sure, pain is highly subjective and can only be defined by the person who experiences it. Today, our understanding of pain should be towards the concept of totality. Instead of the traditional dichotomy between 'somatic complaints/pain' and 'psychogenic pain', we should view and assess **'total pain', with physical, psychological, experiential, and spiritual dimensions**. Pain is like a cry addressed to others, especially to carers, asking for the suffering to be heard and addressed.

Children feel pain when having a disease, an injury, with procedures and examinations that hurt, and they retain traumatic memories. Next time, when they encounter similar situations (environment, smell, sight of personnel), they have 'anticipated pain', negative feelings flashback, overwhelming them. This lasts long, as commonly seen in children with frequent visits and follow ups in hospitals and clinics. In pediatrics, there should be more, because a child's subjective experience may invariably generate emotional response in their family members (parents, siblings, close relatives) and their feelings will resonate with that of the child.

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The main goal of pain management is to understand better the personal experience of the individual, and to adapt management to relieve their (subjective) sufferings. This concept is well received in adult practice and should also be our preaching as well for child care workers. We therefore adopt the following approaches in practice:

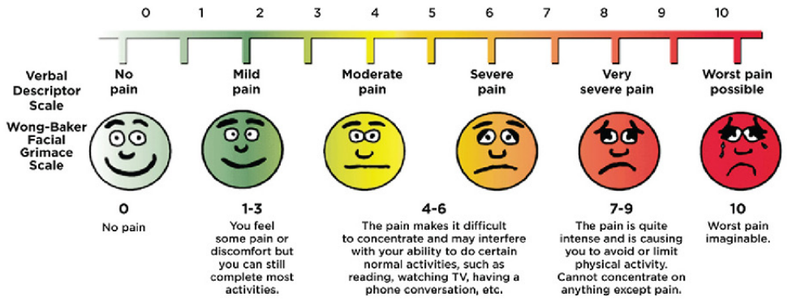
Preventive measures:

- Provide children and family with **friendly and supportive environment** (physical, facilities, toys and pictures, intonation, gestures, etc)
- **Anticipate anxiety** raised in discussion and examination procedures
- **Build trusting relationship** with family and child, **facilitate therapeutic communication** so that the child can feel secure and adequately protected by health care workers
- **Minimize painful procedures**, and have age-appropriate communication and explanation whenever possible
- **Demonstrate respect to child as a whole person** (despite their limited cognitive level and young age) who has interests of their own
- **Spend time** to talk and soothe, especially for a child who anticipated pain, who is already in distress and overwhelmed. Reduce their level of anxiety and be patience, be supportive and gentle, not forcing the way for a procedure. Remember: the memory of pain can be more damaging than its initial experience!

Pain management measures:

- Use **distraction** if possible to down-modulate the perceived intensity of pain, as informed by our understanding from neurophysiology of pain and pathways. Talking with the child about his/her favorite topics and interests are very helpful.
- **Reassure the parents** as well by well preparing them through good therapeutic communication. Adequate information should be shared. They can be the best comforters for the child and help facilitating a smooth process for us. They also help monitoring and sharing information of the progress, and ensure good compliance of pharmacological treatment if given.
- **Pain assessment protocol and age-appropriate assessment tools** are in use, for both general screening purpose on admission and ongoing clinical monitoring when situation warrants, e.g. pre and post operation, diseases with pain, or with procedures caring pain and discomfort. We use neonatal/infant pain scale, objective pain scale, revised FLACC scale, Wong-Baker Faces scale and numerical rating scale according to age of patients
- **Non-pharmacological intervention** (positional, diversional therapy, play therapy, distraction, etc.) will be used first
- **Pharmacological intervention** is used when indicated, together with the above.
  For newborn babies, we can use oral sucrose solution as analgesia. This is a novel evidence-based practice in us recently in neonatal wards (including NICU) for moderate pain, e.g. before blood taking, eye-examination using speculum, lumbar puncture procedures.
  For children, besides acetaminophen, EMLA topical cream for mild analgesic purpose, we use opioids (morphine, fentanyl, remifentanil, etc.) for moderate/severe pain control.

It is important to engage the patient and family to participate in pain management, e.g. in use of PCA device, in reporting effectiveness and clinical progress. Open communication and honest acknowledgement of subjective painful experience and patient's own meaning throughout the process is vital. Health care workers should also address other personal needs of patient and care for members of the family, when pain experienced by a sick child is knowingly associated with high level of anxiety and coping difficulties among other carers.



Revised FLACC Scale

Categories	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested, sad, appears worries	Frequent to constant quivering chin, clenched jaw, distressed looking face, expression of fright/ panic
Legs	Normal position or relaxed, usual tone and motion to limbs	Uneasy, restless, tense, occasional tremors	Kicking, or legs drawn up, marked increase in spasticity, constant tremors, jerking
Activity	Lying quietly, normal position, moves easily, regular, rhythmic respirations	Squirming, shifting back and forth, tense, tense/ guarded movements, mildly agitated, shallow/ splinting respirations, intermittent signs	Arched, rigid or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint,occasional verbal outburst, constant grunting	Crying steadly, screams or sobs, frequent complaints, repeated outbursts, constant grunting
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort, pushing caregiver away, resisting care or comfort measures

Each of the five categories is scored from 0-2, which results in a total 0-10

Occupational Therapy in *Pediatric Cancer Pain*

Barbara Chan CM, Occupational Therapist, Prince of Wales Hospital

Pain is a common and burdensome symptom experienced by most of cancer children. At diagnosis and during the active treatment phase about 50% of children experienced cancer-related pain (Ljungman G et al 2000). A survey reported at approximately 50% of the patients assessed in hospital, and 25% of the patients assessed in the out-patient clinic were found to be experiencing some degree of pain (Miser et al 1987). An effective pain management is dependent on understanding the causes of pain, appropriate selection of pain assessment, and the therapeutic use of pharmacological and non-pharmacological strategies.

Causes of pain

- Cancer pain can result from acute procedure-related pain to progressive chronic pain associated with the progression of the disease or sequel of treatment.

Pain assessment

- The aim of pain assessment is to identify the presence of pain, estimate its severity and assess the effectiveness of any interventions (Ashley 2009). Pain assessment can help to detect pain early and prevent it, or reduce the number of painful episodes. According to the guidelines from the Association of Pediatric Anesthetists of Great Britain and Ireland, pain assessment should be based on self-report; observational, behavioral and physiological (Howard et al 2008). Pain assessment should be ongoing and performed regularly to achieve validity.
- Self-report measures: It is one of the best methods measuring pain. However, it has limitation in children as it is dependent on cognitive development. Children aged 3 to 7 years can verbalize their feeling on pain (Ashley 2009). Wong-Baker FACES pain rating scale (2009) i.e. a happy face indicating no pain up to a crying face indicating severe pain is commonly used. By the age of 7 years, children visually can score the pain level. Visual analogue or numerical rating scales (Collins et al 1997) are used to mark their pain with a number or score it using a linear scale.
- For neonates, younger children and those with cognitively impaired, pain indicators of these groups can be observed in their behaviors, crying, altered facial expressions and body movement. These children may display individual reactions such as withdrawal or fighting to alleviate their pain. Physiological changes such as increases in blood pressure, heart and respiratory rate; and sweating are noted (ANZCA 2005).
- Other examples of pain assessment tools are Premature Infant Pain Profile (PIPP) – Stevens et al 1996; Crying, Requires oxygen administration, Increased vital signs, Expression, Sleeplessness (CRIES) – Krechel & Bildner 1995; Face, Legs, Activity, Cry and Consolability (FLACC) – Merkel et al 1997; Poker Chip – Hester et al 1990; Pieces of Hurt – Hester et al 1990.

Non-pharmacological Pain Management

While pain medication is essential for pain relief, a variety of non-pharmacological pain management could be used for mild pain or in combination of pain medication for moderate-to-severe pain among children (Caty et al, 1995). The principle of CANCER is applied on Occupational Therapy management in pediatric cancer pain.

COGNITIVE BEHAVIORAL METHODS

- Distraction shifts attention from pain towards more interesting and pleasant experiences e.g. playing games, bubbles play, chatting, counting, listening music, watching TV, performing art and craft work. Successful distraction therapy can offer children's choice which can develop their sense of empowerment especially when they feel most vulnerable. Among all cognitive behavioral methods, distraction was most frequently used by children for pain relief (Polkki et al 2003).

Cognitive interventions

- Visualization or guided imaginary – child-led guided imaginary empowers them to construe an image that is pleasant and under their control.

Behavioral interventions

- Progressive muscle relaxation training – progressive tensing and relaxing of muscle groups
- Breathing exercises – deep breathing or combined with a related activity such as blowing bubbles
- Modelling – demonstration of positive coping behaviors
- Positive reinforcement – providing positive statements or tangible rewards e.g. stickers, toys

ASSISTING IN ACTIVITIES OF DAILY LIVING

- Pain may be occurred in cancer patients when they performed activities of daily living. Occupational therapists address and treat deficits in activities of daily living with the use of adaptive equipment. Assisting children in participating routine daily activities such as bathing, feeding, dressing and toileting can relieve pain. Adaptive equipment such as shower / toileting aids, special seating system, transfer board and dressing aids are suggested.

- Splintage can be used to improve and optimize best joint mechanics, compensate for motor deficits or relieve pain in daily life. Examples of splintage included shoulder immobilizer, wrist resting splint, soft neck collar, corset, foot splint and heel protector.

NICE AND COMFORTABLE ENVIRONMENT

- Despite the negative consequence of hospitalization, it should not be regarded as an environment of pain and suffering. Evidence have shown that children preferred a comfortable environment with good lighting and familiar personal belongings as it exerted a positive influence on their pain experience in the hospital (Polkki et al 2003). Taking own games and toys; and putting own art work and family photos in the hospital are encouraged.

CONTROLLED POSITIONING

Physical positioning can help children relieve their own pain as they make adjustments to their own body. Some children preferred sleeping, resting and lying down to try to escape from their pain (Sng et al 2013). Different positioning assistive devices are introduced such as positioning pillows, reclined bed, air mattress, reclined seating system, and air seating cushion, head and body support system.

EMOTIONAL SUPPORT

- Emotional support included reassuring, comforting, touching and empathizing with the children. Reassuring words can comfort and cheer children up. Touching can help children relieve pain e.g. holding children's hands, patting their bodies and hugging them. Parental presence is a valuable source of emotional support and comfort for children especially when they experienced pain and discomfort.

RELIGIOUS SUPPORT

- Parents or family may seek ways to strengthen their hope of cure; religion becomes an important source of support. Religion practices e.g. prayer are helpful and it was regarded a cure or relief of cancer pain.

Conclusion

A therapeutic pain management is based on the understanding the causes of pain, the appropriate selection of pain assessment tool and the application of pharmacological and non-pharmacological intervention. "CANCER" is the principle that Occupational Therapists adopt when providing cancer pain management in children.

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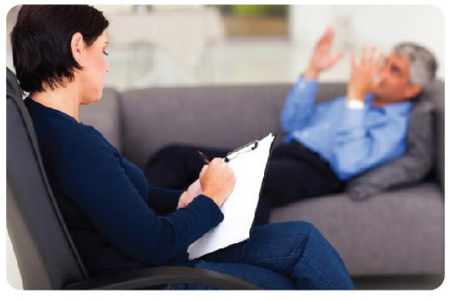
Role of Psychiatry in Chronic Pain Management

Dr Wong Chung Hin Willy (Specialist in Psychiatry)
MBBS(HK), MRCPsych, FHKCPsych, FHKAM (Psychiatry)

Chronic pain complaints are commonly seen in patients in a psychiatric clinic. It was reported that 38% of psychiatric inpatients and 18% of psychiatric outpatients present with pain as their significant symptom. **(1)** Patients with psychiatric illnesses, such as depressive disorder, anxiety disorder, dysthymia, somatization disorder, hypochondriacal disorder, can present with painful somatic symptoms. Similarly, patients with longstanding or severe painful symptoms can end up in psychiatric problems such as adjustment disorder, depressive di sorder, dysthymia, alcohol and substance abuse. By the time these patients present themselves to a psychiatrist, they may have already consulted doctors of other disciplines. They might be receiving different kinds of medications for pain relief. Working with patients with chronic pain is challenging and a psychiatrist can play an important role in a multidisciplinary pain management.

- **First of all**, a positive therapeutic relationship is important in managing patients with chronic pain. These patients can present with significant distress and despair as a result of the pain, as well as other psychiatric comorbidities. These emotions could lead to negative reactions in the health care professionals, which would be detrimental to the management. This could happen especially when the pain is psychogenic without any organic cause identified. A psychiatrist should develop good rapport with the patients in a way that the patients feel free to talk about their pain and feel supported. Usually, personal pain experiences in a psychiatrist could help to develop more empathy with the patients.



- **Next**, a psychiatrist can perform a detailed psychological and psychosocial assessment for these patients. A large discrepancy exists between a patient's need to tell the story and the social support network's capacity to hear it. **(2)** Hearing and acknowledging the patients' battle with pain can provide much relief for them. Besides, their social support network could be explored. The patients could be encouraged to reengage themselves with their family, friends, doctors and other acquaintances.

The risk of addictive disorders should be assessed. **(3)** Patients with chronic pain may develop tolerance and dependence on medications for pain relief. A meta-analysis showed that the overall incidence of opioid addiction in patients receiving chronic opioid analgesic therapy was 3.27%; in a subgroup with no history of substance abuse or addiction, the incidence was 0.19%.

(4) Sometimes, patients request prescription of pain killers and benzodiazepines for them. Some even advance their follow up before the scheduled session to request for additional prescription. They are prone to self-medication and polypharmacy. The efficacy of the pain medicine should be assessed by pain score and level of functioning. The adverse effects of pain medicine could not be overlooked in the explanation. The '4Cs' for recognizing addiction include negative consequences of medication use, loss of control over use, compulsive use, and craving or preoccupation related to medication use. **(5,6)** Setting up a treatment agreement/medication contract with the patients could be beneficial. It is important for the patients to know that periodic review is necessary if they are receiving chronic analgesic therapy. To address the issue of pain medicine addiction, psychoeducation and motivational interviewing can be arranged. It should be emphasized that benzodiazepines are not useful in chronic pain, unless the patient has comorbid anxiety disorder.

Apart from medication treatment for pain and other comorbid psychiatric conditions, psychotherapy should be considered as a part of the management. There are many types of psychotherapy. Examples of these include relaxation training, operant behavioural therapy, cognitive behavioural therapy and hypnosis. **(7,8)** The aim of the psychotherapy is to help patients gain control of pain symptoms, regain a sense of value, redevelop a new normal and meaningful life. For example, supportive psychotherapy and cognitive therapy could be employed. **(9,10)** Simple advice like striking a balance between activity and rest could be given. Cognitive therapy could be employed to predict the difficulty of carrying out a task under the influence of pain and the final outcome of the task. Difficult tasks could be broken down into manageable steps for gradual adaptation. Through psychotherapy, the patients would feel confident to handle their own pain and the associated emotional experience, and would not be affected by any negative cognition.

Chronic pain has remained a challenging and complex problem to health care professionals. It requires a multidisciplinary management, in which a psychiatrist can play an important role especially in the psychosocial and psychological aspects. Referral to a psychiatrist should be considered if a patient with chronic pain shows emotional, cognitive and behavioural problems. Psychiatric care should not be seen as the last resort in chronic pain management.

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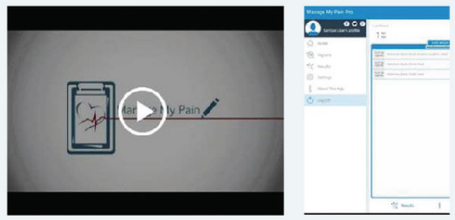
Pain Apps

Assessment

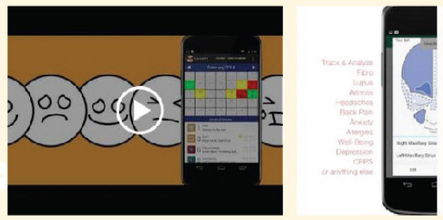
Manage My Pain Lite

Manage My Pain helps you and others better understand what you are going through. It has helped thousands of people with conditions like fibromyalgia, migraines, arthritis, or back pain better understand their symptoms and provide evidence of their pain for their doctors, insurance companies, or government agencies. Manage My Pain creates reports designed by doctors for doctors - ones that your doctor will actually read!



My Pain Diary

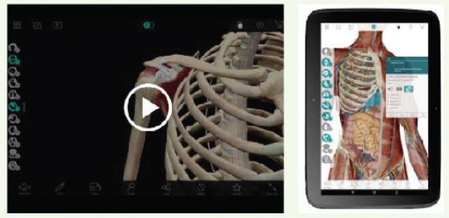
My Pain Diary is an easy to use chronic pain and symptom tracker. Users are tracking chronic pain conditions such as Fibromyalgia, MS, Migraines, Headaches, Back Pain, Rheumatoid Arthritis, Endometriosis, Anxiety, Depression, Lupus, RSD, Crohn's and over 60 other chronic health conditions. Track just about anything!



Management

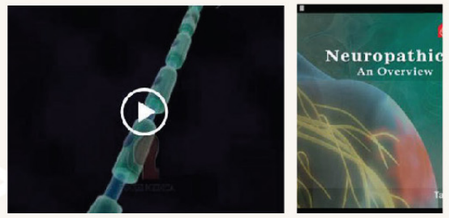
Human Anatomy Atlas

Visible Body's Human Anatomy Atlas is the most anatomically accurate 3D atlas of the male and female human body, with over 4,600 structures in each model (male and female). This app also includes additional content not available in other 3D anatomy apps: microanatomy models of senses and over a dozen free patient education other 3d atlas.



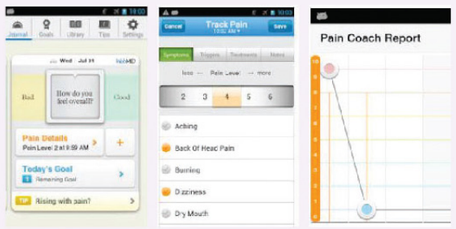
Neuropathic Pain

Neuropathic Pain - helps in understanding the disease condition through ANIMATED VIDEOS. This animation provides information about nociceptors - the nerves that respond to injury or damage to tissues, different types of neuropathic pain, causes, symptoms and treatment with medication and invasive procedures.



WebMD Pain Coach™

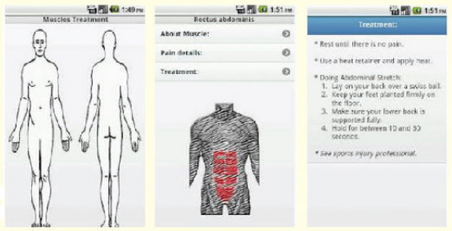
WebMD Pain Coach™ offers a holistic approach to balancing lifestyle with chronic pain conditions to help inspire a better day. WebMD's new app is a mobile companion to help you through daily health and wellness choices so you can better manage your chronic pain. Enjoy a personalized experience as physician-reviewed tips



Pain Treatment

Muscles Pain Treatment application designed for you, it contains many muscles stretching methods, exercises and treatments by rest, cold, heat...

You can also read about specific muscle, find the pain caused by specific muscle and all treatment methods for it.



Event Highlight:

Hong Kong Pain Foundation Kick-Off Ceremony

Mission of Hong Kong Pain Foundation:

Our mission is to support patients who are impoverished and suffering from chronic pain, and to enhance public awareness of this common but often overlooked condition. Our Executive Board members come from a range of health care specialties including medicine, nursing, physiotherapy and occupational therapy. They represent the public, private and university settings. Donations we raise will be used for providing education, treatment and rehabilitation services to patients who are in need and are suffering from chronic pain with the aim of improving their quality of life.

Date: 2 June, 2015
Venue: Ballroom, 18/F, The Mira Hong Kong

To celebrate the establishment of Hong Kong Pain Foundation, a cocktail reception as a kick off ceremony was hosted and an opening speech was given by Dr. Ko Wing-man BBS, JP, Secretary for Food and Health, followed by a sharing from Ms. Tsai Hiu-wai Sherry, 3-time Olympian, 9-time Hong Kong Female Swimmer of the Year. Other programs included seminar about the latest medical technology and development including spinal card stimulation and a patient sharing session.

When systemic relief of pain isn't enough, call on the local expert. The pain of post-herpetic neuralgia (PHN) burns through everything, including patients' quality-of-life.[1] Fighting it can sometimes require an analgesic that works directly at the site of pain. Recommended as a first-line treatment for PHN, the ***Lignopad***® medicated plaster provides targeted pain relief[2-6] with minimal systemic absorption and drug interactions as compared to systemic analgesics.[5,7,8] All these combined with convenient once-daily application[9] make the ***Lignopad***® medicated plaster an excellent choice for smothering the flames of pain.

Lignopad® **medicated plasters 5% w/w - ABRIDGED PRODUCT INFORMATION**

Composition: Each 10 cm x 14 cm plaster contains 700 mg (5% w/w) lignocaine

Indications: ***Lignopad***® medicated plaster is indicated for the symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN).

Dosage and Administration: *Adults and elderly patients:* The painful area should be covered with the plaster once daily for up to 12 hours within a 24 hours period. Only the number of plasters that are needed for an effective treatment should be used. When needed, the plasters may be cut into smaller sizes with scissors prior to removal of the release liner. In total, not more than three plasters should be used at the same time. The plaster must be applied to intact, dry, non-irritated skin (after healing of the shingles). Each plaster must be worn no longer than 12 hours. The subsequent plaster-free interval must be at least 12 hours. The plaster must be applied to the skin immediately after removal from the sachet and following removal of the release liner from the gel surface. Hairs in the affected area must be cut off with a pair of scissors (not shaved). Treatment outcome should be re-evaluated after 2-4 weeks. If there has been no response to ***Lignopad***® medicated plaster after this period or if any relieving effect can solely be related to the skin protective properties of the plaster, treatment must be discontinued as potential risks may outweigh benefits in this context. [Please refer to full prescribing information.]

Contraindications: Hypersensitivity to the active substance or to any of the excipients, patients with known hypersensitivity to other local anaesthetics of the amide type e.g. bupivacaine, etidocaine, mepivacaine and prilocaine. The plaster must not be applied to inflamed or injured skin, such as active herpes zoster lesions, atopic dermatitis or wounds. Patients under the age of 18.

Precautions: The plaster should not be applied to mucous membranes. Eye contact with the plaster should be avoided. The plaster contains propylene glycol which may cause skin irritation. It also contains methyl parahydroxybenzoate and propyl parahydroxybenzoate which may cause allergic reactions (possibly delayed). Use with caution in patients with severe cardiac impairment, severe renal impairment or severe hepatic impairment. There are no adequate data from the use of lignocaine in pregnant women. Therefore, ***Lignopad***® medicated plaster should not be used during pregnancy unless clearly necessary. Lignocaine is excreted in breast milk. However, there are no studies of the plaster in breast-feeding women. Since the metabolism of lignocaine occurs relatively fast and almost completely in the liver, only very low levels of lignocaine are expected to be excreted into human milk. After first opening the sachet, the plasters must be used within 14 days.

Adverse Reaction: *Most common:* administration site reactions (such as burning, dermatitis, erythema, pruritus, rash, skin irritation, and vesicles). *Uncommon:* skin lesion, skin injury. *Very rare:* open wound, anaphylactic reaction, hypersensitivity.

Interactions: No interaction studies have been performed. No clinically relevant interactions have been observed in clinical studies with the plaster. The plaster must be used with caution in patients receiving Class I antiarrhythmic medicinal products (e.g. tocainide, mexiletine) and other local anaesthetics since the risk of additive systemic effects cannot be excluded.

Presentation: Box of 5 plasters per sachet x 2, 5 plasters per sachet x 4, or 5 plasters per sachet x 6.

Full prescribing information is available upon request.

References: 1. Johnson RW, McElhaney *J. Int J Clin Pract* 2009;63:1386-1391. 2. Dworkin RH *et al. Pain* 2007;132:237-251. 3. Finnerup NB *et al. Pain* 2005;118:289-305. 4. Finnerup NB *et al. Med Gen Med* 2007;9:36. 5. Attal N *et al. Eur J Neurol* 2006;13:1153-1169. 6. Dubinsky RM *et al. Neurology* 2004;63:959-965. 7. Garnock-Jones KP, Keating GM. *Drugs* 2009;2149-2165. 8. Hans G *et al. Curr Med Res* 2009;5:1295-1305. 9. ***Lignopad*** ® Medicated Plaster 5% w/w Package Insert. Mundipharma (Hong Kong) Ltd. January 2013.

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