Results: There was no significant deference in PDT for neither CS1 nor CS2. A median split subanalysis on CPM-responders versus CPM-nonresponders to the TS + CS1 combination. Using this grouping, there was significant increase in PDT when comparing TS to TS + CS1 or TS + CS2 (4.0 mA vs 5.6 mA; $P < 0.05$, 4.0 mA vs 5.1 mA; $P < 0.05$).

Conclusions: The study indicates that CPM can be evoked in a subgroup of subjects by applying the electrical test stimulus and cuff pressure conditioning stimuli to the same experimental site.

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The effect of facilitated temporal summation of pain, widespread pressure hyperalgesia and pain intensity in patients with knee osteoarthritis on the responds to Non-Steroidal Anti-Inflammatory Drugs – A preliminary analysis

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Background: Non-Steroidal Anti-Inflammatory Drug (NSAID) treatment is recommended as the first step in the treatment of knee osteoarthritis (KOA). Due to the risk of side-effects of NSIADs and low responds rate, methods for selection of NSAID responders are highly warranted. Recent studies suggest that pain sensitization in KOA might be predictive for the effect of surgical treatment, why the purpose of the present study was to evaluated whether quantitative sensory testing (QST) could be predictive for the effect of NSAID treatment in KOA.

Material and methods: 100 patients were enrolled and assessed using temporal summation of pain (TSP), pressure pain thresholds (PPT) and pain intensity (visual analog scale, VAS; 0: no pain and 10: worst imaginable pain) before and 8 weeks after daily treatment of Ibuprofen 400 mg × 3, Paracetamol 1 g × 3 and Pantoprazole 20 mg × 1. TSP was assessed by the difference in pain scores to one PinPrick stimulus followed by 10 PinPrick stimuli. PPT was assessed at the extensor carpi radialis longus muscle. Responders were categorized as decrease in pain intensity of at least three VAS-points.

Results: 80 patients had complete data at follow-up. 28 patients were categorized as responders and 52 patients as non-responders. Pre-treatment pain intensity (responders: 7.5 (SD: 1.6) vs. non-responders: 6.5 (SD: 2.3), $P < 0.03$) and TSP (responders: 1.9 (SD: 2.5) vs. non-responders: 1.0 (SD: 1.5), $P < 0.05$) were significantly higher in responders compared with non-responders. Pre-treatment PPT at the arm trended towards significantly lower in responders (293 kPa (SD: 85)) compared with no responders (339 kPa (SD: 124), $P < 0.06$).

Conclusions: This preliminary analysis indicate that KOA patients with high pain intensities, facilitated TSP and widespread pressure hyperalgesia respond to NSAIDs.

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How to obtain the biopsychosocial record in multidisciplinary pain clinic? An action research study

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Background: Patients with complicated chronic non-malignant pain (CCNMP) should be referred to the multidisciplinary treatment based on the biopsychosocial pain model. This is not a trivial task to obtain the biopsychosocial record (BPSR) during the first visit in multidisciplinary pain center – some important data can be missing, but it is difficult to choose the right questions.

Purpose: To find the optimal method for obtaining of BPSR in patients with CCNMP.

Methods: The action research methodology is used. First, the literature search was done. Second, the meetings between therapists were hold. Third, the patients are asked about their experiences with obtaining of BPSR.

Results: The following area of interest were identified: (1) patient's demographic data, (2) lifestyle factors, (3) previous diseases, (4) concurrent diseases, (5) previous pain treatments, (6) pain intensity and effect of the actual pain treatment, (7) general activity, (8) mood, (9) walking activity, (10) work ability, (11) home activities, (12) relations with other people, (13) sleep, (14) enjoyment of life, (15) patients expectations from treatment, and (16) treatment goals. Patients are asked about those variables. Either Visual Analogue Scale or Numeric Rating Scale is used for assessment of pain intensity and pain influence on variables (7) to (14). First, data about variables (1) to (6) are collected by the physician. Next, data about variables (7) to (15) are gathered under interview with the nurse. Last, the physician and the nurse keep the meeting on treatment goals and treatment course. Up to date (February 2017), 8 patients were asked about their experience with obtaining of BPSR. All but one patient were very satisfied.

Conclusions: The method presented above seems to be promising approach to obtaining of BPSJ in patients with CCNMP. The study is ongoing and updated results will be presented at the conference.

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Experimental neck muscle pain increase pressure pain threshold over cervical facet joints

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Aims: Evaluate pressure pain threshold (PPT) over cervical facet joints before and after injection of experimental pain in the trapezius and multifidus muscles.

Methods: Fourteen healthy subjects (6 women) received randomized ultrasound-guided injections of hypertonic saline (5.8%), in the right multifidus muscle medial to C4/C5 facet joint and in the right trapezius muscle at the midpoint between C7 spinous process and acromion. The saline-induced pain intensity was assessed on a VAS scale. Before and during saline-induced pain PPTs were