



BRAINSTEM

AUSTRALASIAN NEUROSURGICAL NURSES ASSOCIATION

On behalf of the A.N.N.A. executive I am very pleased to introduce our first newsletter. We hope to produce a copy of Brainstem every season. I believe the newsletter's success will depend on all A.N.N.A. members. I urge members to please write to the executive with any new or unique neurosurgical or neurological trends or techniques used by yourself or staff in your own area. This will certainly help to promote and expand Brainstem and more importantly spread ideas to all members. Hopefully in turn this will be replicated in other neuro areas.

In an effort to combat the communication problems within the association a problem corner will be established. Hopefully the problems members are experiencing may be solved directly by the executive who may be able to research the information. We may be able to direct you to sources which can assist you or a member may be able to share from experience the way she dealt with the problem.

By establishing the newsletter we are able to link more closely the members scattered throughout Australasia. Your enthusiastic support and involvement in this newsletter will assist in promoting this major aim. Best wishes for this new venture, hoping to see a bigger and better newsletter in a years time.

Narelle Glass

HISTORICAL DEVELOPMENT

The World Federation of Neurosurgical Nurses was founded by Miss Agnus Marshall of the U.S.A. in 1971 for the purpose of advancing neurosurgical nursing, that through this avenue of communication we may further advance the nursing sciences and the standards of patient care, throughout the world. The World Federation of Neurosurgical Nurses also bears the unique privilege of being an associate of its medical counterpart, the World Society of Neurosurgeons.

Miss Antonia Koenen of Australia was present at the meeting of the World Federation of Neurosurgical Nurses in Tokyo in 1973 and together with Miss Marita Pigden (who was accepted in absentia) were accepted as the first Australian members of the association. Miss Koenen was subsequently elected to the Executive of the World Body as Australian Delegate and Editor of Publications.

The terms of the appointment of delegates to the Executive are that members return to their countries and establish a viable neurosurgical nurses association within four years, or relinquish their position as delegates.

So it was that Miss Koenen returned to Australia and chose the occasion of the Annual Scientific Sessions of the Neurosurgical Society of Australasia, held in Canberra in May, 1974, as the venue for the gathering together of the foundation members of A.N.N.A. Unfortunately there was a mail strike on at this time, which made communications difficult, but due to the tireless efforts and ingenuity of our Foundress, Miss Koenen notification of the projected meeting was forwarded to each State and New Zealand.

On May 4th, 1974, at "Maruka" Motel in Canberra, the founding First Annual General Meeting of A.N.N.A. took place. Representatives from Australian Capital Territory, New South Wales, Tasmania, Victoria and Western Australia were present. Unfortunately representatives from New Zealand and Queensland and South Australia were unable to be present, and it was decided unanimously to proceed to formally found A.N.N.A. So it was accomplished.

There was a total of 42 members from New Zealand and 5 states of Australia with interest in the association spreading. Since those early times a viable Neurosurgical Association has been established within the set 4 years and growth continues.

Our membership is now 121, this is broken down in the following way:

Victoria.....	7
Queensland.....	17
Western Australia.....	20
New South Wales.....	67
Tasmania.....	4
A.C.T.....	3
New Zealand.....	3

One member originally from N.S.W. is now resident in Sri Lanka.

The Treasurers balance for April 1975 was \$192.81
balance for January 1980 was \$2114.38
(this amount includes NSW State funds.)

We submit our newsletter "Brainstem" as a continuation of the vision and unflinching endeavour shown by Antonia Koenen when she set the foundations of our association.

THE CONCEPT OF PAIN AND SUFFERING

Pain is a symptom that we have all dealt with at some time during our nursing career. From our neurosurgical or neurological experience we have probably become aware of the differences between acute and chronic pain. In the following series I plan to discuss the concepts associated with pain and suffering. The definitions, attitudes, evaluations, nursing management and goals. Topics such as hypnosis, acupuncture and biofeedback will be discussed in later issues. How do we deal with terminal pain? Some of the issues raised will hopefully create discussion so please write in with your ideas.

The ideas and information collected for this topic arose out of the need to formulate my thoughts for a seminar on Pain held at the Australian college of Nursing. Perhaps it would be best to begin with several of the main available definitions of Pain.

"Pain is an unpleasant experience, whether physical or mental which the patient dislikes." — C.S. Lewis.

Merskey defines it as an unpleasant experience, which we primarily associate with tissue damage or describe in terms of tissue damage or both.

A nursing definition has been given by Sternback. "Pain is whatever the patient says it is and exists whenever he says it does."

It is important for the nurse to understand the principles of pain, types of pain and its evaluation and management. Hackett (The Surgeon and Difficult Pain Problems) suggests the following. "The definition of pain as a reaction to actual or impending tissue damage would imply that the greater the tissue damage, the greater the reaction."

Defining pain in stimulus and response terms is inadequate. Clinically, pain for which no apparent stimulus can be demonstrated still exists.

The mysterious aspects of pain demonstrates the complexity of defining and examining the pain response. Pain has a Sensory component similar to other sensory processes. It is discriminable in time, space and intensity. However pain also has an essential aversive, cognitive-motivational and emotional component that leads to behaviour designed to escape or avoid stimuli.

Pain is a psychological experience. Behavioural and emotional variables can affect the manner in which it is perceived. Emotional and psychological factors can also cause pain.

For the sake of completeness it will be necessary to examine briefly some aspects of acute pain, some aspects of which will concern the topic of chronic pain. The area of chronic pain is for the most part the condition with which most of us will have had the most experience.

How can pain be evaluated?

Pain is firstly a subjective phenomenon so that only the sufferer can say for certain whether there is pain, where it is, and how long it has been present. The individual character of the subject and the circumstances of the pain can greatly influence the response.

It is necessary to accurately assess the pain to establish the cause and determine the correct course of treatment. A history includes previous experiences that could be related to the onset of the pain, its site, radiation and character. There may be exaggeration or suppression so that the patient should be examined for confirmatory objective evidence. This may be response to pressure or movement, a furrowed brow, facial contortions, gritted teeth, sounds of anguish especially if accompanied by pallor, sweating and tachycardia.

Measures of pain are important both in the routine treatment of patients and the evaluation of pain killing drugs.

The nurse in many situations has to administer a prescribed treatment, but the time of administration is often to her discretion. Knowing when the patient is suffering can be important in successfully spacing treatment.

The following are methods which may be used to assess the degree of pain.

1. The Graded Method.

- The pain may be assessed as: mild, moderate, severe or agonising.
- Alternatively it may be graded on a 1 to 4 basis. One would represent mild pain and 4 represent the most severe pain.
- Pain may also be represented in terms of percent e.g. 25, 50, 75 and 100 severe.

2. The Visual Analogue Method.

The degree of pain is expressed by placing a line vertically through the horizontal line as shown below.

no pain ————— as much pain as you could possibly imagine.

Pain relief may also be determined by comparing the pain before and after treatment. The difference is the measure of pain relief and can be graded as excellent,

good, poor, absent. Alternatively it may be graded as none, slight, moderate or complete. By using visual analogue methods pain relief may be expressed below.

no improvement ————— Pain completely relieved.

3. Objective Measures.

A presumption of pain relief may be made if restriction of an activity in a painful area is relieved by treatment and relapses when treatment ceases. A patient's demand for treatment can be used as an index of pain relief. It can often be assumed that the number of demands made by the patient are related to the degree of pain felt. of pain felt.

Next issue — Chronic Pain, Types and Nursing Management.

NEWS AND COMING EVENTS.

N.S.W. state delegate, Sue Miller, has resigned after taking over as Sister-in-Charge of a non neuro ward at Royal North Shore Hospital. We mourn her loss as a very valuable member but wish her well in her new ward.

N.S.W. members are very lucky to have Robin Morton our Vice President add the duties of state delegate to those she already has and is filling both positions ably with many enthusiastic ideas.

Western Australia has also lost their delegate, Patricia Pilling, who has set her feet on a travelling road. Sounds really great. We wish her well and thank her for all her past work and efforts for the association. W.A. becomes the second state, the other being Victoria, without a delegate until the next annual meeting. If you feel you would like to give it a go in 1980 then write and let us know or better still come to the next A.G.M. to be held in Canberra at the end of April.

Some N.S.W. members may know Meran Bright. She has written to the Executive requesting that we maintain contact with her in new job. Meran has taken up a position in an orphanage in Sri Lanka.

The Association is pleased to note the establishment of new neurosurgical units at Townsville (Qld.) and Canberra. We hope to hear how they are going and offer any support that may be needed in the future. We also hope to have information on the Neuroradiology, Neurosurgery and Neurology facilities at Westmead Hospital N.S.W.

Fund Raising: This is a method by which each state can accumulate monies which they can utilize according to their own needs. Robin would like suggestions from N.S.W. members about how they would feel if we took advantage of day light saving to have twilight barbecues at the beach or park. It would be a B.Y.O.G. partners/friends welcome. A donation would be asked and a raffle drawn. Sounds ideal not just for fund raising, but also for communication among members.

There has been some discussion about nationalizing neurological observations with Bryan Jennett's coma assessment scale as the foremost example. Perhaps you use this chart and would like to comment or perhaps you just have a great chart you would like us to know about. Please send a copy of the chart to us with an explanatory letter telling us how you use it in your ward. Any other ideas about national cerebral observation charts or problems about the use of the particular chart you are using would provide an excellent topic for discussion.
