Persistant Back Pain
Interdisciplinary and Focused Approach

Philippe Mavrocordatos
p.mavrocordatos@swisspain.ch
www.swisspain.ch

SWISS PAIN INSTITUTE
INSTITUT SUISSE DE LA DOULEUR

Philippe Mavrocordatos
p.mavrocordatos@swisspain.ch

Clinical Activities

Director/Founder of the Swiss Pain Institute (swisspain.ch)
(Lausanne / Basel / Moutier-Neuromodulation)

Healthcare leadership and organisation

Past-President and co-founder of the Swiss Society for Interventional Pain Management
Founding Chairman of the Swiss Pain Congress since 2009 (SSIPM)
Past-Honorary Secretary World Institute of Pain
President (Swiss Chapter) and Advisory Board member of the Word Institute of Regenerative Medicine

Teaching and Education Activities

In charge for the pre-graduate education pain course (4h/week), Geneva University Medical school
Senior Lecturer Queen Mary University Pain management and Neuromodulation, London
Visiting Professor of Anesthesiology and Pain Management, Kapodistrian University, Athens, Greece)

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Swiss Pain Congress

www.sspim.ch

Lectures in English

World-famous Speakers

2009
50 participants

2025
550 participants

Montreux, Swizerland
December 4-5 2026

SWISS PAIN INSTITUTE
INSTITUT SUISSE DE LA DOULEUR

2 centers (Lausanne-Basel)

- Clinical activity > 11'000 consultations + > 11000 interventions/year
- Pregraduate Education, Geneva University (2-3° year med school 4h/week)
- Postgraduate Education Swiss Med Society, cat. A, University equivalent
- 1 year National Fellowship, 10 swiss physicians graduated since 2017
- 1 year International Fellowship, 6 physicians from other countries

In-house Interdisciplinary Team : Staff = 36

- 11 Pain physicians SSIPM, FIPP, CIPS. (Anesth/Nch)
- 2 Psychologists et 2 Psychiatrists
- 4 Physiotherapists / 13 Pain nurses / 6 Admin assistants

Pain foundation

- Research,
- Quality management
- Education in pain management

Swiss Pain Group

We diagnose, manage and treat persistant to chronic pain

Cervical and Back Pain

Visceral and Pelvic Pain

Cancer Pain

Headache

Neuropathy Central and Peripheral

Post-surgical pain, CRPS

Back pain

- Basic concepts
- Paths to Failure or Glory
- Diagnostic issues
- Intervision
- Therapeutic options
- Future

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WIRM
World Institute of Regenerative Medicine

Historical Foundations of Regenerative Medicine

Philippe Mavrocordatos, MD, PhD, FIPP
Swiss Pain Institute

Switzerland

A Tribute to Humanity

The human species, Homo sapiens, is about 300,000 years old

“Thousands of years of untreated suffering.”

1846 Anesthesia
1928 Antibiotics
1953 DNA, genetics
1960 Stem cells

Definition of Pain (IASP 2020)

Pain: “An unpleasant **sensory** and **emotional** experience associated with, or resembling that associated with, **actual** or **potential** tissue damage.”

1. Pain is always **subjective**.
2. Pain can occur **without** actual tissue damage—**neural mechanisms** may be sufficient.
3. Pain **is influenced** by biological, psychological, and social factors.
4. The inability to communicate **does not negate** the possibility of experiencing pain.
5. Pain and pain-related behaviors are **not always proportional**

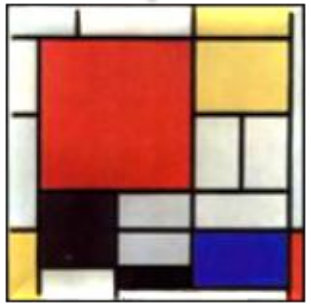
Evolution of concepts

60's-80's
Paradigm Shift

90's-2010's
Technological Step

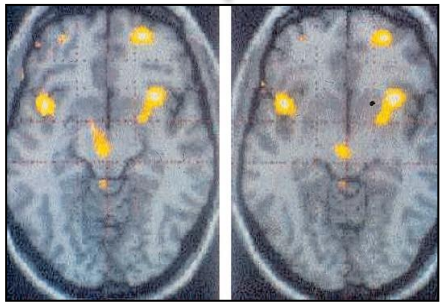
Late 2000's -20's
Endogenous modulation

Late 2010's -26's
Repare-Regenerate.....



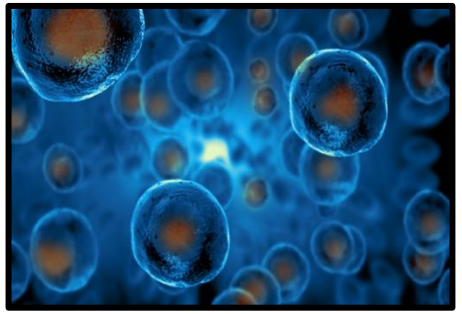
Anatomical and
rigid Model
Complex but stable

Complex and
Changing Model
Evolutive and plastic



Pain imaging
and
Brain activity

Endogenous pain
modulation through
descending inhibitory and
excitatory pathways



Regenerative
medicine
Stem cell/ gene tt, AI

The big picture

« Non-Cartesian » Pathophysiology

Multifactorial

ACUTE PAIN

NO PAIN

BIO PSYCHO SOCIAL FACTORS

ETHNICAL

CHRONIC PAIN

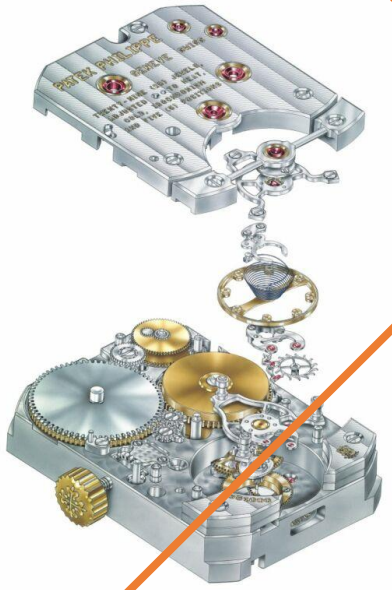
Sequential Barriers to Healing

0-72 h

These elements take place very early in time

The big picture

Complicated phenomenon



- Linear
- Closed
- Static
- Additive
- Proportional

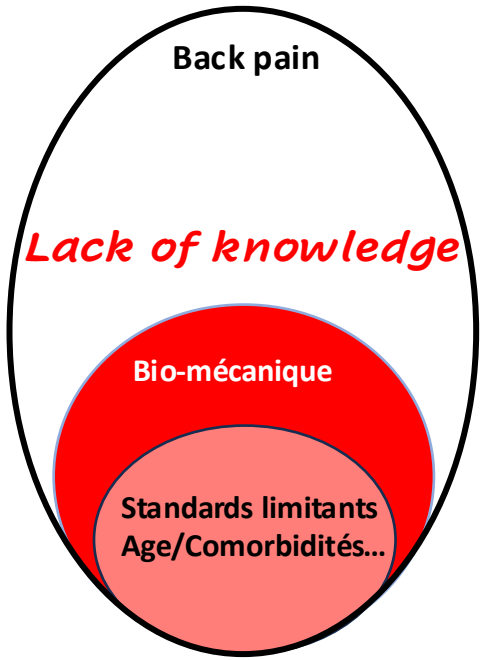
Complex phenomenon

- Non-linear
- Open
- Dynamic

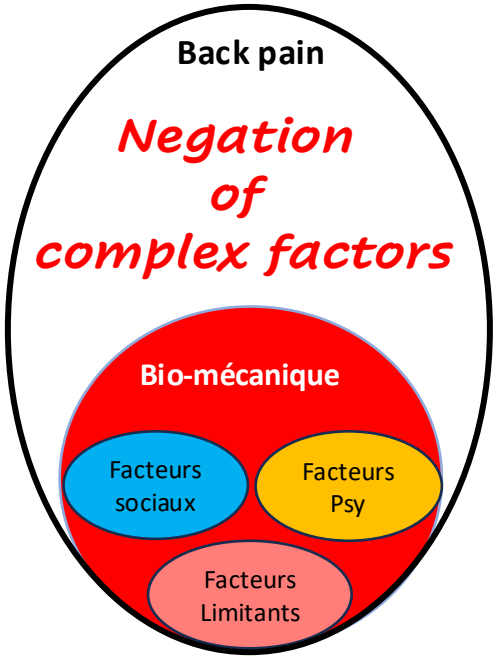
Snowden, D. J., & Boone, M. E. (2007). ***A Leader's Framework for Decision Making****. Harvard Business Review, 85(11), 68–76.*

Back pain management(s)

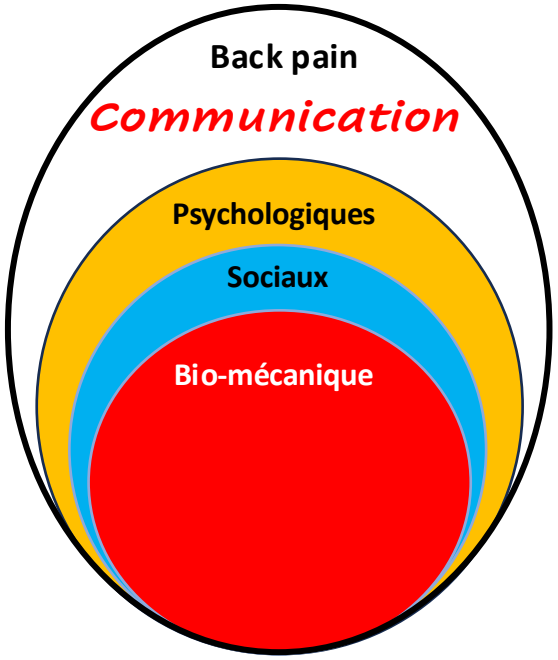
« Bio-Mechanic » Vision	« Pragmatic» narrow Vision	« Multidisciplinary » Vision	Interdisciplinary «Systemic» Vision



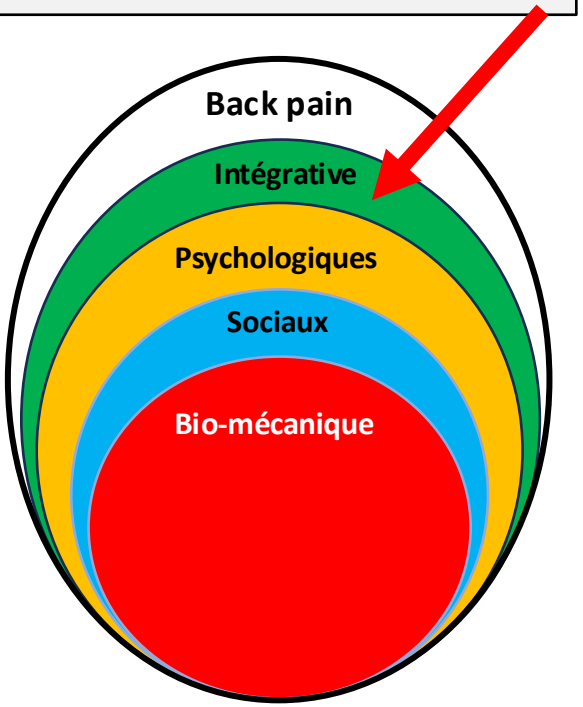
« Tunnel vision »
Narrow focus
Focus Biais
Unidimentional



« One size fits all»
Biais selection
Confirmation Biais
Negation of complex factors



» Atomistic Approach»
No context
Multi-Reductionist
Fragmented
Silo structure



» Systemic Approach»
Holistic
Inter-disciplinary
No dominant discipline

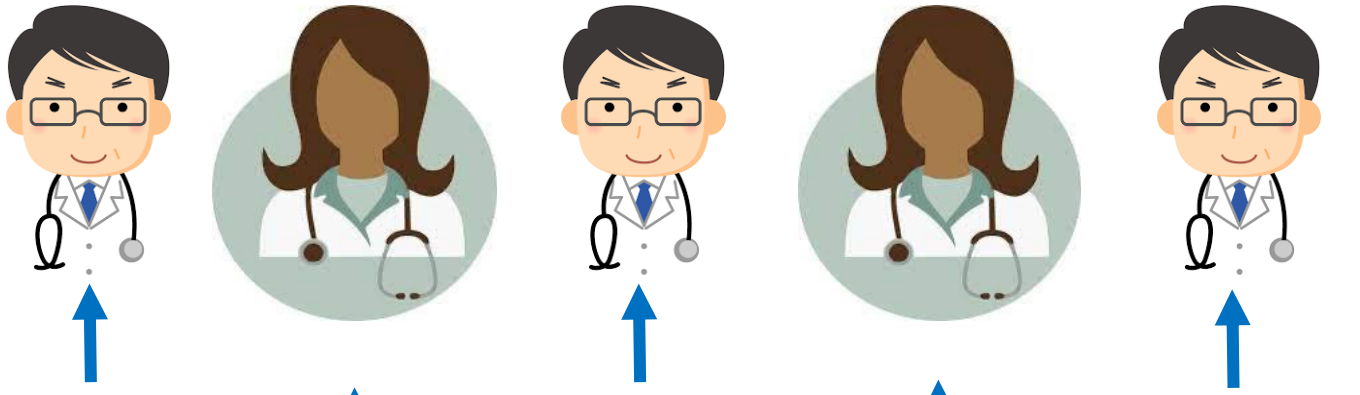
Waddell G. (1998). *The Back Pain Revolution: A Consumer's and Professional's Guide to Safe and Effective Treatment.* Churchill Livingstone.

Back pain

- Basic concepts
- Paths to Failure or Glory
- Diagnostic issues
- Intervision
- Therapeutic options
- Future

What happens every day !

List of specialists consulted FM - NFM (For Me – Not For Me)



Orthopedist Neurosurgeon-ologist Psychologist

Neurologist Anesth-reductionist

1

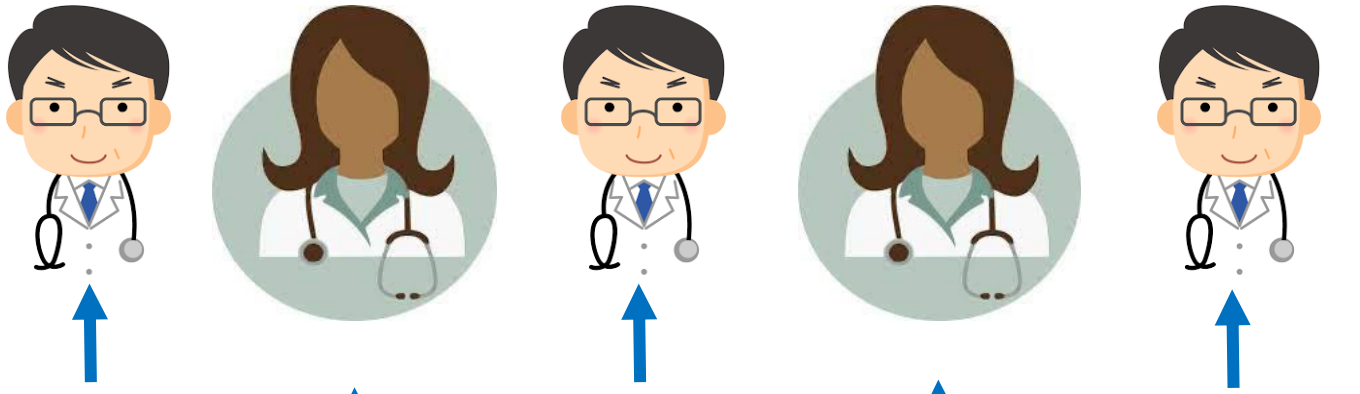
Lack of cohesion between consultations, multiple « unique » consultations

LACK OF EFFICIENCY

What happens every day !

1

List of specialists consulted FM - NFM (For Me – Not For Me)



Orthopedist Neurosurgeon-ologist Psychologist

Neurologist Anesth-reductionist

Lack of cohesion between consultations, multiple « unique » consultations

THESE PATIENTS SHOULD BE MANAGED EARLY

What happens and what should happen today ?

1

DISEASE CENTERED CARE

« The reductionist approach »

1° Not always wrong ! but too often…..

2° Derives from pain just a «symptom»

3° Lack of understanding of the multifactorial aspect of back pain

2

PATIENT PROJECT CENTERED CARE

« The interdisciplinary approach »

1° Not always right ! but it includes the reductionist approach……

2° Time consuming

3° Expensive on a short term (not as much as spinal surgery anyway !)

3° Integrates the multifactorial aspect of back pain

4° Takes account of patient’s expectations

Contemporary approach: «holistic, dynamic thinking»

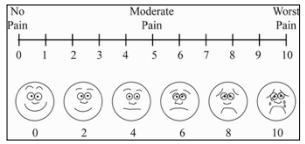
DISEASE CENTERED CARE

PATIENT CENTERED CARE

PATIENT PROJECT CENTERED CARE

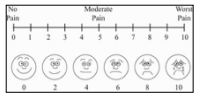
2

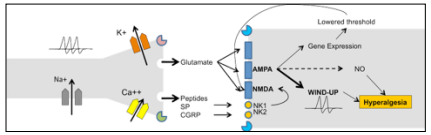
MANAGEMENT AND TREATMENT MUST BE TAILORED TO THE INDIVIDUAL PATIENT



INTENSITY BASED

INTENSITY

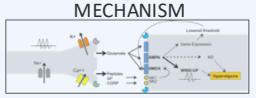




MECHANISM BASED

INTENSITY

MECHANISM



INDIVIDUAL NEEDS

Best possible diagnostic first !!!!

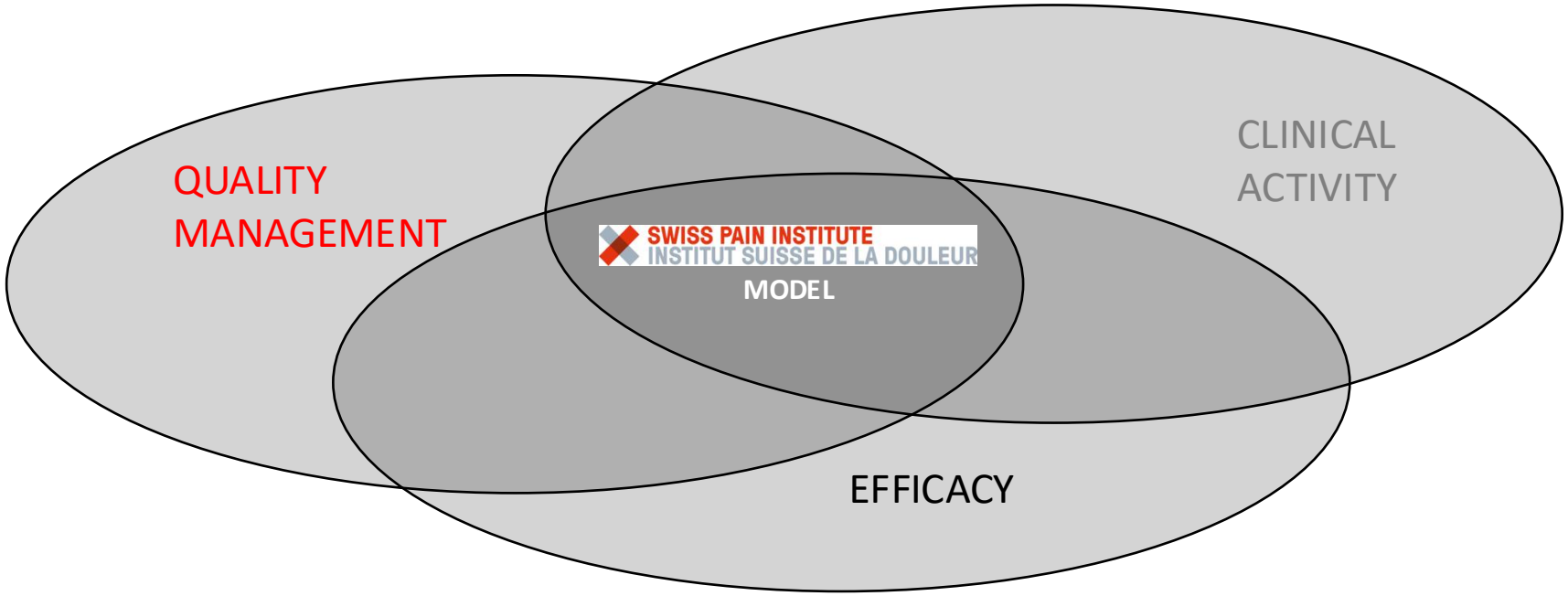
1 What should not be done + 2 What should be done

INTERDISCIPLINARY DIAGNOSTIC

IS AS OR EVEN MORE IMPORTANT THAN

INTERDISCIPLINARY PAIN MANAGEMENT AND TTT

What we do or …….try to do ;)



Chronic pain suffers from lack of efficacy

What medical school does not teach us !

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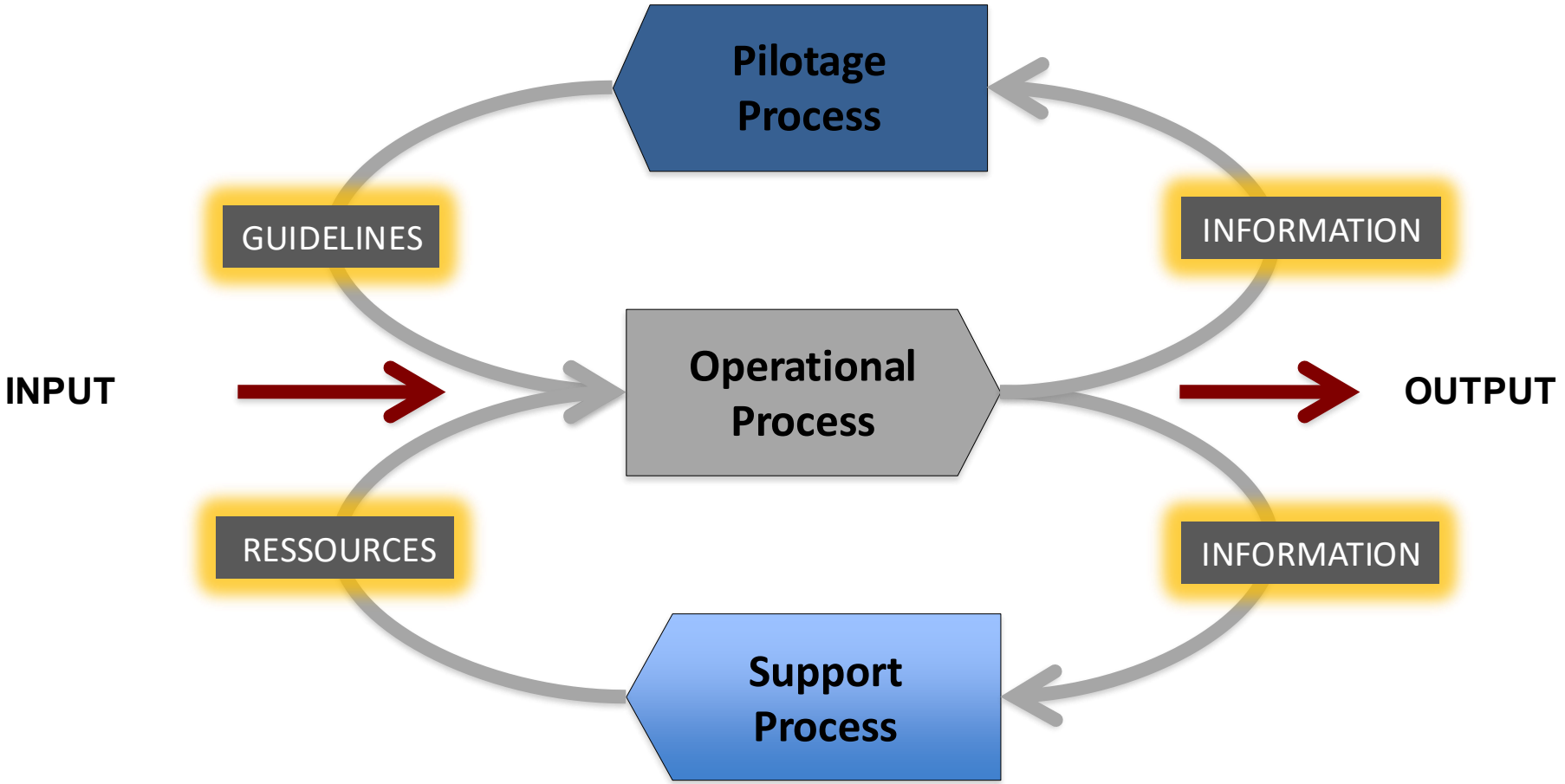

What medical school does not teach us !

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What medical school does not teach us !

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What medical school does not teach us !

PRECLINICAL ORGANISATION

Diagnostic

REFERING PHYSICIAN REQUEST

REQUEST TRIAGE

MEDICAL VISIT NOTIFICATION

ALL PARA-CLINICAL EXAMS, MRI.....

MULTIDIMENTIONAL QUESTIONNAIRE

1° MEDICAL VISIT
FOCUS ON DIAGNOSTIC MODULES

- 0.7.1.1 Diagnostic Module Chronic widespread pain
- 0.7.1.2 Diagnostic Module post-surgical pain
- 0.7.1.3 Diagnostic Module chronic back pain
- 0.7.1.4 Diagnostic Module chronic primary headache, O.F. pain
- 0.7.1.5 Diagnostic Module chronic primary visceral pain (IBS,...)
- 0.7.1.6 Diagnostic Module chronic primary M.S. pain (NSLBP,...)
- 0.7.2.1 Diagnostic Module caused by primary cancer
- 0.7.2.2 Diagnostic Module caused by primary cancer

Focus on the “Bio component”

1. Pathophysiology of persistant pain

2. Interventional diagnostic techniques applied to spinal pain

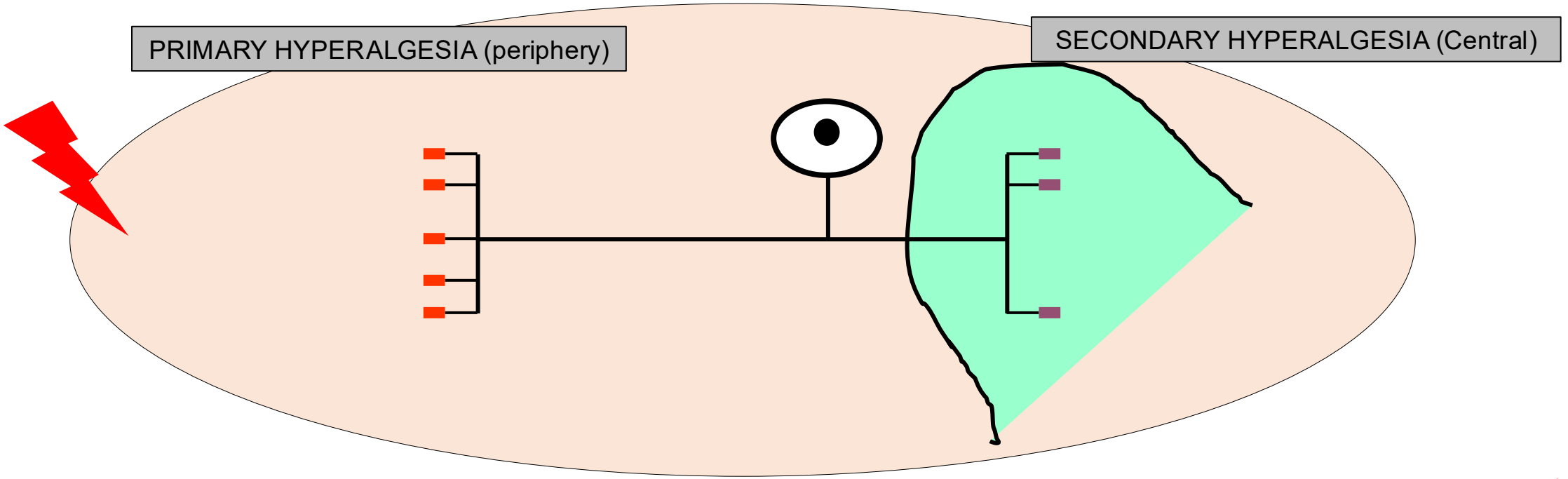
Focus on the “Bio component”

1. **Pathophysiology of persistant pain**

2. Interventional diagnostic techniques applied to spinal pain

What happens in pathologic situations ?

SENSITIZATION



What happens in pathologic situations ?

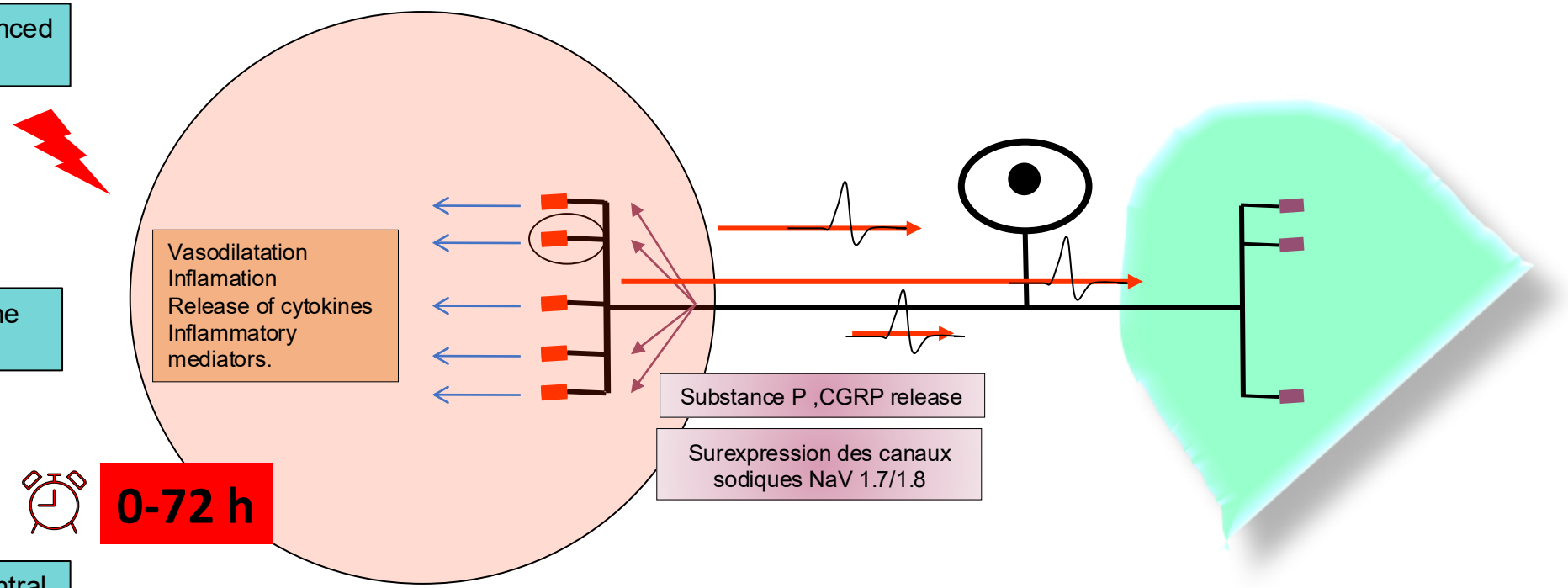
PRIMARY HYPERALGESIA (periphery)

Result of the increase of input from sensitized nociceptors due to ↑ stimulus

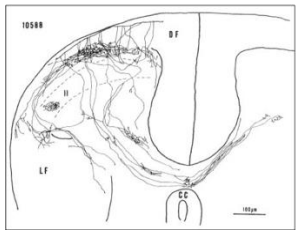
1. Sensitized nociceptors send enhanced afferent discharges to the CNS

2. Evoke an increased pain from the primary hyperalgesic area

3. Contribute to the alterations in central processing



Microglia also plays a role in the inflammatory process



What happens in pathologic situations ?

SECONDARY HYPERALGESIA (Dorsal horn synapse)

Result of central sensitization:
Increased sentitivity of adjacent and even distant areas

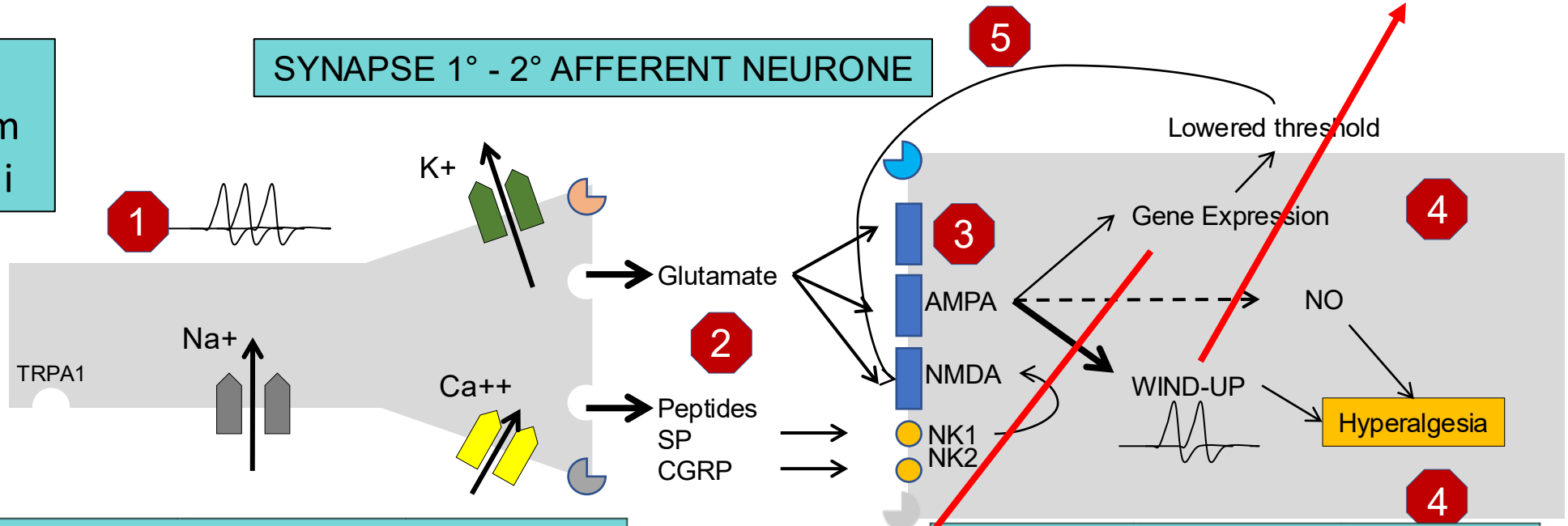
6-12 weeks

Cortical Neuroplasticity
(somatotopic reorganization)
Loss of descending inhibition
Emerging nociplasticity

1-7 days

Altered nociceptive signal processing from peripheral receptors i

SYNAPSE 1° - 2° AFFERENT NEURONE

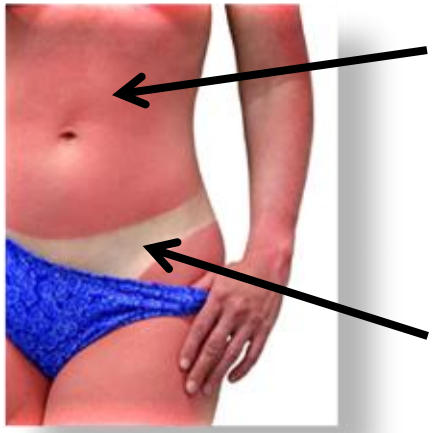


Protoneurone = Nociceptor (C Fiber)

2° neurone = Projection neurone

1-6 weeks

What happens in pathologic situations ?



Primary hyperalgesia

Secondary hyperalgesia

Back pain

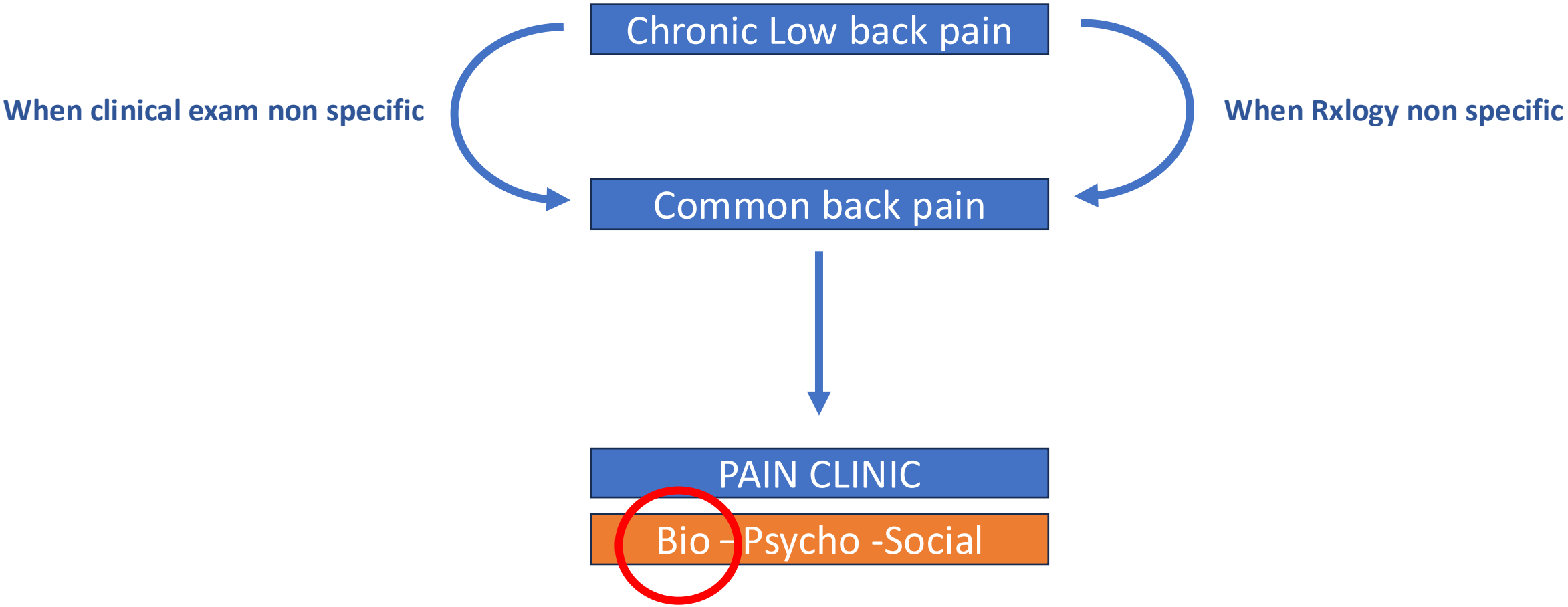
- Basic concepts
- Paths to Failure or Glory
- Diagnostic issues
- Intervision
- Therapeutic options
- Future

Focus on the “Bio component”

1. Pathophysiology of persistant pain

2. **Interventional diagnostic techniques applied to spinal pain**

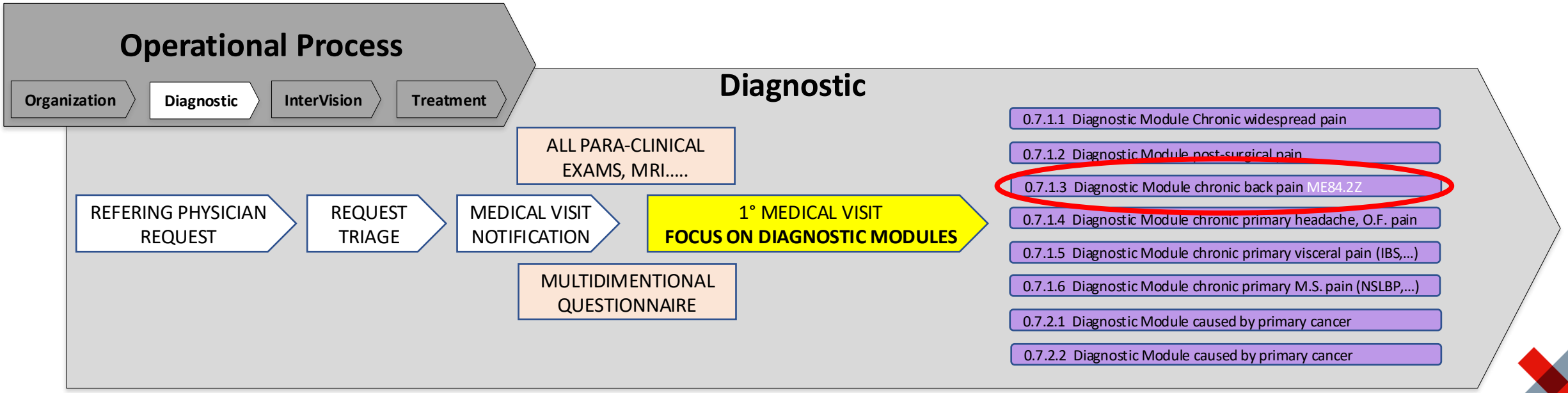
Interventional diagnostic techniques applied to spinal pain



Interventional diagnostic techniques applied to spinal pain

Systemic Approach

- Bio-psycho-social assessment
- Context
- Etablish diagnostic strategy **and after** therapeutic



Interventional diagnostic techniques applied to spinal pain

0.7.1.1 Diagnostic Module Chronic widespread pain

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0.7.1.6 Diagnostic Module chro ic primary M.S. pain (NSLBP,.

0.7.2.1 Diagnostic Module caus d by primary cancer

0.7.2.2 Diagnostic Module caus d by primary cancer

Precise Bio-Psycho-social Diagnosis

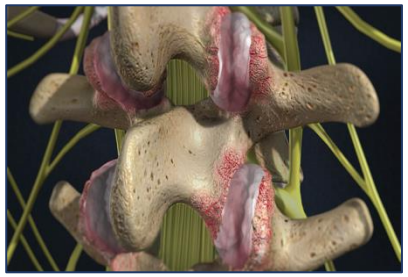
Diagnostic Tool box

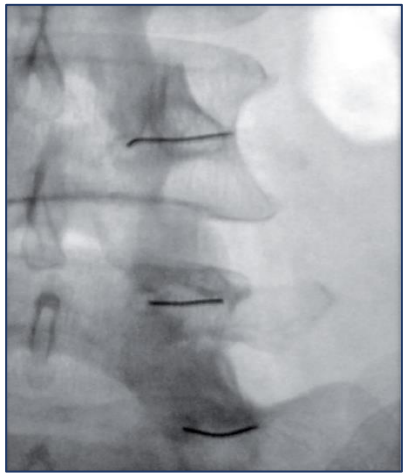
Pain specialized Consultation	History
	Clinical Examen
	IRM etc…
Diagnostic blocks	Local anesthetics only (no steroids !)
	validated test only if performed correctly
Psycho consult	Aggravating Factors
Nurse Consult	Social context
Physio consult	Physical and functional exams

Interventional diagnostic techniques applied to spinal pain

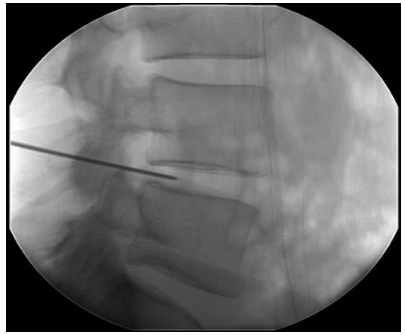
Low back pain

Facet joint pain





Discogenic pain



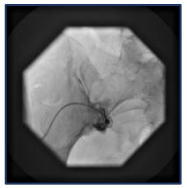
Sacro-iliac pain

Common back pain

Interventional diagnostic techniques applied to spinal pain

Common back pain

Facet joint pain	Discogenic pain	Sacro-iliac pain	Common back pain
30-45% Increase with age	25-40% Decrease with age	15-30% increase trauma/surgery	What remains after all



Diagnostic blocks why and how ?

Why :

1. Clinical examination of the back lack precision, poor kappa score
2. Poor correlation between radiological findings and clinical symptoms (LBP)
3. Numerous studies validate diagnostic blocks as the gold standard (2 tests)

How:

1. Diagnostic blocks are commonly performed with L.A. + steroids 
2. Intra-articular blocks do not provide long term benefit and not prognostic of final ttt

Cohen SP, Shah RV, Kurihara C, Foster CJ. Diagnostic accuracy of lumbar medial branch blocks for facet-mediated low back pain: a systematic review and meta-analysis. *Regional Anesthesia & Pain Medicine*. 2022;47(11):1028–1037.

$$\text{Sensibility} = \frac{\text{True positive}}{\text{True positive + False negative}}$$

The subject has the condition

Diagnostic blocks why and how ?

$$\text{Specificity} = \frac{\text{True negatives}}{\text{True negatives + False positives}}$$

The subject does not have the condition

Clinical examination lack precision

Etiology	Clinical test (s)	Sensibility	Specificity	Reference
Facet joint pain	Provocation (Kemp's, extension-rotation)	57 %	61 %	Laslett et al. (2005)
SI joint pain	Cluster (Thigh thrust + Distraction + Compression)	85 %	79 %	Laslett et al. (2005)
Discogenic pain	Disc Provocation test	54 %	55 %	Young, Aprill & Bogduk (1997)
Radiculopathy	Neurological exam (reflex, strengh, dermatome)	74 %	71 %	Deyo & Weinstein (2001)

Diagnostic Blocks : **Sensibility** > 60% **Specificity** 88-90%

Diagnostic blocks why and how ?

Kappa Score : Reproducibility score of a test between 2 observers

K value	Qualificative score
< 0.00	Very poor (worse than hazard)
0.00–0.20	Poor (slight)
0.21–0.40	Weak to mild (fair)
0.41–0.60	Moderate
0.61–0.80	Significant
0.81–1.00	Robust

Diagnostic blocks why and how ?

Diagnostic blocks predict result of minimally invasive treatments

Kappa score for facet joint

Schneider, Arch Phys Med Rehabil 2013 **0,58 – 0,88** **Significant to Robust**

+

Diagnostic blocks	**Positivity criteria**	**Treatment**	**% success** ≥ 50 % 6 mois	**References**
Medial branch block (2x)	≥ 80 % pain relief w/2 blocks	Radiofrequency	80–90 %	(1), (2), (3)

Diagnostic blocks why and how ?

Diagnostic blocks predict result of minimally invasive treatments

Diagnostic blocks	Positivity criteria	Treatment	% success (≥ 50 % à 6 mois)	References
Medial branch block (1x)	≥ 50 % pain relief	Radiofréquence (RFA)	60–75 %	(1), (2)
Medial branch block (2x)	≥ 80 % pain relief w/2 blocks	Radiofréquence (RFA)	80–90 %	(1), (2), (3)
Intra articular blocks	≥ 50 % immediat pain relief	i.a. therapeutic injection	~ 50 %	(2), (4), (5)

Manchikanti L, Hirsch JA, Falco FJE, et al. *Effectiveness of lumbar medial branch blocks in chronic lumbar facet joint pain: a systematic review of controlled trials.* **Pain Physician.** 2012;15(3):E271-E304.

Falco FJE, Manchikanti L, et al. *Systematic review of the diagnostic utility and therapeutic effectiveness of lumbar facet joint interventions.* **Pain Physician.** 2012;15(3):E335-E371.

NICE. *Low back pain and sciatica in over 16s: assessment and management (NG59).* 2016.

Cohen SP, et al. *Randomized, double-blind, placebo-controlled study evaluating lateral branch radiofrequency denervation for sacroiliac joint pain.* **Anesthesiology.** 2008;109(2):279-288

van Wijk R, et al. *Radiofrequency denervation of lumbar facet joints in the treatment of chronic low back pain: a randomized, double-blind, sham lesion-controlled trial.* **Clin J Pain.** 2005;21(4):335-344.

Back pain

- Basic concepts
- Paths to Failure or Glory
- Diagnostic issues (Non Bio)
- Intervision
- Therapeutic options
- Future

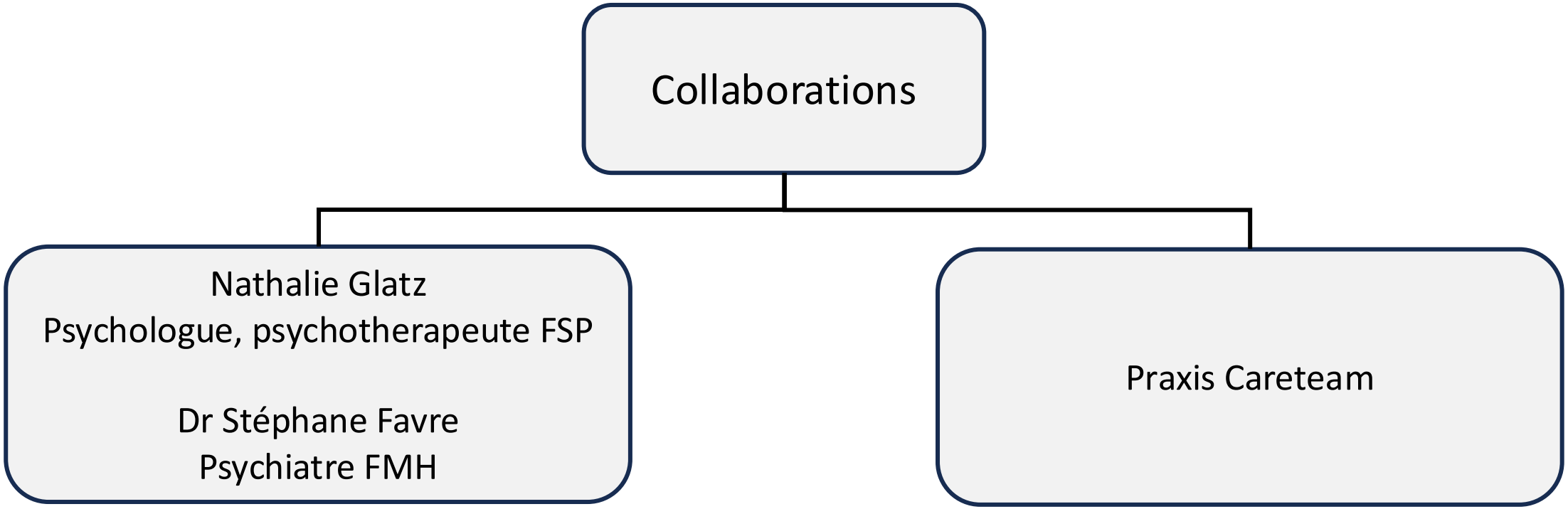
Diagnostic Role of the **psychologist/psychiatrist**

Assessment	Collection, analysis, and interpretation of data Multidisciplinary discussion (weekly case meetings) Feedback provided to the patient in a strategic and therapeutic way

Indications	To a psychological follow-up ? Prior to Spinal cord stimulation Suitable for all patients with or without individual psychotherapy Particularly helpful for those with: difficulties in mentalization, in expressing emotions

Evaluation	No long term follow-up Evaluation towards inclusion in the therapeutic group Evaluation the need of a follow-up (elsewhere)

Psychology



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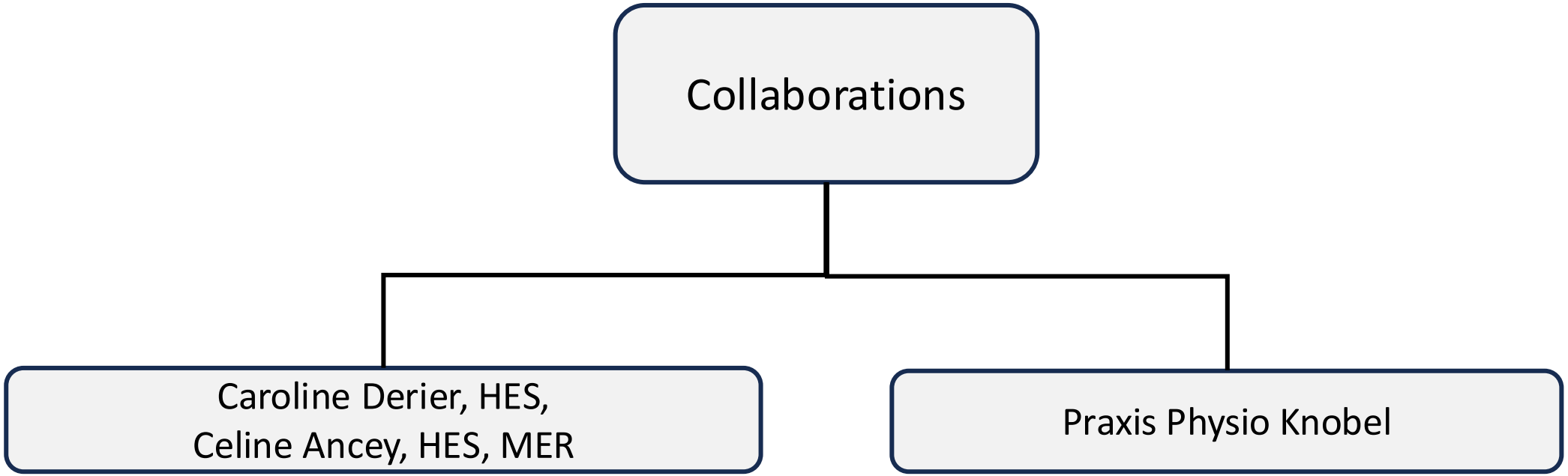
Diagnostic Role of **the physiotherapist**

Assessment	Physical assessment. Collection, analysis, and interpretation of Multidisciplinary discussion (weekly case meetings) Feedback provided to the patient in a strategic and therapeutic way

Indications	Important help in physical evaluation (Physio have a better Kappa score !!!!) Prior to Spinal cord stimulation To a physio follow-up ?

Physiotherapy



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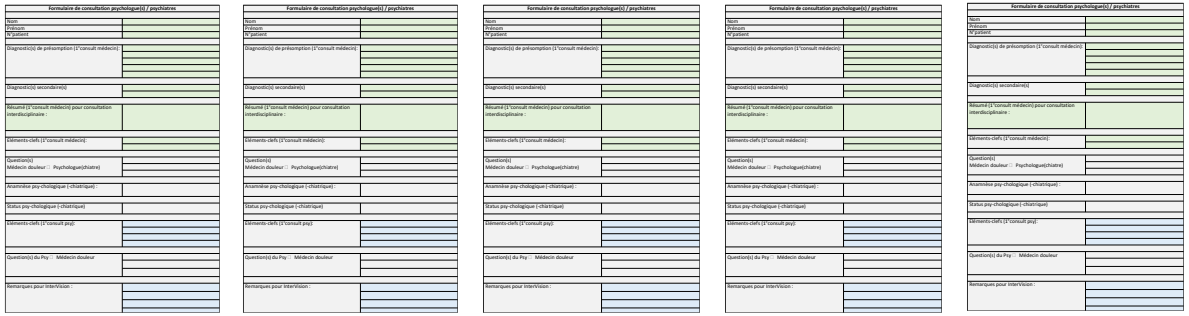
Back pain

- Basic concepts
- Paths to Failure or Glory
- Diagnostic issues
- Intervision
- Therapeutic options
- Future

Pre-Intervision forms for each specialty



FORMS TO MORE INVESTIGATIONS TO IMPROVE DIAGNOSTIC

DIAGNOSTIC ESTABLISHED MANAGEMENT AND TREATMENT PLANNING

- VISIBLE DIAGNOSTICS AND STRATEGY
- MINIMAL INFORMATION LOSS
- TRACABILITY

Formulaire de synthèse de l'InterVision				
Nom				
Prénom				
N°patient				
Diagnostic(s) retenu(s) (1°consult médecin):	•			
	•			
	•			
	•			
	•			
Diagnostic(s) secondaire(s)	•			
	•			
Résumé de l'InterVision :				
Eléments-clefs médecin douleur:	•			
	•			
Eléments-clefs (1°consult psy)	•			
	•			
Eléments-clefs (1°consult physio):	•			
	•			
Eléments-clefs (1°consult infirmière):	•			
	•			
Eléments-clefs (examens radiologiques):	•			
	•			
Planning management et traitement(s) :				
Médical :	Consultation(s)	☒	Priorité	n° 1
	Intervention(s)	☐		n°
	Médicament(s)	☐		n°
	Perfusions(s)	☐		n°
	Enseignement thérapeutique	☒		n° 2
Psychologique :	Pas de Suivi	☐		n°
	Suivi individuel	☐		n°
	Suivi groupes support	☒		n° 3
	Suivi groupe TCC	☐		n°
Physiothérapie :	Prise en charge ponctuelle (1-2 visites)	☐		n°
	Prise en charge thérapeutique (9 séances ou	☒		n° 4
Infirmière :	Enseignement thérapeutique	☐		n°
	Enseignement de gestion « pacing »	☐		n°
Consultant(s)	Autres	☐		n°

Back pain

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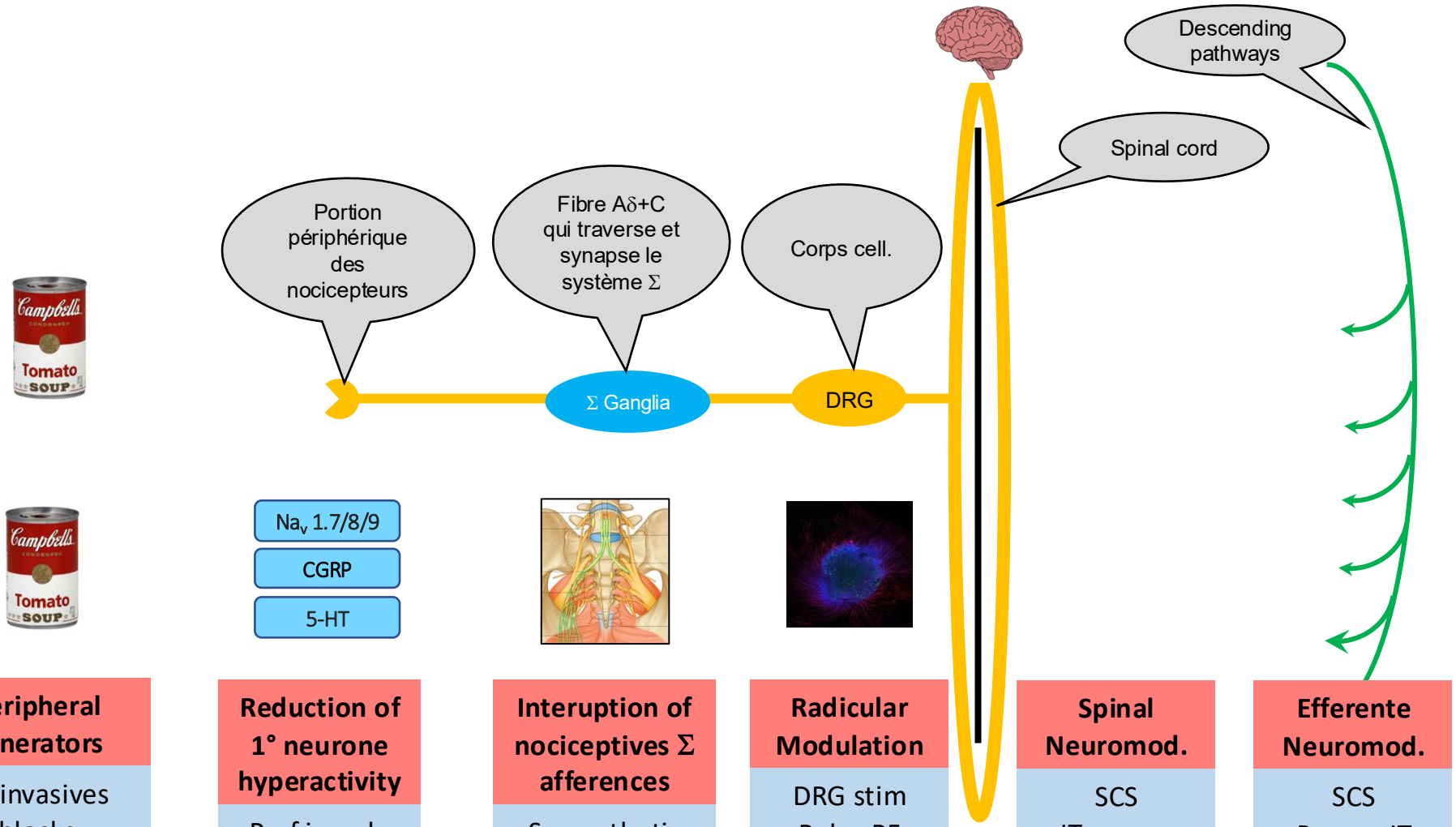
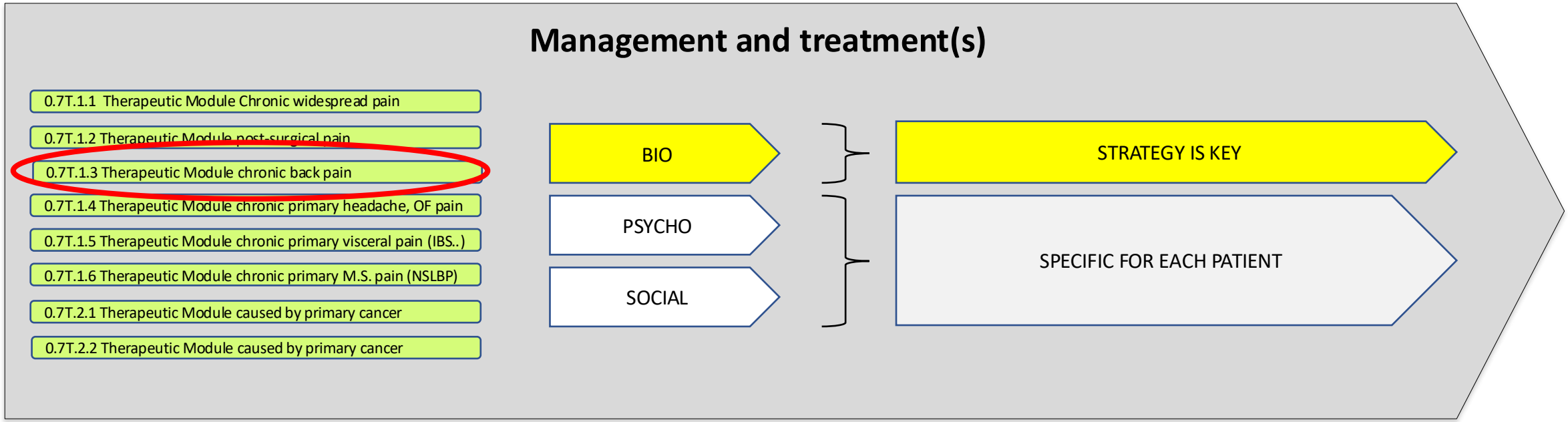
Somatic therapeutic targets



Peripheral generators	Reduction of 1° neurone hyperactivity	Interuption of nociceptives Σ afferences	Radicular Modulation	Spinal Neuromod.	Efferente Neuromod.
M-invasives blocks Médication RF /Cryo	Perf iv xylo Médication RF /Cryo	Sympathetic Blocks (CRPS like)	DRG stim Pulse RF	SCS IT pumps	SCS Pompe IT Médications Mod. Psy

Therapeutic Algorithm



ONE THING AT A TIME TO UNDERSTAND WHAT WORKS

FROM MOST LIKELY TO LEAST LIKELY TO HELP

FROM LESS INVASIVE TO MOST INVASIVE

FROM BEST VALIDATED TO LEAST VALIDATED

Interventionnel therapies

Medication		Not discussed today
Infiltration	Local anesthetics	Nociceptives and inflammatory peripheral targets
	Steroïds	
	Botox	Neuromodulators / antiinflammatory / regenerative
	PRP(s)	
Lesionning	Thermo-ablation(s) RF denervation	Nociceptives and inflammatory peripheral targets
	Cooled-RF denervation	
	Cryo denervation	Block of nociceptive transmisssion
Neuromodulative	Peripheral Nerve Stimulation	Douleurs neuropathiques Neuro-inflammatoires centrales et périphériques
	DRG Stimulation (ganglion spinal)	
	Spinal Cord Stimulation	Nerve and spinal Modulation
	Intrathecal Neuromodulation (IT pump)	

Interventionnel therapies

US /Rx guided

Médicamenteuses		
Infiltration	Local anesthetics Steroïds Botox PRP(s) (Stem cells)	Nociceptives and inflammatory peripheral targets Neuromodulators / antiinflammatory / regenerative
Lesionning	Thermo-ablation(s) RF denervation Cooled-RF denervation Cryo denervation	Nociceptives and inflammatory peripheral targets Block of nociceptive transmisssion
Neuromodulative	Peripheral Nerve Stimulation DRG Stimulation (ganglion spinal) Spinal Cord Stimulation Intrathecal Neuromodulation (IT pump)	Douleurs neuropathiques Neuro-inflammatoires centrales et périphériques Nerve and spinal Modulation

Interventionnel therapies

US /Rx guided

Médicamenteuses		
Infiltration	Local anesthetics Steroïds Botox PRP(s)	Nociceptives and inflammatory peripheral targets Neuromodulators / antiinflammatory / regenerative
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Interventionnel therapies

US /Rx guided

Médicamenteuses		
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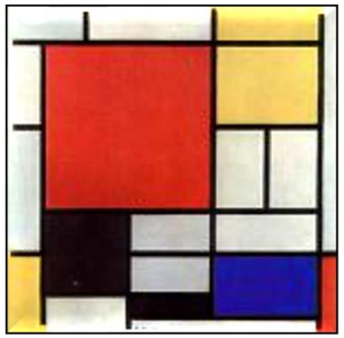
Evolution of concepts

60's-80's
Paradigm Shift

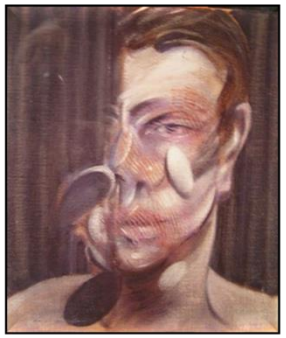
90's-2010's
Technological Step

Late 2010's -20's
Endogenous modulation

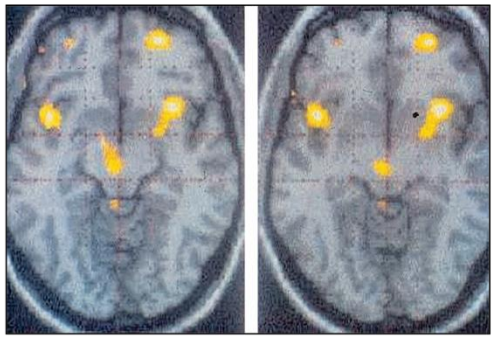
Late 2000-2020's



Anatomical and rigid
Model
Complex but stable

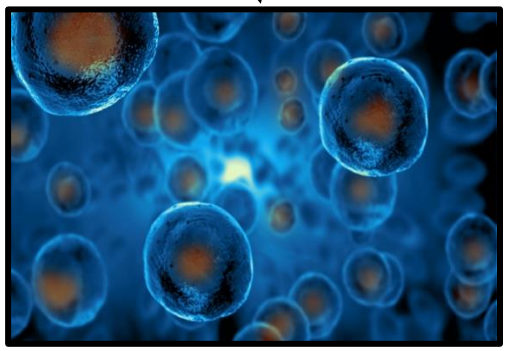


Complex and changing
Model
Evolutive and plastic



Pain imaging
and
Brain activity

Endogenous pain
modulation through
descending inhibitory and
excitatory pathways



Regenerative
medicine
Stem cell/ gene tt, AI

Conclusions

- Holistic view (Interdisciplinary not Multidisciplinary)
- Diagnostic(s) **FIRST**
- Interventional diagnostics and treatments are operator-dependant and require strict rigor (education and training)
- Peripheral and central sensitization contribute to pain complexity
- Request advice form your peers

Conclusions

- Patient with persistant back pain > 3months
- Acute or sub-acute painful disc herniation, MRI documented and no motor deficit
- Complex pain issues
- Pain with a neuropathic component (including CRPS syndrom)
- All uncontrolled painful issues

Swiss Pain Group

We diagnose, manage and treat persistant to chronic pain

Cervical and Back Pain

Visceral and Pelvic Pain

Cancer Pain

Headache

Neuropathy Central and Peripheral

Post-surgical pain, CRPS

UM IHRE PATIENTEN RASCH UND EFFIZIENT ZU BEHANDELN, SCHLAGEN WIR IHNEN VIER MODELLE ZUR TERMINVERGABE VOR

	1. NOTFALLINFILTRATION INNERHALB VON 24 STUNDEN (AN WOCHENTAGEN)	2. NOTFALLKONSULTATION INNERHALB EINER WOCHE	3. DRINGLICHE KONSULTATIONEN IN DEN NÄCHSTEN 2 WOCHEN	4. KONSULTATION INNERHALB VON 4 WOCHEN
INDIKATIONEN	Lumboischialgien Brachiozervikalgien Spinalkanalstenose } radiologisch abgeklärt - *Therapierefraktärer Schmerz ohne neurologisches Defizit* - ***Keine Antikoagulanzien***	Schmerzexazerbation: - bei neuropathischen Schmerzsymptomen - Tumorschmerzen - Persistierende, postoperative Schmerzen	- Therapierefraktäre Schmerzen - Ohne wesentliche psychosoziale Belastungsfaktoren	- Chronisch primäre Schmerzen - Schmerzen, die auf keine Behandlung bis jetzt angesprochen haben und/oder im Zusammenhang mit psychosozialen Belastungsfaktoren stehen.
BEISPIELE	- Akuter Bandscheibenvorfall ohne neurologische Ausfälle, radiologisch verifiziert	- Therapieresistenter Migräneanfall, oder Gesichts/Kopfschmerzen - Tumorpatienten mit Schmerzexazerbation - Algodystrophie (CRPSI/II, vormals Morbus Sudeck)	- Anhaltende starke vertebrale Schmerzen (zervikal, thorakal oder lumbal) - Infiltrationsbehandlung zur besseren Diagnostik und Evaluierung weiterer infiltrativer Therapieoptionen	- Chronische Panvertebralschmerzen, chronische spondylogene Schmerzen - Zentrale oder periphere - Neuropathien - Chronisch persistierende - Schmerzen bei Tumorpatienten - in Remission Chronische KopfschmerzenFibromyalgie, Ganzköperschmerzen.
LEISTUNGEN	- Klinische Untersuchung zur Verifizierung der Diagnose und Indikation. - Evaluierung der bereits durchgeführten Untersuchungen - Gezielte Infiltrationen unter Röntgen/Ultraschall Kontrolle - Weitere Betreuung des Patienten und kontinuierliche Berichterstattung an den Zuweiser und Hausarzt	- Multidimensionale Konsultation (inklusive Fragebogen und Anamnese) - Klinische Untersuchung - Überprüfung der bereits durchgeführten Untersuchungen - Erstellen eines klaren diagnostischen und therapeutischen Therapiekonzeptes - Bei Bedarf kommt ein multidisziplinärer Behandlungsansatz zum Tragen - Interventionelle (infiltrative) Behandlung bei gegebener Indikation - Patientenbetreuung und kontinuierliche Berichterstattung an den Hausarzt		

IHR INTERDISZIPLINÄRER
PARTNER FÜR
SCHMERZTHERAPIE

AESCHENGRABEN 26
CH-4051 BASEL
T. +41 61 319 80 00
F. +41 61 319 80 01
KONTAKT.BS@SWISSPAIN.CH
WWW.SWISSPAIN.CH

SWISS PAIN INSTITUTE
SCHWEIZER SCHMERZINSTITUT

How to refer your patients

Basel	Lausanne
swisspain-bs@hin.ch	swisspain-ls@hin.ch
+ 41 61 319 80 00	+41 21 313 41 41
Brief request letter	Brief request letter
Medication (+ anticoagulants)	Medication (+ anticoagulants)
Xray, consults from other specialists	Xray, consults from other specialists

Phone calls, direct questions, visits always welcome !

…“the most important principle is

neither drug nor technique

but the context of their use”…

Moore DC, Anesthesiology, 1984;61:782