

EVENT REPORT FORM

Project title	Strengthening Capacities for Higher Education of Pain Medicine in Western Balkan countries
Project acronym	HEPMP
Project reference number	585927-EPP-1-2017-1-RS-EPPKA2-CBHE-JP
Coordinator	University of Belgrade
Project start date	October 15, 2017
Project duration	36 months

Event	Second course primary health care: Chronic pain -
Type of event	WP3 (Development of LLL courses and interventional pain medicine courses) 3.4. Delivering of LLL courses of pain medicine in primary health care centers of PCs
Venue	Faculty of Medicine at University of Tuzla
Date	30.11.2019.
Organizer	Faculty of Medicine University of Tuzla
Reporting date	February, 10 th , 2020
Report author(s)	Jasmina Smajic

Project number: 585927-EPP-1-2017-1-RS-EPPKA2-CBHE-JP (2017 – 3109 / 001 – 001)

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EVENT DESCRIPTION

with special reference to goals and outcomes

Number of participants at the event	108
Participants (organisations)	PHCC Kalesija, PHCC Tuzla, PHCC Teocak, PHCC Lukavac, PHCC Tesanj, PHCC Sarajevo, UCC Tuzla
Event description:	
<p>The main objective was to develop LLL course about chronic pain management and deliver it to health care professionals in Primary health care centers in Tuzla canton, but there were also participants out of Tuzla canton. After the development of the training material, selection of trainees, and accreditation of the course by The Chamber of Doctors in Tuzla Canton, the course was held for the purpose to give basic education regarding achronic pain management considering that undergraduate studies do not include modules of pain medicine.</p> <p>Objectives of the course:</p> <ul style="list-style-type: none"> - Teach participants to explain the difference between acute and chronic pain - Teach participants to explain the difference between nociceptive and neuropathic pain - Point out the importance of pain as the fifth vital sign and the pain intensity estimation - Pain intensity estimation methods - Learn about the importance of chronic pain treatment and prevention of chronic pain syndrome - Learn how to devise the most commonly used analgesics - Learn the indications, counter-indications and unwanted effects of the most commonly used analgesics <p>Description of activities</p> <p>After drafting the educational material, fourteen lecturers were selected who, each from the field for whom it was delegated, wrote the material and produced a presentation. The entire educational material was systematized, prepared in the required format and sent for printing to all participants. Educational event accredited as the first category seminar with the highest number of CME credits. The accreditation notice was sent by e-mail, the pdf version of which is attached to this document. A flyer was prepared outlining the program of the event as well as the decision on accreditation. The flyer was uploaded in digital format on the official website of the Faculty of Medicine of Tuzla (http://medf.untz.ba/najave/hepmp-hronicni-bol-poziv-na-edukaciju/), the University of Tuzla (http://www.untz.ba/uploads/file/projekti%20stipendije/ERASMUS+/HEPMP/Akutni-bol-novembar2019/Flajer_Hronicni_bol.pdf), the Medical Chamber of</p>	

the Tuzla Canton (<https://ljktk.ba/v2/1374-2/>), the Newsletter of the University Clinical Center Tuzla, webpage of Association of medical doctors Anesthesiologists – reanimatologists in Federation of Bosnia and Herzegovina (<http://www.udmar.ba/?p=1725>), and the HEPMP facebook page (<https://www.facebook.com/pg/HEPMP-113918870024687/posts/>). In addition, a flyer was sent to potential participants in the form of a call.

The seminar started from 09.00 with a registration of participants. The participants were addressed and greeted by the coordinator of the team of the University of Tuzla, who introduced the participants to the HEPMP project, its goals and tasks through an introductory lecture. In the first lecture, the topic was Overcoming Chronic Pain in Pancreatic Disease, and the characteristics of the pain that occurs with pancreatitis, the mode of onset and transmission were immediately highlighted. Pancreatic pain is a visceral pain that also includes visceral hyperalgesia that occurs due to changes in sensory neurons in visceral tissue and due to the increased sensitivity of sensory pathways in the brain that transmit impulses from visceral organs. Primary hyperalgesia is due to peripheral sensitization at the persistent excitability of visceral nociceptors, while secondary hyperalgesia is due to central sensitization when stimulated visceral nociceptors send impulse and stimulate neurons in the posterior horns of the spinal cord. Pancreatitis pain can also be neuropathic, and this is driven by disease course, genetic predisposition, trauma and therapeutic approach. In the treatment of pancreatitis pain most commonly used is a multimodal approach according to WHO guidelines. The first step is the treatment of mild pain, which is treated with non-opioids and adjuvant medicines. The second step is to treat moderate pain when given opioids with weak opioids and adjuvants. The third step is moderate to severe pain treated with neopioids, strong opioids and adjuvants, while very severe pain (step four) is treated with invasive procedures, adjuvants and neopioids. Combinations of analgesics given for the treatment of pancreatic pain are also presented. At the end of the lecture it was pointed out that the treatment of pancreatic pain is multidisciplinary whereby the team consists of a gastroenterologist, anesthesiologist, surgeon, nutritionist, physiatrist, psychologist, social worker.

This was followed by a presentation on Pain Management after Cardiovascular Surgery, and the introduction introduced the importance of ERAS (Enhanced recovery after surgery protocols after surgery). In the subsequent presentation, other items of ERAS protocol in cardiac surgery with a focus on fast track anesthesia and early extubation are presented. According to the ERAS protocol for the treatment of pain in the postoperative period of cardiac surgery multimodal analgesia should be applied by a combination of multiple analgesics that are applied in different ways. oral analgesia as well as catheter placement in the surgical wound and local anesthetic administration. Finally, it was pointed out that according to the ERAS protocol, patients were referred to the ICU after cardiac surgery, then to the Step down unit and then to the ward.

The third lecture was about neuropathic pain caused by the lesion or disease of the somatosensory part of the central and / or peripheral nervous system.

Prevalence in the general population up to 7-8%, and the importance of studying neuropathic pain is due to the consequences it causes: it reduces physical and work ability, leads to sleep disorders, anxiety, depression, impairs social functioning and quality of life. Then, various clinical conditions in which neuropathic pain from diabetes, herpes, trauma, radiculopathy, stroke, Parkinson's disease are presented. Thus, a wide range of conditions that can be accompanied by neuropathic pain. The characteristics of neuropathic pain are also presented: annealing, burning, tingling, tingling, stabbing, feeling cold, "electrocution". In neuropathic pain, the sensory symptoms are divided into two groups: positive (dysesthesia, paraesthesia, hyperalgesia, allodynia) and negative (hypesthesia, hypoalgesia, analgesia). In the diagnosis of neuropathic pain, the questionnaires filled in by the patient are useful, and according to the obtained score it is determined whether the pain is neuropathic or not. Neurophysiological processing (electromyoneurography (EMNG), quantitative sensory testing, somato sensory evoked potentials) is the key to the diagnosis of underlying disease. The pathophysiological mechanism of neuropathic pain, peripheral and central sensitization is presented below. This was followed by a presentation on the treatment of neuropathic pain. It is pointed out that the treatment is mechanism based, the pathophysiological mechanism of neuropathic pain does not depend on the disease that is the root cause of the pain (the same mechanism in different diseases). One patient may have different mechanisms of neuropathic pain, which give the same symptom, which is a problem when choosing therapy. A therapeutic model for neuropathic pain, with various analgesic combinations, is presented below.

During the fourth lecture, seminar participants had the opportunity to hear about diabetic polyneuropathy as the most common cause of chronic neuropathic pain. Diabetic polyneuropathy occurs as a microvascular complication of diabetes mellitus with a prevalence of 8-10%, while 30-50% of DM patients will receive diabetic polyneuropathy during their lifetime. The most important etiologic factors for the onset of DPN are poor glycemic control while maintaining its high values and duration of diabetes. Possible additional factors are hypertension, smoking, dyslipidemia, hypoinsulinemia, old age. DPN is due to the complex interaction of metabolic, neurovascular and autoimmune factors, resulting in damage to the small blood vessels, oxygenation and nerve nutrition. The first are the distal sensory fibers and the autonomic fibers. Damage to the longest peripheral nerves is ultimately mediated by free radicals. DPN has great socioeconomic importance. DPN is the most important risk factor for the development of diabetic foot and foot amputation. DPN is the cause of 50-75% of non-traumatic foot amputations, and 75% of these amputations could be prevented by better treatment of DM and DPN. The symptoms of DPN and the association between pain that occurs in DPN with anxiety and depression are then presented. DPN pain is neuropathic, and can be piercing, in the form of tingling, burning, burning, numbness, cold feet. The therapeutic approach to neuropathy was then presented. It was emphasized that treatment should be started as early as possible to prevent pathophysiological changes in the spinal cord and brain, as well as clinical complications: ulcer, gangrene and amputation of the foot.

Significant advances in treatment were achieved with the introduction of alpha-lipoic acid at the end of the 20th century following the publication of the ALADIN III study. ALA regimens and analgesics for neuropathic pain with gabapentin and pregabalin as the first line of choice are presented.

In the next lecture, the lecturer presented Chronic non-malignant pain to the participants. The introduction highlights the definition and characteristics of chronic non-malignant pain. Chronic pain is a pain that persists despite healing the cause that caused it. The development of chronic pain does not depend on the severity and type of cause. The likelihood of developing chronic pain in a person depends on previous experience, preference, and the nature of the acute or relapsing pain. The last 10 or so much has been done in raising public awareness of the CNB and educating medical staff to treat it. The problem is far from being resolved, however, because according to Pain in Europe, 10 to 13% of the total population has chronic pain. The importance of pain assessment as well as the recognition of generalized chronic pain is emphasized. Chronic pain syndrome most commonly occurs as osteoarthritis, chronic low back pain, complex regional pain syndrome, fibromyalgia syndrome, osteoporosis. Chronic low back pain that 70-85% of the population suffers during their lifetime is highlighted. Acute low back pain temporarily limits functional capacity, without causing disability, 80-90% of patients should recover functionally within 12 weeks. If functional imbalance recurs and pain persists - let's talk about chronic pain. Potential risks for chronic low back pain, such as smoking, depression, fibromyalgia, are presented. The following section presents a therapeutic approach to chronic pain syndrome, which involves properly selected pharmacotherapy titrated to the optimal dose of the drug + different forms of exercise + patient education + multidisciplinary approach.

The sixth lecture was about a patient who has chronic pain and is preparing for some surgery and anesthesia. At the beginning of the lecture, it was pointed out that the number of surgeries worldwide is increasing greatly, but also a large percentage of patients who have pain of a certain intensity in the early postoperative period, which depends on the type of surgery, age, gender, comorbidity. Improperly treated postoperative pain can cause numerous postoperative complications, but can also translate into chronic postoperative pain. On the other hand, a large number of patients with chronic pain use opiates to treat pain. Such patients are a great challenge for the anesthesiologist because they have more complex postoperative analgesia because such patients may have developed central sensitization and opioid-induced hyperalgesia. Patients using opioids should not reduce the usual dose but not discontinue it during the preoperative period. In these patients, it is necessary to develop an analgesic plan for the perioperative period preoperatively, based on multimodal analgesia and opioid sparing techniques. Schemes of multimodal analgesia and sparing techniques are presented below with the conclusion that opioid-dependent patients have four-fold increased opioid requirements in the postoperative period compared with opioid-naïve patients. The duration of postoperative treatment is about three times longer in these patients compared to opioid-naïve patients. Multimodal analgesia is mandatory to reduce opioid consumption, and regional

analgesia may be useful. Help of patient-controlled analgesia (PCA) or patient-controlled epidural analgesia (PCEA). Opioid antagonists, including naloxone and naltrexone, in opioid users should be avoided (could precipitate withdrawal symptoms).

The short break allowed the educators and participants to refresh, but also to discuss the presented topics in informal circumstances. In the next lecture, the lecturer presented to the participants the specifics of pain management at the primary health level. The treatment of pain in PHC outpatient clinics is a daily task, as pain is the most common reason for patients to report to their chosen doctor (ID). It is especially common in people over 60 years of age. In trying to eliminate or reduce pain, many patients often take various medications themselves, which can cause side effects. When a patient reports his / her ID citing pain as a symptom, it is very important to determine at that time, at the level of PHC, what type of pain it is, nociceptive or neuropathic. However, infrequently pain is mixed, that is, composed of both components (malignancies, back pain syndrome, radicular syndrome, pain after laminectomy). Locomotor system diseases are the cause of pain for about two-thirds of patients visiting their ID. Often these are the people of the most productive age, with acute and / or chronic pain syndrome with or without radicular impairment and neuropathic pain. Malignancies are also accompanied by pain that needs to be addressed or alleviated. The following are injuries and consequent acute severe pain. Pain in various clinical entities (renal and biliary colic) is also often the reason for reporting IDs or emergency services. Of course, this is also an intense pain that requires quick and effective treatment. Chronic pain as a disease is most commonly in the form of chronic non-malignant pain, accounting for 98.5% of all chronic pain. Understandably, these are very demanding patients and their treatment is often not simple and requires a multidisciplinary approach. The goal of good management of a patient with PHC pain is not only the rehabilitation or reduction of pain, but also the improved outcome of treatment, improved function and rehabilitation, reduced suffering, and ultimately reduced community disability. Once the diagnosis is made and treatment is decided upon, we should consider possible therapeutic interventions, both non-pharmacological and pharmacological, as well as the need for referral. Non-pharmacological interventions for the treatment of pain are: physical therapy, exercise, counseling, weight loss, smoking cessation and weight reduction, psychological assessment and evaluation of the patient's goals. The World Health Organization has provided five basic principles for the proper pharmacological treatment of pain at the PHC level: oral administration of analgesics, analgesics should be given at regular intervals, analgesics should be prescribed according to the intensity of pain assessed by the intensity scale, the dosage of analgesics must be individual, analgesics should be prescribed with constant attention to detail. At the end of the lecture it was concluded that the treatment of chronic pain at PHC level is very significant. Evidence-based treatment methods should be used as a first-line strategy. In addition to medicamentous therapies, exercise and cognitive behavioral therapy are preferred. Unrecognized comorbidities and unstable biopsychosocial comorbidities are common in patients with chronic pain,

especially in those who are poorly functioning and are often a barrier to recovery and a risk factor for poor compliance and adherence. The best strategies for treating chronic pain include an interdisciplinary / multidisciplinary approach. The following presentation was devoted to stimulation of the spinal cord in the treatment of chronic pain. Participants were introduced to the definition of spine cord stimulation (SCS) - a neuromodulation technique that reduces pain by bioelectric stimulation of the dorsal spinal cord. Administration is recommended when conventional, multidisciplinary treatment of neuropathic or mixed pain is unsuccessful. It is a system consisting of a pulse generator with a battery that is implanted into the subcutaneous space of the anterior-lateral abdominal wall and the lumbar gluteal junction. It connects to the electrodes implanted in the epidural space that stimulate the posterior columns of the gray mass of the spinal cord, leading to an antidromic or orthodromic flow of action potential that results in segmental and supraspinal effects. The primary indication is FBS, where SCS has been shown to be superior to conservative medical treatment at 6 December and 24 months in the reduction of leg pain (> 50%), improvement of function, and quality of life. Another indication is Complex Regional Pain Syndrome (CRPS) and primarily type I. 95% of patients were satisfied with their SCS treatment after five years of system implantation. SCS provides superior evidence in the treatment of refractory angina (RAP) in terms of pain reduction, improvement of functional status compared with medication. SCS also shows moderately strong evidence in improving functional status and reducing drug use in patients with critical limb ischemia (CLI). SCS has been shown to be successful in reducing chronic lower extremity pain in patients with painful diabetic polyneuropathy after five years of follow-up. 80% of patients still use their SCS system after 5 years. When analyzing the efficacy of this method, comparing it with other treatments, the conclusion is that SCS is a simple, low-risk, minor-complication procedure, completely reversible and in comparison with the conventional treatment, and considering their cost-effective method.

This was followed by a lecture on breakthrough pain in advanced cancer. In the introductory part, the lecturer emphasized the history and definition of pain, as well as the mechanism of its origin, according to which pain is divided into nociceptive, neuropathic and non-somatic. Further presentation shows the onset of cancer pain that can be caused by the tumor itself, tumor treatment, or tumor-related disorders, with 30 to 40% of patients diagnosed with cancer, and 75 to 90% of patients experiencing pain. in the advanced stage of the disease. Participants were then introduced to the definition of breakthrough pain, which is transient sudden pain, which occurs through “underlying” pain during opiate treatment. Breakthrough pain can be INCIDENTAL by cause - (43%) due to: movement, coughing, sitting, distention of hollow organs, psychosocial stimuli; IDIOPATHIC - (27%) occurs spontaneously, unknown cause; “DOSAGE END” (17 - 30%) adequate analgesic treatment (analgesic subdosage or long dose interval). Characteristics of breakthrough pain are shown: fast and paroxysmal onset <3 min, intensity 7-10 on NRS scale, duration of 1- 60 min. (average 15 and 30 min.), frequency of 4 - 7 painful episodes / day (terminal stage of the disease). The most common cause of breakthrough pain is bone pain (27%), local tumor invasion of

the soft tissues (21%), and brachial plexus syndrome (9%). Finally, the lecturer presented a method of treating breakthrough pain in cancer. The treatment of breakthrough pain involves the use of additional so-called. Opiate 'salvage' doses, which should be recorded and included the next day in corrected doses of regular analgesic therapy. Oral short-acting opiate preparations are recommended as the first line of BTcP treatment because they are easy to use and most physicians have experience in using them. Lack of oral opiate treatment is associated with a slower onset of action, with maximal effects after 45 to 60 minutes. Much faster onset of action is achieved with a preparation of the oral transmucosal fentanyl citrate type, which passes through the blood brain barrier in 3-5 minutes, with a peak of action in 20 - 40 minutes and a total duration of 2 - 3 hours after administration. Better effects in BTcP treatment are achieved by the use of fentanyl in the form of: sublingual tablets, Intranasal Fentanyl Spray and Fentanyl buccal soluble film - FBSF.

This presentation was followed by a lecture on opiophobia - the dilemmas and thinking of our doctors. In the introductory part, the lecturer presented the definition of pain, presented pain as a public health problem, and the characteristics and incidence of chronic pain. It was pointed out that more than 1/4 of patients suffer from moderate and severe chronic pain, and that 2/3 of cancer patients are treated with NSAIDs. The following are reasons why primary care physicians avoid prescribing opioids: they are overwhelmed with bureaucracy and a large number of patients, do not have sufficient knowledge and experience in the treatment of chronic cancer pain, will not independently introduce opioid analgesics into therapy, will not independently increase the dose of opioid analgesics, has a fear of ND, primarily respiratory depression. It was pointed out that the solution to this problem is continuous medical education of primary care physicians in the field of chronic therapy cancer pain. Opiophobia is an obstacle to the successful treatment of pain in patients with malignancies. The reasons why patients avoid opioid use are also presented. Continuing education is required to prevent opiophobia. There are two ways to go: inform WHO guidelines, overcome prejudices and change physicians' attitude toward opioid analgesics and their effect in the treatment of malignant pain. Educational programs to raise the awareness of professionals about the extent to which their negative attitude may be detrimental to the clinical decisions they make. The side effects of opioids have also been shown, and one of the conclusions is that strong opioids exist to use them, not to avoid them! Their use is indicated solely by the severity of the pain and not the prognosis or expected survival of the patient!

A lecture on interventional procedures in the treatment of pain followed.

Interventional pain management uses injections of drugs to reduce pain. In addition to its therapeutic benefits, interventional pain management can play a role in identifying the source of the pain. Interventional procedures are commonly done with the use of fluoroscopy (live x-ray guidance). This allows physicians to perform injections with increased accuracy and safety. To ensure patient comfort during minimally invasive procedures, the patient has the option of "twilight" sedation, which makes the procedure virtually pain free. Procedures usually last less than an hour, and the patient is able to walk away from the treatment center

the same day. Some individual analgesic methods are presented below.

A lecture on acupuncture in the treatment of chronic pain followed. The beginning of the lecture presented the history and definition of acupuncture. The scientific basics of acupuncture are presented below, with a detailed explanation of each of these theses. An increasing number of clinical trials on acupuncture treatments have provided more information, especially about the role of acupuncture in the clinical management of pain. Then the lecturer presented several clinical conditions that can be treated with acupuncture: headache, trigeminal neuralgia, temporomandibular joint dysfunction, osteoarthritis, rheumatoid arthritis, carpal tunnel syndrome, lower back pain. The following section presents indications as well as possible complications of acupuncture. Finally, the effectiveness, safety, and cost of acupuncture for chronic pain is presented. Evaluated 304,674 patients over 10,000 physicians and received 10+ acupuncture for pain in USA. Results: acupuncture was an effective and safe treatment. The effects are attributed to specific or nonspecific mechanisms and dependence on the diagnosis-results of a large research initiative.

The following was a lecture on the legal implications of pain. The legal aspects of pain in medicine are studied within the framework of theoretical instruction in a narrow specialization, with harmonization with EU regulations - the main goals being the highest level of patient safety. The rights and duties of patients and the rights, obligations and responsibilities of healthcare professionals are studied. The legal rules governing the medical activity determine the characteristics of the person performing the activity, the relationship with patients, the manner of performing the health care activity. Medicine and law share a common object and goal - caring for life and health in different ways. International sources of medical law presented: WHO - Declaration on the Promotion of Patients' Rights in Europe, June 28, 1994, European Charter of Patients' Rights, November 2002, Ottawa Declaration of the World Medical Association on the Rights of the Child (1988), Ethical principles for Medical Research involving Human Subjects WHO (1964 rev. 2008), WMA - Declaration on the Rights of the Patient, September / October 1981 rev. 2005, UNESCO Universal Declaration of Bioethics and Human Rights (2005). Charter of Hospitalized Patients (1979), International Conference on Primary Health Care - Declaration of Alma-Ata, September 6, 1978, International Alliance of Patients' Organizations [IAPO] Declaration on Patient-Centered Healthcare, February 2006, UNESCO Universal Declaration on the Human Genome and Human Rights (1997), UN Convention on the Rights of the Child (1989), Council of Europe Convention on Human Rights in Biomedicine (1995), Third EU Health Program (2014-2020). Jurisdiction of medicine has been clarified, which is the procedure for controlling the provision of health services. The relationship between the healthcare provider and the patient is increasingly regulated by legal rules. Consequence of Jurisdiction - Emphasizing Patient Rights. The procedures of healthcare professionals are subject to assessment of expertise, timeliness, correctness. The Patient Rights Act is also presented. The right of the patient to the highest level of relief of suffering and pain, according to generally accepted professional standards and ethical principles (European Charter); pain therapy and palliative care. It has been pointed out that the mere

relief of suffering and pain does not imply euthanasia.

The last lecture was devoted to the financial aspects of project activities.

After each lecture, participants had questions, mini-discussions were initiated, and participants were encouraged to communicate with HEPMP lecturers in informal settings during the breaks to communicate with Strengthening Capacities for Higher Education of Pain Medicine in Western Balkan Countries. After the presented topics, a discussion was opened and the lecturers answered the participants all the questions raised regarding chronic pain and its treatment. Participants were also advised to download educational material in pdf format from the HEPMP website. The seminar was completed by completing an exit knowledge test, completing an evaluation questionnaire and awarding certificates to the trainees. The participants were also provided with manuals on acute pain, containing all the lectures presented at the seminar, which is in the pdf version attached to this document.

The exit test of knowledge was analyzed, which gave an overall insight into the knowledge of the participants after the lectures. By evaluating the course by educators, it was estimated that the expected outcomes were achieved:

- Health care professionals (doctors, nurses ...) in the health center have the skills to assess pain
- primary level physicians and pharmacists have acquired the skill of rationally applying pharmacological algorithms for chronic pain management.

An evaluation questionnaire was also analyzed and the results are attached in this document. Interest in the course was extremely high, as was shown by the large number of students - 108. Over 50% of them are highly educated, physicians and pharmacists by structure. The group of listeners was very heterogeneous and consisted of general practitioners, specialists, nurses, pharmacists. The participants rated the choice of education topics, the content of the education program, the methods used, the duration and the organization of the education highly rated. 84% of them estimated that they would use the knowledge acquired during education often or constantly in everyday practice. Participants stated in the evaluation questionnaire that teaching was easy to understand. Each of the lecturers was evaluated individually by the participants, and each received an average grade between 4.68 and 4.98. The participants assessed that the lecturers were prepared for the lectures.

Participants were also given the opportunity to leave a personal comment on the evaluation questionnaire, which a number of them did. The comments referred to comments, suggestions and praise, but also suggested topics in the next continuing education program. Some of the suggestions were to address the topics of thoracic and abdominal pain, as well as cancer pain through future seminars on Strengthening Capacities for Higher Education in Pain Medicine in the Western Balkans - HEPMP

Participants rated the overall impression of the seminar as average 4.94 (out of 5).

The seminar was monitored by the media and a report on the education was broadcast on BH radio (BH radio), whose recording is attached to this document. All lectures are available on the Web, <https://cme.ba/course/hr-bol/>, as well as

at https://www.facebook.com/HEPMP-113918870024687/?ref=aymt_homepage_panel&eid=ARA8kIhqPHnHqFmo9B04JKztRkO41jzEXuZvXSF3bX1kYn5DSYsXHIL1Mfrk8SzKGSNv5dWNMx6zyMK6.
The report on the seminar was also published on the University of Tuzla website, <http://www.untz.ba/index.php?page=hepmp-report-o-lll-kurs-chronic-bol-februar2020>.

Attachments

Agenda (pdf)	Leaflet Chronic pain (pdf)
Attendance sheet (pdf)	Annex 4 - HEPMP-attendance list Tuzla (pdf)
Photos (jpg)	12 (jpg)
Quality control (pdf)	Accreditation by The Chamber of doctors in Tuzla Canton (pdf); Annex 6- HEPMP-Event evaluation list; Output test
Deliverable (pdf)	Leaflet Chronic pain (pdf) Handbook: Chronic pain (pdf) https://cme.ba/course/hr-bol/ https://www.facebook.com/HEPMP-113918870024687/?ref=aymt_homepage_panel&eid=ARA8kIhqpHnHQFmo9B04JKztRkO41jzEXuZvXS F3bX1kYn5DSYsXHIL1Mfrk8SzKGSNv5dWNMx6zyMK6
Presentations (pdf)	01 HEPMP Project., Smajic pdf 02 Treatment of chronic pain in pancreatic diseases, Vintar pdf 03 Treatamnet of pain after cardiovascular surgery, Sostaric .pdf 04 Neuropatic pain, Jevdjic.pdf 05 Diabetic polyneuropathy as the most common cause of neuropatic pain , Vukojevic.pdf 06 Chronic non malignant pain, Hodzic pdf 07 Patient with chronic pain and anesthesia, Smajic.pdf 08 Pain treatment in Primary Health Care, Cvejanov Kezunovic,pdf 09 Medula spinalis stimulation in chronic pain treatment, Bucma.pdf 10 Breakthrough pain in advanced cancer disease, Husic. Pdf 11 Opiophobia - the dilemmas and thinking of our doctors, Zivkovic. Pdf 12 Interventional procedures in the treatment of pain, Golic. Pdf 13Acupuncture in the treatment of chronic pain.Zornic. pdf 14 Legal implications of pain, Santric. Pdf 15 Financial aspects of the HEPMP project, Petricevic. pdf
Other personal remarks	

Organisation details

Invitation sent to	Health centers of the Tuzla Canton
Date of event material release	November 10 th , 2019
Date of participants list's finalisation	November 28 th , 2019
Date of agenda finalisation	November 20 th , 2019
Number of participants (according to the participants list)	108
Comments	

Problems encountered during the event preparation phase

Please add your comments, if any:

Strengths and limitations of the event (please include comments received)

Strengths of the event and contributions or activities by participants	Participants of the seminar have learned the methods of pain assessment as well as different modes of treatment with an emphasis on multimodal approach to treatment. It is recognized that inadequate pain treatment can lead to a serious consequences that are difficult to deal with.
Suggestions for the improvement	
Any further comments	

Evaluation details

Results of evaluation of the general organisation of the event

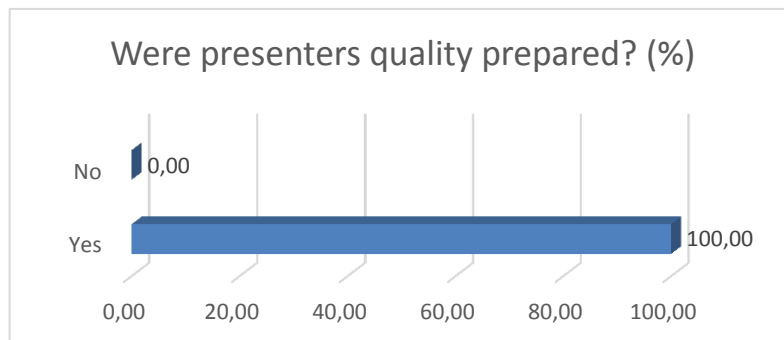
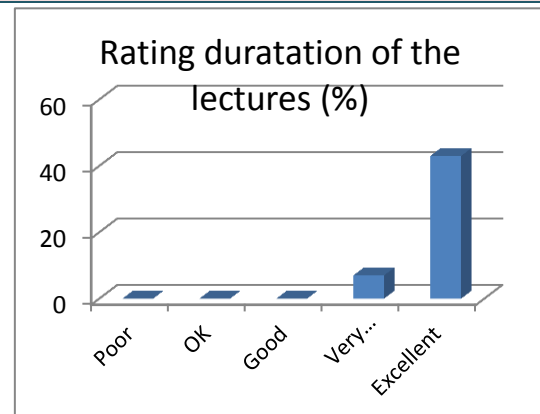
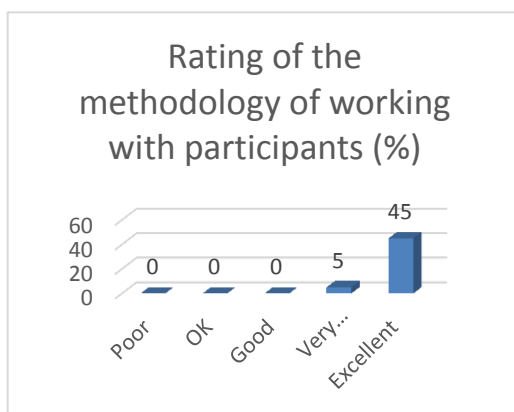
Description																								
The participants highly rated the choice of educational topics, the content of the education program, the method used, the duration and organization of the education.																								
Table(s)/Figure(s)																								
<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <p>Relevance of the topic (%)</p> <table border="1"> <caption>Relevance of the topic (%)</caption> <thead> <tr> <th>Rating</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Poor</td> <td>0</td> </tr> <tr> <td>OK</td> <td>0</td> </tr> <tr> <td>Good</td> <td>0</td> </tr> <tr> <td>Very Good</td> <td>1</td> </tr> <tr> <td>Excellent</td> <td>49</td> </tr> </tbody> </table> </div> <div style="text-align: center;"> <p>Rating organization (%)</p> <table border="1"> <caption>Rating organization (%)</caption> <thead> <tr> <th>Rating</th> <th>Count</th> </tr> </thead> <tbody> <tr> <td>Excellent</td> <td>47</td> </tr> <tr> <td>Very Good</td> <td>3</td> </tr> <tr> <td>Good</td> <td>0</td> </tr> <tr> <td>OK</td> <td>0</td> </tr> <tr> <td>Poor</td> <td>0</td> </tr> </tbody> </table> </div> </div>	Rating	Count	Poor	0	OK	0	Good	0	Very Good	1	Excellent	49	Rating	Count	Excellent	47	Very Good	3	Good	0	OK	0	Poor	0
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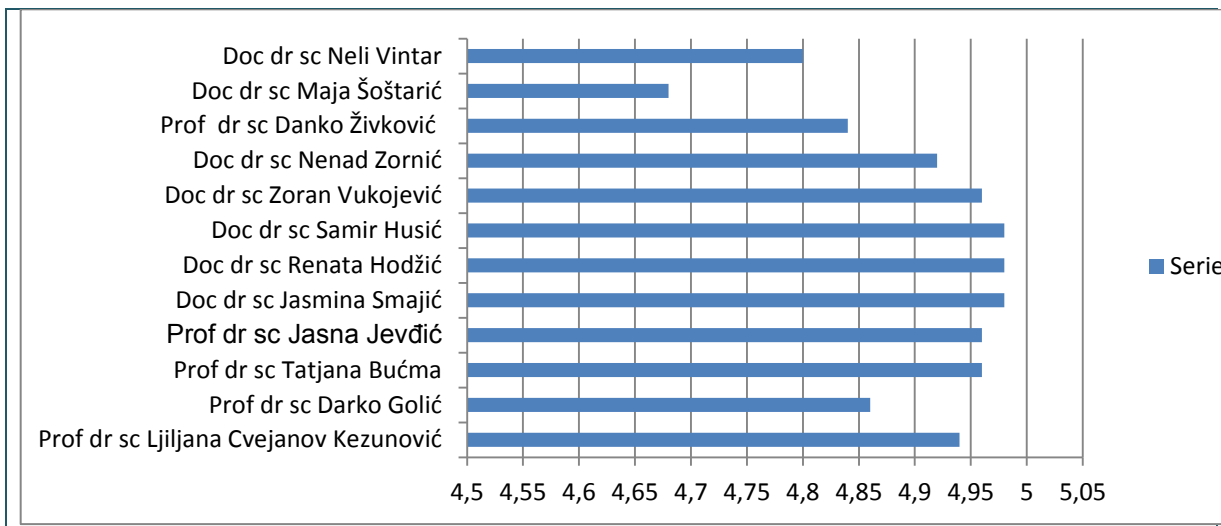
Results of evaluation of general working communication

Description

Participants in the evaluation questionnaire stated that the teaching was easy to understand. Each of the lecturers was individually evaluated by the participants, and each received an average rating of between 4.68 and 4.98. The participants evaluated that the lecturers were prepared for the lectures.

Table(s)/Figure(s)





Results of evaluation of overall success of the event

Description												
The participants rated the overall impression of the held seminar with an average score of 4.94 (out of 5).												
Table(s)/Figure(s)												
<p>The overall rating training (%)</p> <table border="1"> <thead> <tr> <th>Rating</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>Poor</td> <td>0%</td> </tr> <tr> <td>OK</td> <td>0%</td> </tr> <tr> <td>Good</td> <td>0%</td> </tr> <tr> <td>Very Good</td> <td>~10%</td> </tr> <tr> <td>Excellent</td> <td>~90%</td> </tr> </tbody> </table>	Rating	Percentage	Poor	0%	OK	0%	Good	0%	Very Good	~10%	Excellent	~90%
Rating	Percentage											
Poor	0%											
OK	0%											
Good	0%											
Very Good	~10%											
Excellent	~90%											

Please indicate your suggestions for further event's improvement:

Location, date

Tuzla, February 10th, 2020

Signature

