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	Acute and chronic pain-on line
Type of event	WP3 (Development of LLL courses and interventional pain medicine course Delivering of LLL courses of pain medicine in Primary Health Care Centers and Hospital of PCs
Venue	Hospital Prijedor
Date	13.12.2019.
Organizer	Faculty of Medicine, Univesity of Banjaluka
Reporting date	15.12.2019.
Report author(s)	Darko Golić

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EVENT DESCRIPTION
with special reference to goals and outcomes

Number of participants at the event	30
Participants (organisations)	General Hospital Prijedor, Primary Health Care Prijedor, Primary Health Care Kostajnica, Primary Health Care Dubica, Primary Health Care Novi Grad

Event description:

The main objective was to develop LLL course about acute and chronic pain management and deliver it to health care professionals in Primary and Higher levels of Health Care Centers in Prijedor, Kostajnica, Dubica i Novi Grad, Republic of Srpska. After the development of the training material, selection of trainees, and accreditation of the course by The Ministry of Health and Social Welfare, the course was held for the purpose to give basic education regarding acute and chronic pain management considering that undergraduate studies do not include modules of pain medicine.

Objectives of the course:

- A historical review of pain
- Understandning and importance of treatment of acute and chronic pain
- Teach participants how to treat acute and chronic pain
- Teach participants how to treat cancer pain
- Learn the mehnism of action of oral opioids and their administration
- Get acquainated with non- pharmacological methods of pain treatment
- Learn what are the invasive procedures for treating acute postoperative and chronic pain

Description of activities -

After drawing up a draft of educational material, eleven lectures were selected who, each in the area for which they were delegated, wrote the material and made a presentation. The overall educational material is systematized, prepared in a demanding format and sent for the printing of the handbook received by all participants. Educational event was accredited as a first category seminar with the high number of CME points. The accreditation notice is posed by mail, the pdf version of which is enclosed with this document. A flyer was prepared in which a Program of events was presented, as well as decision on acreditation.In adddition, the leaflet was sent in the form of a call to potential participants.

A major problem in the organization was the Corona-19 pandemic. Therefore, we limited the number of participants to 30 while respecting all epidemiological measures.

The Seminar started from 14,00 p.m. by the participants registration. The Project Coordinator of the University of Banjaluka , professor Golić , welcomed the audience and announced a session on acute and chronic pain and emphasized the importance of the course and understanding of the issues related to the treatment of acute and chronic pain. He highlighted the importance of the participation of the Faculty of Medicine in Banjaluka in this project, as well as the importance of the topic being dealt with. Prof. Golić , said that he welcomed all the people present and stressed the importance of the project and the implementation of health care education activities on the issue of pain, which is very significant but often insufficiently understood. Then there was an introductory lecture through which the participants were introduced to the HEPMP project, its goals and tasks. Thereafter he announced the first lecture , prof. Golic, to present the topic: **Pathophysiology of acute and chronic pain**. In the lecture, special attention is paid to the ways of transmitting pain sensations and the place of action of drugs and procedures in pain therapy. Prof. Golic emphasized that pain is an evolutionary mechanism and one of the oldest know stressors. Thereafter he referred to the conception of pain in the twentieth century and the way in which it is treated today. He then explained the need for pain control in all the diseases in which it is present as an integral part of multimodal treatment. He said that it was necessary to improve knowledge of pain through education and awareness of the importance of the problem.

The second lector was Prof. Golic. He gave a lecture **Pain assessment and pharmacotherapy**. In the lecture, different, simple scales of pain are presented and explained, and after that, certain therapeutic principles in the treatment of acute and chronic pain are explained. "Sedare, dolorem-divinum opust est", to calm down is a divine work, this old Latin saying has its full meaning even today. Indeed, nothing is more rewarding than relieving pain. Analgesics are traditionally divided into non-opioid, opioid and adjuvant analgesics, while new divisions are based on mechanisms of action. In the treatment of pain, drugs with different mechanisms of action are often combined, which achieves their greater efficiency and safety. Nonsteroidal anti-inflammatory drugs (NSAIDs) block the enzyme cyclooxygenase, inhibit prostaglandin synthesis, and prevent peripheral and central sensitization. There are no significant differences in efficacy between individual NSAIDs, but there are differences in the type and incidence of side effects. Opioids are very effective analgesics because they act through several different mechanisms: they inhibit the excitation of nerve endings in the periphery, inhibit the transmission of pain in the posterior horn of the spinal cord, activate descending inhibitory pathways of pain and alter the emotional response to pain. The cannabinoid CB1 receptor is localized praesynaptically and its activation inhibits neurotransmitter release and synaptic transmission. CB2 receptors are located mainly on the periphery, inhibit the migration of inflammatory cells, release cytokines / chemokines, have anti-inflammatory effects and modulate chronic pain. The use of cannabinoids in the treatment of pain should be reserved only for refractory cases of chronic pain with mandatory monitoring of side effects. Capsaicin activates TRPV1 channels and causes analgesia: by desensitization of the canal (the effect is short-lived) and by defunctionalization or ablation of the axon at

the site of application (the effect lasts longer).). Local anesthetics relieve pain (blockade of voltage-gated sodium channels), hyperalgesia (blockade of TRPV1 channels) and have an anti-inflammatory effect (directly or by inhibiting neurogenic inflammation). Glucocorticoids inhibit peripheral and central sensitization by modulating gene transcription (for cyclooxygenase-2, cytokines, inducible nitric oxide synthase) and reducing the synthesis of mediators of inflammation and the immune response. Antibodies to the tumor necrosis factor alpha receptor (TNF-α; etanercept), TNF-α (infliximab and adalimumab) and nerve growth factor (NGF; tanezumab) reduce the peripheral and central sensitization caused by TNF-α and NGF, respectively. N-methyl-D-aspartate receptor (ketamine) antagonists reduce central sensitization. Anticonvulsants may have an analgesic effect by blocking voltage-gated sodium channels (carbamazepine, phenytoin and lamotrigine), blocking calcium channels (gabapentinoids, carbamazepine, lamotrigine), blocking glutaminergic (gabapentinoids, potencyazecin, lamotrigine, carbamazepine, lamotrigine) , levetiracetam, topiramate). Adrenergic α2 receptor agonists have an analgesic effect in the brain, spinal cord and periphery. Activation of presynaptic α2 receptors inhibits transmitter release, and activation of postsynaptic α2 receptors inhibits postsynaptic spinal cord neurons. Antidepressants inhibit the uptake of serotonin and norepinephrine into presynaptic nerve endings and thus enhance endogenous descending inhibitory pathways of pain. Botulinum neurotoxin reduces the release of neurotransmitters and blocks the movement of TRPV1 channels to the cell membrane. It also reduces muscle spasm and frees nerve fibers from compression by the contracted muscle, which indirectly reduces pain. Alpha-lipoic acid exhibits an analgesic effect by blocking voltage-gated calcium channels (CaV 3.2) on primary afferent neurons and counteracts the increased activity of neurons in the spinal cord caused by blockade of potassium-chlorine cotransporters. After the first and second lecure discussed the principles of a comprehensive approach to pain management and psychological problems related to pain, the recommendation of modern guides, the management of a patient with primary care pain (PHC), the assessment of pain and the effects of treatment in PHC, pharmacological and non-pharmacolocical chronic pain management.

The following presentation was **Acute pain** by prof. Bucma. Acute pain is a complex process involving activation of nociceptors, chemical mediators and inflammation. Medications can be used to target each of the key elements within the pain pathway and eliminate or reduce the sensation of pain. Pain management begins, when possible, prior to the tissue trauma and continues throughout the perioperative period. When acute pain is appropriately managed, patient's clinical outcomes and satisfaction are improved. Beginning in 1999, TJC (The Joint Commission) initiated a new focus mandating improvement in the treatment and evaluation of pain for patients. As a result, physicians of all specialties and hospitals began to implement processes to improve pain management through a variety of modalities. Key junctures of the pain cycle were targeted with the ultimate goal to interrupt or minimize factors within the pain pathway. Many advocated preemptive anesthesia, with the goal of preventing the pain message before it enters the central nervous system.1 Despite numerous studies, there is no consensus regarding a single

treatment protocol for acute or chronic pain. This article provides a broad basic background for understanding options regarding acute pain management for physicians outside of anesthesiology.

Next lecture **Opioids- Opiophobia** by Prof. Golic. The lecture explains the mechanism of action of opioids, the strength and duration of action, as well as side effects and interactions with other drugs. It was especially pointed out that our doctors have unjustified opiophobia. The fear of opioids was demystified through the lecture. Opiophobia is defined as an excessive fear of the therapeutic use of opioid analgesics. In a narrower sense, it is the fear of using morphine in the treatment of cancer pain, in the first place the fear of developing iatrogenic dependence, tolerance and side effects of morphine (in the first place, respiratory depression). Patients avoid the use of opioid drugs for fear that they will turn them into addicts, that they will eventually get used to them, ie that they will stop working, but also for fear of side effects. Doctors are afraid that by prescribing opioid analgesics for the treatment of cancer pain, they will iatrogenically cause opioid dependence. Physical dependence and tolerance are the expected consequences of the drug's action and are not in themselves sufficient for the diagnosis of addiction. The presence of other phenomena, which constitute the addiction syndrome, is also required. If used properly and for therapeutic purposes, opioids are safe drugs. Clinicians and regulators must work together to ensure that patients are adequately treated with opioids without abuse and misuse.

Next lecture **Acute headaches,** Ass prof. Vukojevic. Headache (cephalea) belongs to the transmitted and parietal pain, and often accompanies other diseases of the body. It is estimated that two thirds of people have a headache at least once in their life. About 15-20% of people suffer from very severe headaches. After a toothache, it is the most common human pain so it is a serious social, economic and health problem. As with other types of pain, there is a direct irritation of the body sensitive to pain or the pain is caused by the release of allogeneic substances. The causes of triggering painful signals are mechanical (most often), thermal, electrical, and often chemical. Mechanical are stretching, pressure, twisting, narrowing and widening of arteries, arterioles and veins. They act on sensitive bodies inside and outside the skull. The skin, subcutaneous tissue, muscles and arteries, the epidermis, some parts of the eye, ear, sinuses and oral cavity are sensitive to pain. In the cranial cavity, the venous sinuses and associated veins, parts of the dura and the accompanying arteries at the base of the brain, some nerves (trigeminus, glossopharyngeus and the first three cervical nerves) are sensitive. The brain, spinal cord and some parts of the meninges are not sensitive to pain. In principle, headaches can be classified as functional and symptomatic etiopathogenetically. Etiopathogenetic mechanisms (infections, injuries, stroke, etc.) are clearly expressed in the background of symptomatic headaches. Headaches that occur in these conditions are the result of stimulation of algogenic bodies in the head by basic pathological processes.

Lecture **Lumbosacral pain** by Prof. Bucma Back pain (lumbago, lumbalgia) is a very common disease and practically more than 80% of people experience an episode of low back pain at least once during their lifetime. Data from the US show that 50%

of able-bodied people experience back pain at least once a year. The prevalence increases in early adulthood and reaches a maximum between 35 and 55 years of age, after which it gradually declines. The socio-economic impact of acute back pain is very important. For people under the age of 45, back pain is the leading reason for the incapacity of these people. About 1% of the U.S. population is chronically incapable of work due to back pain, and an additional 1% are temporarily incapacitated at any given time. Back pain is the second most common reason for visiting a family doctor and the third most common reason for surgical treatment. The annual cost of treating back pain in the United States is estimated at $ 38-50 trillion. Definition Lumbar pain syndrome means sudden and severe pain in the lumbar region of the spine, accompanied by reduced mobility. Pain can be acute or chronic. Acute back pain usually occurs after lifting a load or after direct trauma to the lumbar segment of the spinal cord, while chronic pain with occasional acute can occur after lifting a load, prolonged walking, work in a forced-bent position, awkward movement. Acute lumbar pain syndrome is characterized by sudden severe pain in the lumbar region of the back, localized or with irradiation to the hips, with difficult and painful movements in the lower back, and tense and palpable painful paravertebral muscles.

Lecture **Neuropathic pain** by Ass.Prof. Vukojevic. It is a painful feeling that occurs due to damage to the peripheral or central nervous system, without the simultaneous stimulation of the nocioceptors. According to the mechanism of occurrence, we distinguish three types of neuropathic pain. These are deafferentation pain, peripheral neuropathic pain, and pain that supports sympathetic activity. Deafferentation pain occurs by cutting the peripheral and central nocioceptor fibers so that the impulse input from the nocioceptor is absent. Intersection can lead to spontaneous eruption proximally from injury or from the spinal ganglion. The absence of afferent impulse input from the periphery may reverse segmental inhibition of spinothalamic pathway neurons and allow for their spontaneous eruption. Central injuries of the nocioceptive system (damage to the spinothalamic pathways in the spinal cord, medulla oblongata, midbrain, and damage to the thalamus) cause spontaneous outbursts of superior neurons with a sense of pain. Such pain occurs spontaneously with various sensory disturbances corresponding to the site of injury.Peripheral neuropathic pain is caused by damage to peripheral nerves that stimulate nocioceptive impulses. It is possible that there are nocioceptors nervi nervorum, which are stimulated by nerve injury. At the site of injury of the myelin sheaths of nerve fibers, a short circuit can be established between the fibers by which the action potentials pass from one fiber to another. Such a connection is called efapta, and conducting efaptika conducting or "cross-talk". By ephaptic conduction, impulses from other afferent fibers or motor efferent fibers can be applied to nocioceptive fibers. Then the stimulus from the mechanoreceptor or motoneuron feels like pain. Sympathetic activity can stimulate, stimulate, or intensify pain in several ways. We have already stated that increased sympathetic activity stimulates the sensation of pain by inducing, and by direct effect increases the sensitivity of nocioceptors. Increased sympathetic activity also increases the spontaneous eruption of damaged nocioceptor neurons. This effect may be due to the establishment of a short circuit and ephaptic conduction between

the demyeninated nocioceptive fiber and the efferent sympathetic fiber with damaged Schwann cells. It is possible for adrenergic receptors to move from the surrounding cells to the damaged part of the nocioceptive fiber, so that this fiber becomes directly sensitive to adrenergic effects.Pain induced by increased sympathetic activity is likely to cause reflex sympathetic dystrophy. It is a painful syndrome with a disorder of autonomic functions that most often develops on the distal parts of the limbs after injury, damage to peripheral nerves, but also after myocardial infarction and stroke. The syndrome is manifested by burning pain (causalgia), redness, heat and edema of the affected area (hands, feet). Later, the skin becomes pale and cold, and the subcutaneous tissue, muscles, and skeleton atrophy.

After this lecture it was a coffe break.

Next lecture **Pain in diabetic neuropathy** by Ass.Prof.Vukojevic. Diabetes, a silent killer, is a leading cause of neuropathy. Around 50% of diabetic patients develop peripheral neuropathy in 25 years. Painful diabetic neuropathy manifests as burning, excruciating, stabbing or intractable type of pain or presents with tingling or numbness. The pathophysiology of this condition is due to primarily metabolic and vascular factors. There is increase in sorbitol and fructose, glycated endproducts, reactive oxygen species and activation of protein kinase C in the diabetic state. All these factors lead to direct damage to the nerves. The first step in the management of painful diabetic neuropathy is a tight glycaemic control. Currently there is no drug which can halt or reverse the progression of the disease. Most of the therapies prevalent aim at providing symptomatic relief. Antidepressants like tricyclic antidepressants (TCAs) and selective norepinephrine reuptake inhibitors (SNRIs) have good efficacy in controlling the symptoms. Selective serotonin reuptake inhibitors have not shown the same consistent results. Anticonvulsants including pregabalin, gabapentin and lamotrigine have shown good results in the control of symptoms whereas same was not found with carbamazepine, oxcarbazepine and topiramate. Topical agents (capsaicin, topical nitrates and topical TCAs) and local anaesthetics have also been used with good results. Use of opioids and non steroidal anti-inflammatory drugs although common but is not preferable. The newer therapies under studies are NMDA antagonists, aldose reductase inhibitors, neurotropic factors, vascular endothelial growth factor, Gamma linolenic acid, protein kinase C beta inhibitors, immune therapy, hyperbaric oxygen and alpha lipoic acid.

The following presentation was devoted to **Complex regional pain syndrome** presented Prof Bucma. Participants are enrolled with definite and shared KRBS, methods of diagnosis and treatment. KRBS is a painful condition where pain is disproportionate to the initial event in time and degree, with distal predominance and the existence of sensory, motor, co-motional, vasomotor and / or trophic changes and the inability to explain pathology to some other condition. The cause is multifactorial: immune, autonomic disregulation, neuronal plasticity, psychological factors, genetics. Treatment is multimodal: pharmacotherapy, physical therapy, botulinum toxin A, intrathecal application of bactlofen, sympathetic nerve block, spinal cord stimulation, spinal dorsal ganglion

stimulation. Then there was a lecture on acute acne chronology. In the introductory part, the lecturer highlighted the advantages of good acute pain treatment: early release of patients from intensive care units with shorter total duration of treatment, less serious complications that significantly extend treatment time, fewer days of physical disability (work), significantly reduced treatment costs a healthier system, greater patient satisfaction, reduced frequency of chronic pain development, more efficient use of health care staff, more efficient and rational use of expensive hospital equipment. The lecturer stressed that the causes are bad acute pain treatment: clinicians are undereducated about the need to treat acute pain, and the consequences of untreated, in most hospitals, the intensity estimation pain is not performed, more than 50% of all hospitals in Europe do not have pain management protocols , in more than 50% of the hospital's pain is treated only at the patient's request, there is a tendency not to recognize the pain intensity, which states the patient, there is no general consensus on optimal choice of analgesic medicine and techniques for individual clinical conditions, there is no interdisciplinary co-operation of a clinician in treating pain and the responsibility for bad treatment. In the following lecture, the participants have been implicated with results of poor acute pain treatment, which arises because untreated acute pain is the most powerful stress response trigger that triggers a vitally cascading metabolic and inflammatory response cascade. One of the consequences of badly treated acute pain is the occurrence of chronic pain syndrome. The lecturer presented chronic postoperative pain syndrome as a consequence of specific neurobiological changes in the central nervous system (CNS) caused by prolonged inflammatory nociception and osteoarthritis (neuropathy), lasting longer than 3-6 months. He pointed out that HPPS is becoming a silent epidemic, an unrecognized and underestimated professional and public health problem that requires additional attention and training of specialists involved in the patient's surgical treatment.

Next lecture **Neuromodulation in pain therapy** by Prof.Bucma The field of neuromodulation is undergoing a renaissance of technology development with potential for profoundly improving the care of chronic pain patients. New and emerging targets like the dorsal root ganglion, as well as high-frequency and patterned stimulation methodologies such as burst stimulation, are paving the way for better clinical outcomes. As we look forward to the future, neural sensing, novel target-specific stimulation patterns, and approaches combining neuromodulation therapies are likely to significantly impact how neuromodulation is used. Moreover, select biomarkers may influence and guide the use of neuromodulation and help objectively demonstrate efficacy and outcomes.

Final lecture **Interventional procedures in pain therapy** by Prof.Golic

Interventional pain management procedures are most often used in concert with other analgesic regimes. Such invasive or interventional procedures are used for managing cancer pain that is poorly responsive to conventional pharmacotherapy or associated with intolerable side effects. These interventions may be used at any time during the course of the disease. In fact, in some situations, the use of such

interventional options may be less troublesome to the patient than the ongoing aggressive medication management.

Such invasive procedures should be employed only after a thorough history and physical examination have been done. Preexisting neurologic lesions should be documented. Pathophysiologic disturbances that may impair the tolerance of such invasive procedures should be addressed, if possible. Because many cancer pain patients may be undergoing chemotheraphy and radiation therapy at the same time, it is important to ensure that the patient is in an optimal immunologic state and that the coagulation profile is normal. Coagulopathy, site infection, and sepsis are contraindications to such invasive procedures. Interventional therapies should be used in the context of a multidisciplinary approach to care. After interventional procedures, the onset of "profound" analgesia may lead to overnarcotization, and such patients need to be carefully monitored after the procedure. The profound analgesia may also prompt the discontinuation of opioids, leading to withdrawal symptoms if a gradual tapering is not initiated.

The goal of such interventional therapy should further those of the patient, and the therapy should only follow a full discussion of the risks and benefits. For instance, neurolytic blocks may result in permanent sensory/motor deficits. Informed consent is necessary.

After each lesson the participants had questions, mini discussions were launched, and participants were encouraged to communicate during the break with the HEPMP lecturers in informal circumstances with the Strengthening Capacities for Higher Education of Pain Medicine in Western Balkan Countries. After the presented themes, discussion was opened and the lecturers responded to the participants on all questions related to acute pain and its treatment. Also, the participants were given the recommendation that HEPMP can download educational material in the form of presentations in pdf format. The seminar was completed by solving the knowledge transfer, completing the evaluation questionnaire and awarding the certificates to the trainees. Participants were also presented with acute pain handouts containing all the lectures presented at the seminar, which are in pdf version attached to this document. At the end of the seminar, the host thanked all participants for their interest and attendance at the lecture.

30 listeners were present, mostly selected doctors for adults from health centers, medicine specialists, internal medicine specialists.The entrance and exit tests were identical and contined 15 questions pertainig to the diagnosis and tretament of pain. Listened were ask to encrypt their questionares so taht an individual shift in the number of points could be monitored.The question were designed to reflect the content of the course.The entrance test was completed by 30 participants.The averaged 8,18 points (6-10 range). The exit test was complited by 28 participants.They averaged 11,9 points (ranging 9-12).Individual shifts in score could be observed in 24 participants (who wrote identical codes in both questionnnaires. The number of points increased by average of 3,9 (range 2-8).

By evaluating the course by the educators, it was estimated that the expected outcomes were achieved:

- health professionals (doctors, nurses ...) from HC gained skills in acute pain assessment
- Pharmacists have acquired the skill of rational application of algorithms for pharmacological treatment of acute pain.

An evaluation questionnaire was also analyzed, and the results are given in the annex of this document. The interest in the course was extremely high, as well as a large number of listeners – 30. 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.

The participants were very presentative topics and discussed with the lecturers the practical examples below. They rated 4.81 as the overall program rating (out of 5).

Attachments

Agenda (pdf)	Acute and chronic pain (pdf)
Attendance sheet (pdf)	Anex 4-HEPMP-attendance list Gradiska (pdf)

Photos (jpg)	3 (jpg)
Quality control (pdf)	Accredition by The Ministry of Health and Social Welfare; Event evaluation list- Anex 6 HEPMP Output test
Deliverable (pdf)	Website of the Faculty of Medicine of the University of Banja Luka http://www.med.unibl.org/index.php/sr/template/oglasne table/zdravstvena-njega/content/4-novosti
Presentations (pdf)	01. Patofiziologija akutnog i hroničnog bola.....Prof. dr D.Golić,pdf 02. Procjena i farmakoterapija bola....Prof. dr D.Golić,pdf 03.Akutni bol.....Prof. dr T.Bućma,pdf 04. Opijati-opiofobija.....Prof.D.Golić,pdf 05. Akutne glavobolje....Doc. Dr Z.Vukojević,pdf 06. Bol u lumbosakralnom segmentu----------Prof. Dr T.Bućma,pdf 07. Neuroptaska bol.....Doc dr Z.Vukojević pdf 08. Bol kod dijabetične polineuropatije...Doc dr Z.Vukojević,pdf 09. Kompleksni regionalni bolni sindromi Prof. Dr T.Bućma,pdf 10.Neuromodulacija.....Prof dr T.Bućma,pdf 11. Interventme procedure u terapiji bola .....Prof dr D.Golić,pdf
Other personal remarks	

There was a great interest in the lecture, which shows how rarely pain is present in postgraduate teaching. Most of the participants agreed that lectures of this type should be organized more often, especially in smaller cities.

Organisation details

Invitation sent to	General Hospital Prijedor, Primary Healt Care Center Prijedor Primary Health Care Center Kostajnica Primary Health Care Center Novi Grad Primary Health Care Center Dubica
Date of event material release	15.12..2019.
Date of participants list's finalisation	13.12.2019.
Date of agenda finalisation	15.12.2019.
Number of participants (according to the participants list)	65
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 learned that different pain states, as well as diseases associated with pain syndrome, are recognized, assessed for the intensity of pain, and determined by the intensity of the type of therapy. They were also introduced to the side effects of analgesic therapy. They are aware of the biggest mistakes that doctors make in their offices when treating pain.
Suggestions for the improvement	In the next seminar, we planned more time to discuss after the lecture and exchange of practical experiences
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)

Results of evaluation of general working communication

Description
Table(s)/Figure(s)

Results of evaluation of overall success of the event

Description
Table(s)/Figure(s)

Please indicate your suggestions for further event's improvement:

_____
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Location, date

Gradiška, 26.062020.

Signature