



ESRA European Diploma of Pain Medicine



Exam Regulations

January 2025



Curriculum & Regulations for ESRA European Diploma of Pain Medicine

CONTENTS

1. Introduction
2. Implementation
3. Examinations
4. Eligibility
5. Application procedure
6. Referrals and guidance
7. Representation and appeals
8. Infringements

Appendix 1: Structure of the examination

Appendix 2: Curriculum

Appendix 3: Training in Pain Medicine

Applications are available on the European Society of Regional Anesthesia & Pain Therapy website

<http://esraeurope.org/>



1. INTRODUCTION

This document provides information regarding training, curricula and exam regulations for the ESRA European Diploma of Pain Medicine of the European Society of Regional Anaesthesia & Pain Therapy.

These regulations govern the content and conduct of the examination leading to the award of the ESRA European Diploma of Pain Medicine. They specify the requirements which must be satisfied before a candidate is eligible to apply to take the examination. They also specify the procedure to be followed in order to apply, limit the number of attempts and provide guidance in the event of failure. They describe the procedure for making representations and provide sanctions for infringements.

Definition of Pain Medicine

The specialty of Pain Medicine is the study evaluation, treatment, and rehabilitation of persons in pain. Some conditions may have pain and associated symptoms arising from a discrete cause, such as postoperative pain or pain associated with a malignancy, or may be conditions in which pain constitutes the primary problem, such as neuropathic pains or headaches. The evaluation of painful syndromes includes interpretation of historical data; review of previous laboratory, imaging, and electrodiagnostic studies; assessment of behavioural, social, occupational, and a vocational issues; and interview and examination of the patient by the pain specialist. It may require specialized diagnostic procedures, including central and peripheral neural blockade or monitored drug infusions. The special needs of the paediatric and geriatric populations, and patients' cultural contexts, are considered when formulating a comprehensive treatment plan.

The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing interventional procedures, directing a multidisciplinary team, coordinating care with other health care providers and providing consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from pain. The pain physician may work in a variety of settings and is competent to treat the entire range of pain conditions in all age groups.

Purpose of assessment

The purpose of assessment of a European examination should be a complete assessment of the competence of medical specialists in respect of relevant knowledge and judgement. As part of this, several aspects of training need to be covered, i.e. knowledge, skills and attitude.

Different assessment formats are available to assess these different aspects of training, multiple-choice questions (MCQs), (structured) oral assessments (viva voce), situational judgement testing (SJT), and objective structured clinical examinations (OSCE) among others.

For the assessment of the knowledge aspect MCQs and structured oral assessments can be considered



valid options, while oral assessments (whether structured or not), SJT and OSCE will be more appropriate for the evaluation of skills and attitude. ESRA European Diploma of Pain Medicine board advises as a minimum a knowledge assessment, although evaluation of skills and attitude are strongly encouraged.

The purpose of the ESRA European Diploma of Pain Medicine is to *harmonize and improve quality standards* for safe, independent practice of interventional pain medicine in Europe and elsewhere.

The Diploma Program assesses the minimal competencies necessary to practice as a pain medicine specialist.

The Diploma Program is intended to be *complementary to national standards* and enhance the *competent, ethical, and professional* care of pain medicine.

The **VISION** of the ESRA European Diploma of Pain Medicine is to be recognized as the reliable standard of high quality care in pain medicine throughout Europe and beyond.

Diploma Program 1-Year Objectives

Organize first part 1 examination during ESRA annual congress in Lugano on 14 September 2017

- Engage candidates in Part 1 of the program.
- Provide a clearly defined pathway for Part 1 and Part 2 candidates.

2. IMPLEMENTATION

2.1 These regulations come into force on 1st January 2017, and are valid until a necessary change is agreed by the ESRA European Diploma of Pain Medicine Board.

3. EXAMINATION

3.1. The examinations of the ESRA European Diploma of Pain Medicine will be completed in one sitting per part.

3.2. Normally there will be one sitting of the examination in each academic year. However, the Faculty may at any time decide, subject to adequate notice, to adjust the number of sittings of the examination in any year.

3.3. Examination fees:

The examination fee for part I is €350 (€350/sitting) and part II is €1000 (€1000/sitting) and must be paid in advance upon confirmation of application. Please note that cheques are not accepted.



3.4. Transfers /Deferrals

In exceptional circumstances a transfer request may be granted, if there is a serious medical condition that prevents the candidate sitting the examination and the request reaches the Exams Office no later than 2 weeks prior to the first date of the exam. Transfer requests received after that date will not be entertained.

Transfer requests due to visa difficulties and/or postal delays will not be entertained.

Transfer requests must be addressed to the ESRA European Diploma of Pain Medicine Office, and must enclose supporting documentation and the administrative fee. A request will be rejected in the absence of the administrative fee or supporting documentation, otherwise the request will be tabled for the next meeting of the Examinations Committee.

If the transfer request is granted, the administrative fee will be processed and the candidate will immediately be withdrawn from the current exam, transferred to the next exam, and notified by telephone and/or email within 3 working days. The candidate will then incur a further charge if there is an exam fee increase in the next exam. If the transfer request is not granted, the administrative fee will be returned and the candidate will be given the option of remaining on the current exam in order to attempt it, or withdrawing from the current exam. The Exams Office will seek the candidate's decision immediately.

3.5. Withdrawals

A withdrawal request submitted to the Examination Office before the closing date of applications is entitled to a refund of the exam fee, minus an administrative charge, which is automatically deducted from the refund.

A withdrawal request submitted after the closing date of applications is not entitled to any refund.

3.6. Administrative Charges

The standard administrative charge that applies to all withdrawals and to successful transfers is €150.

3.7. Waiting Lists

Candidates who remain on a waiting list and do not receive an exam place are not automatically transferred to the next sitting. Their applications are returned and they must apply afresh.

Withdrawal from a waiting list does not invoke a refund process. The payment is simply returned with the application form.



4. ELIGIBILITY

4.1. An individual is eligible to enter for the ESRA European Diploma of Pain Medicine who:

- (a) Has, or is eligible for, full registration as active member of the European Society of Regional Anesthesia & Pain Therapy, with valid, active membership
- (b) The applicant has been in an official anaesthesiology training program before applying for the examination
- (c) Has passed a Fellowship or equivalent in a hospital recognized for this training, completed a minimum of 6 months training in Pain Medicine.
- (d) Effective on the date of application, must have been engaged in the clinical practice in pain medicine for at least 6 months after completing a formal residency-training program, or has completed training and possesses a recognized certification on pain medicine like DPMCAI, FIPP, FFPMRCA, FFPMANZCA, or equivalent exams.
- (e) The applicant must have good command of English (as demonstrated at the examination)

4.2. Applicants who are already practicing as specialists or consultants at their institution need to produce a letter from the chair of the department or employer specifying that they are engaged in sessions of chronic pain management.

5. Application Procedures

5.1. Dates of examinations shall be published in the examinations calendar of the European Society of Regional Anesthesia & Pain Therapy and information may be obtained from the website <http://esraeurope.org/edpm/>

5.2. Application forms for admission to the examinations may be obtained from the examinations Office. Applications must reach the examinations Office not before the conclusion of the previous examination and not after the published closing date for the relevant sitting.

5.3. Applications must be accompanied by the appropriate fee and any stipulated certificates as required.



6. Referrals and guidance

6.1. A candidate who is unsuccessful in an examination may, subject to the provisions of the regulations below, enter for the next or any subsequent sitting of that examination.

For the purpose of this regulation, guidance may consist of:

- (i)** Written communication with the candidate in which details of his/her performance may be divulged and discussed.
- (ii)** Attendance at an interview arranged by the Chairman of the Examination Committee (Faculty).

7. Representation and appeals

7.1. A candidate, or any person on behalf of that candidate, wishing to make representations in respect of the conduct of an examination or to appeal against any result, must address such representation or appeal to the Chairman of the board of the **ESRA European Diploma of Pain Medicine**, in writing, within 30 days of the results being published. The Examination Committee will consider representations and appeals.

7.2. Should the reply received by the Chairman not be satisfying for the candidate, the candidate could request to lodge an appeal panel, the panel would be composed of the Chairman, 1 Vice-Chairman and 1 examiner. The fee to convene the appeal panel is €150. This fee could only be refunded to the candidate in the advent that the appeal is upheld.

8. Infringements

8.1. This is an electronic exam taken on your laptop or tablet. Candidates are not permitted to bring any materials or information which may assist them including mobile telephones or smartwatches into the examinations. Failure to comply with these examination regulations may result in disqualification from the whole of that examination sitting.

8.2. The Faculty may refuse to admit to an examination or proceed with the examination of any candidate who infringes any of the regulations, or who is considered by the presiding examiner to be guilty of behaviour which prejudices the proper conduct and management for the examination or who has previously been found guilty of such behaviour. If, in the opinion of the Faculty, any examination result has been secured by cheating, deception or fraud of any kind whatsoever, the Faculty may nullify the result of any qualification resulting from it and withdraw the Diploma and or Fellowship so obtained.



APPENDIX 1

ESRA European Diploma of Pain Medicine: Structure of the Examination

Assessment venue

For the organisation of examinations, a suitable venue is essential. Special attention needs to be paid to the security issues of the venue, not only in respect of standard precautions such as fire, but also in terms of security of the examination materials.

Should the number of candidates exceed the capacity of a single venue, the ESRA European Diploma of Pain Medicine Board may utilise multiple venues (preferably simultaneously, in the interest of uniformity of candidate experience), including the use of individual computer-based assessment terminals.

For practical reasons, the examination will be organized alongside the Annual European Society of Regional Anesthesia & Pain Therapy congress.

Assessment structure and duration

When assessment formats other than MCQs are used, UEMS-CESMA advises a duration of at least 1 hour in total. For oral assessment of candidates, UEMS-CESMA strongly advises supplying the examiners with a pre-defined set of questions (preferably structured), allowing room for further questions if felt necessary, in order to achieve an objective assessment of the candidates. The duration of each part of an examination should be sufficient to ensure validity of the assessment across all candidates.

There are 2 sections:

1.- Part 1 Examination will be compulsory for all candidates.

Multiple choice questions (MCQ) -comprising questions related to study, evaluation, treatment, and rehabilitation of persons in chronic pain. All the Syllabus subsets were part of the questions: Multidimensional Nature of Pain; Pain Assessment and Measurement; Management of Pain; Clinical Conditions.

1. Will be a 60 MCQ paper with a stem and 5 possible answers. Candidates will be asked to distinguish True and False statements.
2. There will be no negative marking for candidates who choose the wrong answer.
3. Candidates will be allowed 90 minutes to attempt the MCQ paper.

The multiple-choice question (MCQ) assessment format has several advantages. Besides being a fairly robust and highly objective method to assess the level of knowledge of candidates, this format has the advantage of easy statistical analysis. The questions will be set to reflect a broad pain curriculum and will be weighted to represent the importance of an area of the curriculum as viewed by the examination faculty.

The following statistical parameters are traditionally calculated when performing the primary statistical validity analysis of questions:



- level of difficulty of the questions;
- degree of discriminative power of the questions;
- general reliability (internal consistency) of the assessment.

The reliability of the statistical analysis procedure will increase with the number of questions and with the number of candidates. Therefore, the primary statistical validity analysis may present more difficulties when small-scale (or even medium-sized) assessments are concerned.

Primary statistical validity analysis is not necessarily restricted to the MCQ assessment format only, but can also be applied to alternative examination formats.

MARKING SYSTEM

The pass mark will be decided annually by the ESRA European Diploma of Pain Medicine board. Besides the pass-fail status, candidates will receive a detailed report including their score per topic compared to the average percentage score of all candidates taking the examination.

2.- Part 2 will consist of two components, a viva examination set around different clinical scenarios and Assessment of Clinical Expertise in Pain (ACEP) Practical Examination

(a) Viva

Conducted over a 30-minute period each with two examiners.

Viva : Clinical case

For assessment of candidates, the examiners will have a pre-defined set of questions around a specific chronic pain clinical scenario allowing room for further questions if felt necessary, in order to achieve an objective assessment of the candidates. The clinical scenario will allow for exploration of other aspects of practice such as use of equipment and investigations, procedures, quality of practice and audit. The duration of each part of an examination should be sufficient to ensure validity of the assessment across all candidates, but being the maximum duration of 30 minutes.

There will be further 4 questions based on the following categories:

- a) Pathophysiology of a pain condition
- b) Pharmacology related to pain management
- c) Pain procedures
- d) Pain syndromes / Specific pain conditions

The European Diploma of Pain Medicine (ESRA-DPM) will introduce a new Practical Examination, **the Assessment of Clinical Expertise in Pain (ACEP)**, alongside **the written (MCQs)** and **oral (Viva)** examinations from September 2026. This addition follows comprehensive consultation with international pain medicine education experts and feedback from Diplomates



Purpose

The ACEP examination objectively assesses candidates' clinical and procedural expertise in pain medicine, ensuring certified individuals demonstrate both theoretical knowledge and performance of safe, procedural skills. Its introduction establishes international certification standards and aligns with the ESRA-DRA examination structure and ESRA principles.

Examination Structure

The ACEP practical examination consists of three distinct skill stations, each lasting up to 10 minutes:

1. Clinical Assessment Skills:

Candidates perform a focused physical examination/ clinical assessment relevant to pain management on a simulated patient or model.

2. Ultrasound-Guided Interventional Skills:

Candidates demonstrate recognition of key anatomical structures and targets, as well as correct probe handling and procedural technique for performing ultrasound-guided interventions on a live model.

3. Fluoroscopy-Guided Interventional Skills:

Candidates are assessed on their understanding of radiation safety, ability to interpret fluoroscopic images, and precision in performing procedures on a cadaver or high-fidelity phantom.

Each station is objectively scored by two independent ESRA-DPM examiners using standardised marking rubrics. Examiners undergo regular training and calibration to ensure consistent and fair assessment across all examination sessions.

Implementation

The ACEP Practical Examination will be introduced in the upcoming examination cycle, commencing at the 43rd ESRA Annual Congress in Lisbon, Portugal (9–12 September 2026), and will thereafter be held at additional international centres according to the published schedule.

Key Information

- Candidates must pass the written examination (MCQs) to be eligible for the oral (Viva) and practical (ACEP) components.



- Those who have completed the written examination (MCQs) before 10 April 2026 may choose between the previous format (two Viva sets) or the new format (one Viva and ACEP).
- To be awarded ESRA-DPM candidates must pass both VIVA and ACEP components
- Comprehensive details on registration, venues, schedules, and examination guidelines—including the list of required procedures—will be available on the ESRA-DPM website.

MARKING SYSTEM

A close marking system is used.

2+ exceptionally good

2 pass

1+ fail by a narrow margin

1 bad fail

The minimum grades necessary to pass the examination are: 2, 2.

A discussion of the candidates performance during a post exam meeting is included in the marking.

Besides the pass-fail status of candidates, ESRA European Diploma of Pain Medicine will provide more detailed feedback or counselling for failed candidates, in order to provide these candidates more insights into the details of their assessment.

Archiving

ESRA European Diploma of Pain Medicine board through its office will document clearly all aspects of the (practical) organisation of assessments, and keep archives of these documents (electronically wherever practical) for a period of **at least** five years.

A permanent electronic and properly secured database of the successful candidates should be maintained by the *Steering Committee*. The minimum information to be included within this database comprises: full name, country, date and place of the assessment.

APPENDIX 2

Curriculum for ESRA European Diploma of Pain Medicine

The curriculum is based on the science and practice of pain medicine and should be integrated into the clinical environment. It should include the following topics:

I. Multidimensional Nature of Pain

A. Epidemiology

1. Pain as a public health problem with social, ethical, legal and economic consequences
2. Epidemiology with overview of statistics related to acute, recurrent and/or persistent (chronic) and cancer pain
3. Barriers to effective pain assessment and management: individual, family, health professional, society, political institutions

B. Development of pain theories

1. Historical development of pain theories and basis for current understanding of pain
2. Definition of pain and pain terms
3. Classification systems of pain
4. Differences between nociception, pain, suffering and harm
5. Pain and behaviour

C. Mechanisms

1. Anatomy and physiology to include neural mechanisms [peripheral pain mechanisms, dorsal horn processing, ascending and descending modulation and central mechanisms]
2. Multiple dimensions of pain to include physiological, sensory, affective, cognitive, behavioural, social/cultural/political
3. Pathological consequences of unrelieved pain, and implications of being a multidimensional experience (biological, psychological and social)
4. Factors influencing neurophysiology (e.g. genetics, age, sex, ethnicity)

D. Ethics

1. Ethical standards of care (provision of measures to minimize pain and suffering) for health care professionals
2. Ethical standards and guidelines related to use of analgesics (e.g. inadequate analgesic prescribing; over-medication; confusion regarding physical dependence, tolerance and addiction, abuse screening, use of placebos)
3. Inadequate pain management for specific groups including infants, children, elders, those with communication difficulties and/or learning disabilities
4. Legal issues related to disability, compensation
5. Political and societal issues related to access to pain management and attitudes to marginalized populations
6. Experimental pain issues related to appropriate and meaningful measures and methods

II. Pain Assessment and Measurement

A. Interprofessional and Multiprofessional Collaboration

1. Assessment of patient priorities as a team where possible (interprofessional) and/or communication of planning between individual health care professionals (multiprofessional) to ensure:
 - Comprehensive assessment especially when pain problems are complex e.g. pain sensory characteristics, treatment history, impact of pain on functional status, perception of self/relationships, and past pain experiences



- Clear documentation of pain assessment and measurement data
- Ongoing communication for comprehensive and consistent approaches
- Monitoring of efficacy and effectiveness of management plan
- Consideration of appropriate assessment and measurement approaches for people with
 - special needs (e.g. infants, children, older adults, developmentally challenged, cognitively impaired)
- Development of interprofessional consultant networks (informal/formal) when needed for adequate assessment with complex patients

B. Assessment

1. History

- Pain location, onset and duration, severity, quality, alleviating and aggravating factors
- Impact on mood, usual activities/function/quality of life/sleep
- Previous pain and treatment history
- Ongoing response to treatment, adverse effects
- Comorbidities impacting pain (e.g. chronic disease, surgery, trauma, mood, cognitions, abuse history, medications)
- Personal characteristics (e.g. age, sex, race, religion, culture, language)
- Expectations of pain management and current understanding of the condition

2. Physical examination

- Neurological and musculoskeletal assessment
- Posture and range-of-motion evaluation
- Focused according to the presenting condition

3. Review of clinical records

4. Investigations

- Laboratory tests
- Imaging studies, e.g.:
- X-rays (flexion/extension views if needed)
- Ultra Sound (U/S)
- MRI, CT, Bone scan

C. Measurement

1. Approaches

- Qualitative
- Quantitative

2. Testing issues

- Feasibility
- Validity
- Reliability
- Sensitivity
- Clinical utility

3. Tools (uni- and multi-dimensional)

- Numerical Rating Scales (NRS)
- Visual Analogue Scales (VAS)
- Verbal/categorical scales
- Faces scales
- Pain drawings
- Comprehensive pain questionnaires
- Functional measures (e.g. pain-related disability, specific activities, health status)
- Measures of psychological status (e.g. depression, anxiety, beliefs)
- Measures for special populations (e.g. non-verbal, infants, cognitively impaired)



III. Management of Pain

A. Goals of Pain Management

1. Reduction of pain intensity
2. Enhancement of physical functioning
3. Improvement of psychological functioning
4. Reduction of healthcare utilization
5. Promotion of return to work/school and/or role within the family/society
6. Improvement of health-related quality of life

B. Pain Management Planning Decisions

1. Develop, monitor and modify the management plan as an interprofessional and/or multi-professional team
2. Involve patient and family caregivers in establishing clear, realistic goals
3. Use combinations of methods where appropriate including physical, psychological, pharmacological and interventional
4. Provide patient information/education including: communication methods, management options, management of potential adverse effects
5. Develop transparent treatment plan with realistic goals

C. Treatment Considerations

1. Type(s) of pain
2. Multidimensional nature of pain (e.g. biological, psychological, social)
 - Use of combinations of pharmacological and non-pharmacological methods
3. Patient issues
 - Access to clinics, treatment centre, advantages of early intervention
 - Patient involvement/understanding of management plan/motivation to change
 - Cultural/societal limitations
4. Caregiver issues
 - Understanding of pain (false beliefs)
 - Fears and anxieties (e.g. drug addiction, side effects)
 - Understanding of patient goals/needs
5. Health professional issues
 - Understanding of pain (false beliefs)
 - Fears and anxieties (e.g. drug addiction, adverse effects)
 - Understanding of current evidence supporting management strategies
6. Political issues
 - Pain management as a human right
 - Access to clinics, treatment centres
 - Access to pain relieving medications
 - Access to interventional treatment
7. Substance abuse issues
 - Define aberrant drug-related behaviour and substance dependency (abuse)
 - Assessment/screening of risk of abuse

D. Pharmacological Methods

1. Include for each analgesic selected the following:

- Mechanisms of action
- Indications for use
- Pharmacokinetics including mechanisms of toxicity where appropriate
- Adverse effects and their management
- Equianalgesic dosing
- Interactions with other drugs

- Formulations (short and long acting)
- Administration routes
- Age-specific therapies (including, neonate, infant and elderly)
- Disease, surgery, cancer and/or trauma pain-specific strategies

2. Clarify tolerance, physical dependence and psychological dependence

3. Utilize combinations of analgesics and adjuvants where appropriate:

- Over the counter medications (acetaminophen/paracetamol)
- Non-steroidal anti-inflammatory drugs (NSAIDS)
- Opioids
- Antidepressants
- Anticonvulsants
- Local anaesthetics
- Topical agents
- Other

4. Knowledge of legislative requirements and current guidelines regarding controlled drugs

E. Non-pharmacological Methods

1. Utilize combinations of physical and psychological strategies, where appropriate:

- Clinician therapeutic use of self (e.g. active-listening, being empathic)
- Physical strategies to support home and occupational function and activity (e.g. heat, cold, positioning, exercise, massage, wound support, exercise, mobilization, manipulation, reach devices, other comprehensive rehabilitation approaches)
- Psychological and behavioural strategies (e.g. cognitive-behavioural strategies, coping strategies, biofeedback, patient-family education and counselling)
- Neuromodulation (e.g. transcutaneous electrical nerve stimulation [TENS], acupuncture, brain and spinal cord stimulation)
- Neuroablative strategies (e.g. neurolytic nerve blocks, neurosurgical techniques)
- Procedural/Interventional (e.g. injections)
- Surgery
- Complementary alternative medicine (CAM)
- Palliative radiotherapy (e.g. cancer pain)
- Information and communication technologies (e.g. virtual reality, computer-assisted interventions, smartphones)

F. Evaluation of Outcomes

1. Monitor management outcomes related to pain severity and function levels, adverse effect management, and impact on mood, family and quality of life issues
2. Utilize an interprofessional and multiprofessional team approach to insure integration and coordination of care
3. Consider barriers related to treatment availability and costs at the patient-family, institution, society and government levels

IV. Clinical Conditions

The following list includes suggestions under each to help with decisions about the selection of patient cases for interprofessional small group learning. The choice of clinical condition and detail will depend on the students and specific patient populations to be studied.

A. Taxonomy of Pain Systems

1. Distinction between acute, recurrent, incident, and or persistent (chronic) pain (may have combination of more than one type)
2. Distinction between nociceptive (somatic, visceral) and non-nociceptive (neuropathic) pain (may have both nociceptive and neuropathic pain)
3. Distinction between commonly used pain terms in clinical practice (e.g. allodynia, analgesia,



dysesthesia, hyperalgesia, paraesthesia, pain threshold, pain tolerance)

4. Involvement of biological, psychological and social factors influencing the perception of pain

B. Pain in Special Populations

1. Pain in infants, children and adolescents
2. Pain in older adults
3. Pain in individuals with limited ability to communicate
4. Pain in pregnancy, labour, breast feeding
5. Pain with psychiatric disorders
6. Pain in individuals with substance abuse

C. Acute Time-Limited Pain

1. Surgery
2. Trauma
3. Infection
4. Inflammation
5. Burn

D. Cancer Pain

1. Primary pain
2. Local invasion
3. Metastatic spread
4. Treatment-related
5. End-of-life

E. Visceral Pain

1. Referred patterns
2. Cardiac and non-cardiac chest pain
3. Abdominal, peritoneal, retroperitoneal pain
4. Pelvic pain (male and female)
5. Sickle cell crisis

F. Headache and Facial Pain

1. Headache
2. Orofacial pain
3. Trigeminal neuralgia

G. Neuropathic Pain

1. Primary Lesion Central
 - Multiple sclerosis
 - Post-stroke
 - Spinal cord injury
 - Traumatic brain injury
 - Syringomyelia
2. Primary Lesion Peripheral
 - Degenerative disc disease with radiculopathy in neck and low back
 - Peripheral neuropathies (diabetes, cancer, alcohol, hiv)
 - Post herpetic neuralgia
 - Acute disc herniation with radiculopathy
 - Complex regional pain syndrome ii (crps ii) (causalgia)
 - Phantom limb
3. Mixed or unclear origin
 - Complex regional pain syndrome I (CRPS I) (reflex sympathetic dystrophy)
 - Irritable bowel syndrome
 - Fibromyalgia
 - Other



H. Musculoskeletal

1. Rheumatoid arthritis, osteoarthritis
2. Neck pain, whiplash and referred pain
3. Low back pain and referred pain
4. Injuries from athletics
5. Myofascial pain syndrome





Appendix 3

Training in Pain Medicine for Diploma Eligibility

1. A candidate must have completed a minimum of 6 months training in accredited Pain Medicine training posts in order to be eligible to take the examination. The minimum continuous period that will qualify for this purpose is 2 months. Any alternative training arrangements need to be agreed with the Faculty in advance.
2. A major part of the 6 months must be devoted to acquiring the knowledge and skills to manage patients with chronic and cancer pain.
3. The need for continuity of training is stressed. A training programme must be organized in such a way that a broad knowledge base can be acquired.
4. Training programmes should include input from all disciplines involved in Pain Management.
5. Each hospital providing training in pain medicine must nominate a consultant to supervise training. This consultant must have Pain Medicine sessions and be a Fellow of the Faculty in good standing.

Trainees should have an understanding of the principles and where possible the practice of the majority of the following treatment modalities:

1. A full range of peripheral nerve and sympathetic plexus blocks
2. Epidural and subarachnoid injections and infusions
3. Injection into and around joints
4. Neurolytic techniques as applied to peripheral nerves in the epidural and subarachnoid spaces
5. Radiofrequency lesioning
6. Spinal cord stimulation
7. Relaxation techniques
8. Psychological approaches to pain assessment and management