is some confusion as to what are the differences and similarities, if any, between PTSD and MI.

Background
While there is currently no internationally agreed upon definition or official diagnostic criteria for MI, the Australian Defence Force (ADF) has proactively defined MI based upon current international research as: '…a trauma-related syndrome, caused by the physical, psychological, social and/or spiritual impact of grievous moral transgressions, or violations, of an individual's deeply held moral beliefs and/or ethical standards' (ADF, 2021). Core symptoms commonly identifiable are: (a) shame, (b) guilt, (c) a loss of trust in self, others, and/or transcendental/ ultimate beings, and (d) spiritual/ existential conflict including an ontological loss of meaning in life. Secondary symptomatic features often include (a) depression, (b) anxiety, (c) anger, (d) re-experiencing the moral conflict, (e) social problems, (f) relationship issues, and ultimately (g) self-harm – and potentially suicide. While some researchers regard the ADF definition of MI as being the "most comprehensive and inclusive definition of MI to date" (e.g., Buhagar, 2021, p. 3102), nevertheless determining the boundary between MI and PTSD is proving a challenging task for both researchers, clinicians, and other allied health carers (Carey & Hodgson, 2018).

Purpose
This paper, in accordance with the conference theme ('Planning for the Unexpected') will present and discuss the current similarities and differences between MI and PTSD, so as to proactively assist medical, nursing, and allied health professionals in their further understanding of the relationship between the two mental health spheres. Using a bio-psycho-social-spiritual paradigm, this paper will also suggest some future and possibly unexpected criteria to be considered with respect to MI being incorporated into the DSM-VI.

Method
Current literature and research with regard to the uniqueness of MI and PTSD, as well as the overlapping similarities between both, will be presented. In addition to the empirical evidence being noted regarding MI, various diagrams will be utilized to visually present both the distinct and overlapping factors between MI and PTSD, as well as proposed MI diagnostic criteria based on the work of Koenig et al (2023).

Conclusion
Consideration of the current theoretical and empirical research literature, regarding the intersection between MI and PTSD, is an important aspect that needs ongoing attention in order to effectively ensure the appropriate intervention of holistic care for the well-being of veterans.

References are available on request.

[This submission was cleared by: (1) Governance Support Officer, Directorate of Health Research, Health Protection and Policy, Joint Health Command; 03MAR23, and (2) Director, DSHW, Joint Health Command; 09MAR23].

Biography:

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Nasal Disinfection as a Front-Line Defence in Future Pandemics

Prof Peter Friedland[1]

1 *University of Western Australia/Sir Charles Gairdner Hospital*

The nasal cavity is the primary site of infection for SARS-CoV-2 and other highly pathogenic respiratory viruses. Nasal disinfection is an appropriate and logical extension of hand disinfection and PPE in the defence against pandemic viruses.

In particular, the presentation focuses on the potential of intranasal povidone-iodine (PVP-I) for

nasal disinfection. This topical microbicidal agent has been used for more than six decades in clinical practice for skin disinfection and antisepsis of wounds and burns. PVP-I is a uniquely appropriate nasal disinfectant. It is the only broad-spectrum microbicide that inactivates all viruses, but it is safe to use on mucous membranes at the right concentration and in the correct formulation. In addition, it has the significant added benefit of not inducing viral resistance.

Early into the pandemic, there was keen research interest in the potential of intranasal PVP-I to arrest viral shedding and intervene in COVID-19 disease progression and transmission. Since 2020, multiple published clinical trials have reported on the use of intranasal PVP-I in COVID-19.

There is no approved PVP-I nasal spray, so all the trials, apart from one, were conducted with research-stage formulations. The presentation identifies the technical barriers to developing a commercial PVP-I nasal spray.

There is one GMP-developed and regulatory-compliant PVP-I nasal spray (Nasodine Nasal Spray), and the history of this product's development over several years prior to the pandemic is presented, including the results of six clinical trials, including two trials targeting COVID-19.

One published pilot study assessed its pandemic potential, which showed a reduction in nasal shedding of SARS-CoV-2 after a single dose. The results of a randomised, controlled, multidose Phase II shedding study showed that when used eight times daily over three days, the product cleared the virus from the nasal passages in 100% of subjects by the fourth day.

COVID-19 will not be our last viral pandemic. While vaccination may be the preferred medium-term strategy for managing any pandemic, in the early stages, nasal disinfection with PVP-I can play a critical role in protecting healthcare workers and potentially reducing transmission in the general population.

Biography:

Peter Friedland is an Ear Nose and Throat surgeon at Sir Charles Gairdner Hospital and Joondalup Health Campus and the Garnett Passe Rodney Williams Professorial Chair in Otolaryngology-Head and Neck Surgery (OHNS) at UWA. He leads Australian and international human trials on the treatment and prevention of the common cold and COVID-19 viruses.

Friedland is the WA chairperson of the OHNS Regional Surgical Trainee Committee of the Royal Australasian College of Surgeons. He holds memberships of the Australian Government Professional Services Review, the Panel of Clinical Experts of the Australian Department of Health and Ageing, Medical Benefits Scheme National ENT Taskforce, Australian Society of OHNS Board, an Editorial Board of the Australian Journal of Otolaryngology and founding Board Member of the Laryngology Society Australia. He has presented over 150 papers at national and international conferences and is Squadron Leader, No 1 Expeditionary Health Squadron, RAAF Amberley.

Prior to emigrating from South Africa in 2009, Friedland was clinical Head of Department of OHNS at Donald Gordon Medical Centre, Faculty of Health Sciences, University of Witwatersrand, South Africa. The highlight of his career was the privilege of attending Nelson Mandela for 9 years and learning invaluable lessons and insights at his bedside.

Non-Specific Low Back Pain a 'Novel Approach': Looking at New Evidence to Manage an Old Problem

Dr Catherine Kelaher[1]

1 Joint Health Command

Low back pain is common, around one in six Australians report back problems and 80% experience back pain during their lives.[1] The prevalence of low back is increasing globally and this is a problem because it is often associated with considerable disability. Globally, low back pain is a leading cause of Years Lived with Disability (YLDs).[2] In 2017 it resulted in 64.9 million (95% UI: 46.5 million–87.4 million) YLDs, a 52.7% increase from 42.5 million (95% UI: 30.2 million–57.2 million) in 1990.[3] In Australia, it is the second most common reason for people to go to their GPs, and it is the most common reason for middle aged Australians to retire early and is the number one cause of lost productivity, early retirement and income poverty.[4-6]

Over the last six years, the ADF has averaged around 7000 unique presentations of back pain per year. Noting some caveats around denomination data, the estimated point prevalence equates to approximately 11.3% compared to 7.5% in the global population. (3) Of those presenting with back pain, 24% become non deployable, for those who return to a deployable category rehabilitation takes an average of 162 days. Over the last six years the number of ADF members being discharged with a diagnosis of back pain has increased year on year and back pain is the 5th most frequent DVA claim by defence members.