Early Treatment Is Key for Neuropathic Pain

BY SUSAN LONDON
Contributing Writer

VANCOUVER, B.C. — The best approach to managing neuropathic pain is to treat it early, when it is most likely to respond, according to Dr. Rob Hewko, a psychiatrist at Vancouver (B.C.) General Hospital.

"Neuropathic pain is common and extremely incapacitating," said Dr. Hewko at the annual Canadian Hospitalist Conference. About 5%-10% of people will develop the condition in their lifetime.

And although this type of pain is classically associated with postherpetic neuralgia and diabetic neuropathy, it can arise from a diverse group of other illnesses and events, such as gallbladder and cardiac surgery, lupus, and chemotherapy.

Neuropathic pain has a complex pathogenesis that involves several mechanisms, he said at the conference, which was sponsored by the University of British Columbia. These include sensitization of peripheral nerves, activation of the dorsal horn nuclei in the spinal cord, and changes in descending inhibition from the brain.

Diagnosis can be challenging, for a variety of reasons: the diverse symptomatology, the numerous etiologies, patients' difficulty in articulating their symptoms, and the variable response to treatment.

A number of tools are available to help with diagnosis and assessment. "I would suggest that you choose one of these and use it exclusively, unless you have unlimited time," Dr. Hewko advised. In cases in which the diagnosis is uncertain, he recommended the DN4 pain questionnaire (Pain 2005;114:29-36), which can be completed in about 10 minutes.

The best management of chronic neuropathic pain is effective management of acute neuropathic pain, Dr. Hewko said.

Most patients with acute neuropathic pain "will get better over time, so that's your backup position—do nothing and hope they get better," he said. "But there's a downside to that, which is the longer you wait, the less likely they are to respond to treatment."

'The longer you wait, the less likely [patients with neuropathic pain] are to respond to treatment.'

DR. HEWKO

Medication strategies can exploit the nature of neuropathic pain, by using agents with differing actions to target the different mechanisms and to potentiate each other. First-line agents include two of the tricyclic antidepressants (nortriptyline and desipramine), gabapentin, and pregabalin.

Opioids should not be used as first-line agents because patients rapidly develop tolerance to them in this setting, according to Dr. Hewko. And amitriptyline should not be used at all because of its many adverse effects.

National pain societies generally recommend a single-agent approach to the initial pharmacotherapy for neuropathic pain. However, he noted, "the likelihood of an excellent response to a single agent is really low in my experience."

He therefore recommended combining two first-line agents—a tricyclic antidepressant plus either gabapentin or pregabalin—as initial therapy. The drugs should be started at low dosages and titrated every 24-48 hours.

This approach has the advantage of producing rapid relief. Fully 90%-95% of patients with acute neuropathic pain have a response within several days.

Third-line agents, such as opioids, cannabinoids, and topiramate, should be selected with consideration of the mechanism they target so that they complement other agents being used.

Among the opioids, which are more effective against peripheral than against central neuropathic pain, "methadone is the best option because it is the only narcotic that has an [*N*-methyl-D-aspartate] antagonistic effect," he observed.

Measures such as cognitive-behavioral therapy and spinal cord stimulation can be useful when pain persists despite medical therapy.

Dr. Hewko is a member of a medical advisory board for Pfizer Canada. ■