



# Home Study Activity With Podcasts

Clinical Decision Points:  
Profiles in Patient Care for Nurse Practitioners and Physician Assistants  
Based on a Series of National CME/CE Symposia

## Q&A: Neuropathic Pain

### What Your Colleagues Around the Country Want to Know...

#### **Q: Are opioid therapies appropriate for treating neuropathic pain?**

**A:** Anticonvulsant agents (gabapentin and pregabalin) and antidepressants (tricyclic and dual reuptake inhibitors of both serotonin and norepinephrine) have been recommended as first-line treatment for neuropathic pain by an international coalition of experts under the auspices of the International Association for the Study of Pain (IASP).<sup>1</sup> Opioids can be added as a coanalgesic for patients in need of additional analgesia, as opioids may have the capacity to induce a synergistic beneficial effect. These agents also can be used as first-line agents in select clinical scenarios.<sup>1-4</sup> When initiating any of these therapies, best practice is to “start low and go slow” (referring to dose and titration).

**Q: I do not see many patients with complex regional pain syndrome (CRPS) in my practice; however, I do regularly treat patients, typically older adults, with postherpetic neuralgia (PHN). Are these neuropathic pain conditions managed similarly? If not, please explain a strategy for treating PHN.**

**A:** The origins, underlying mechanisms, symptoms, and signs of neuropathic pain are heterogeneous.<sup>5</sup> While CRPS is commonly the result of a crush injury and is more frequent in young and middle-aged adults, PHN is a sequela of a herpes zoster infection and is more common within the aging population. Both conditions manifest with extremely severe pain, however, the diagnosis of PHN usually is more straightforward, than the diagnosis of CRPS. Although PHN can present as pain without a herpetic rash, in most cases the pain is followed by a rash and presents as a stinging sensation in the affected dermatomal area just before the rash appears. The associated changes in sensation have been characterized specifically as burning pain and allodynia, more commonly with the absence of deep pain and paresthesia/dysesthesia.<sup>6</sup> Typically, the rash has a thoracic localization and presents in a bandlike distribution across one dermatome, on one side of the body.<sup>7</sup>



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There is significant overlap among the recommended therapies for CRPS, PHN, and other types of neuropathic pain. Guidelines and systematic reviews on treating neuropathic pain associated with PHN have recognized tricyclic antidepressants (TCAs), gabapentin, pregabalin, opioids, and lidocaine patch 5% as appropriate therapies due to their efficacy established by randomized controlled trials.<sup>5,8,9</sup> However, as many of the patients who present with PHN are older adults, the burden of potential side effects, such as orthostatic hypotension (TCAs), arrhythmias (TCAs), and constipation (opioids); and the risk of drug-drug interactions have to be considered carefully when selecting a medication. Topical agents such as lidocaine patch 5% have a low risk of these systemic adverse effects or interactions.<sup>5,10</sup>

## References

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