



Non-Opioid Pharmacologic Management of Pain


Melissa Tornero-Bold, MD, FASA
Associate Professor, Clinical
Department of Anesthesiology and Pain Medicine

MedNet21
Center for Continuing Medical Education

THE OHIO STATE UNIVERSITY
HERSCHEY MEDICAL CENTER

Financial Disclosures

- None



Navigating Pain Management with Multiple Competing Goals

https://commons.wikimedia.org/wiki/File:Maid_of_the_Mist_VII_approaching_the_Horseshoe_Falls,_West_view_20170418_1.jpg
DXR, CC BY-SA 4.0, via Wikimedia Commons

Objectives

- Practical non-opioid treatment pa
- Focused pain assessment
- Current best practices
- Clinical case scenarios



<https://commons.wikimedia.org/wiki/File:LEDFlashlight.jpg>
Torindkft at English Wikipedia App, Public domain, via Wikimedia Commons

Non-opioid Medications



- Topical analgesics
- Local anesthetics
- Acetaminophen
- NSAIDs
- Muscle relaxants
- Antidepressants
- Antiepileptic Drugs (AEDs)
- Corticosteroids
- NMDA antagonists

https://commons.wikimedia.org/wiki/File:Antilirium_Placebo.jpg
 NIH, objects donated by Elaine and Arthur Shapiro, Public domain, via Wikimedia Commons

Journavx (Suzetrigine): Novel Non-opioid FDA Approves January 30, 2025

- NaV1.8 Selective Na channel blocker
- Moderate to severe acute pain
- 2 RCTs acute surgical pain



- AEs: itching, muscle spasms, increased blood level of creatine phosphokinase, rash

<https://www.fda.gov/news-events/press-announcements/fda-approves-novel-non-opioid-treatment-moderate-severe-acute-pain>
 DigiGal DZiner, CC BY-SA 4.0, via Wikimedia Commons

CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 (Updated)¹



- Non-opioid recommendations
- Determining whether or not to initiate opioids, then how to implement for **outpatients**

https://upload.wikimedia.org/wikipedia/commons/7/71/CDC_logo_2024.svg

Does **NOT** apply to¹



- Children <18 years
- Sickle cell disease
- Cancer
- Palliative
- End-of-life care
- Hospitalized, emergency, or observational setting that might transition to inpatient care
- Prescribing for opioid use disorder

Comprehensive Evaluation to Improve Function

- Multimodal treatment:
 - Nonpharmacologic
 - Medication
 - Surgery
 - Early rehabilitation
- Barriers:
 - Resource allocation
 - Insurance noncoverage
 - Other (rural, transportation)



<https://commons.wikimedia.org/wiki/File:QuestionMarkWoman1922.jpg>
Library of Congress, Public domain, via Wikimedia Commons

Pain Medication Targeted Assessment

- Where is the pain?
- Localized versus generalized?
- Character, quality, timing, duration?
- Medical comorbidities?
- Preexisting medications?
- Surgery / Procedure?
- Risks versus benefits?
- Physician / Patient preference?



https://commons.wikimedia.org/wiki/File:Clipboard_check.svg
Mahua Sarkar, CC0, via Wikimedia Commons

International Association for the Study of Pain (IASP) Definitions Revised 2020²

- **Nociceptive pain** is from actual or threatened damage to non-neural tissue (skin, musculoskeletal, certain soft tissues) and is due to the activation of nociceptors
 1. *somatic pain* - skin, musculoskeletal, connective tissue
 2. *visceral pain* - internal organ
- **Neuropathic pain** is direct consequence of a lesion or disease of the somatosensory nervous system
- **Nociplastic pain** is augmented central nervous system pain and sensory processing and altered pain modulation



Agency for Healthcare
Research and Quality



- CDC funded AHRQ in 2018-2019 to conduct systematic reviews for updated 2022 CDC Opioid Prescribing Guidelines:
- Evaluate effectiveness for medications for specific types of pain, considering function, QOL, AEs
- **Nonopioid treatments for acute and chronic pain^{3,4}**

https://commons.wikimedia.org/wiki/File:Agency_for_Healthcare_Research_and_Quality_Logo.png

AHRQ Comparative Effectiveness Reviews¹

- Data sources: Electronic databases (Ovid® MEDLINE®, Embase®, PsycINFO®, CINAHL®, Cochrane Central Register of Controlled Trials, and **Cochrane Database of Systematic Reviews**) through September 10, 2019
- Review methods: **Randomized controlled trials (RCTs)** of non-opioids in patients with pain
- Non-opioids for chronic pain: 185 RCTs and 5 systematic reviews

Agency for Healthcare
Research and QualityGrading of Recommendations Assessment,
Development, and Evaluation (GRADE) framework¹

- **Magnitude** of effects:
Small, Moderate, or Large
- Assessed **strength** of evidence
- Meta-analyses were conducted
- Reviewed
 - Study quality
 - Specific drug
 - Dose
 - Pain type

Agency for Healthcare
Research and Quality

The Data: Non-opioids for Chronic Pain:

7 Pain Conditions

- Neuropathic pain
- Fibromyalgia
- Osteoarthritis
- Inflammatory arthritis
- Low back pain
- Chronic headache
- Sickle cell disease

3 Time Durations


- Short term (1 to <6 months)
- Intermediate term (≥6 to <12 months)
- Long term (≥12 months)

Intermediate and long-term outcomes mostly not assessed**Pain Duration¹**

- Acute pain (<1 month)
- **Nonopioid therapies are effective for many types of acute pain**
- ***Nonopioid therapies preferred for subacute and chronic pain***
- Subacute pain (1-3 months)
- Chronic pain (>3 months)
- *Many patients do not experience benefit in pain or function from increasing opioid dosages to ≥50 MME/day but are exposed to more risk as dose increases*

AHRQ Agency for Healthcare Research and Quality **CDC** U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Recommendations for Nonopioids¹



https://commons.wikimedia.org/wiki/File:ANKLE_SPRAIN_02b.JPG
Harrygouvas, CC BY-SA 3.0, via Wikimedia Commons

AHRQ Agency for Healthcare Research and Quality **CDC** U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

NSAIDs for musculoskeletal pain (*not low back pain*)^{1,4}



Topical NSAIDs diclofenac +/- menthol gel first-line
then Oral NSAIDs +/- Acetaminophen


ACP American College of Physicians®
Leading Internal Medicine, Improving Lives

AAFP American Academy of Family Physicians

<https://commons.wikimedia.org/wiki/File:ArthriticKnee.jpg>
Centers for Disease Control and Prevention (NIH), Public domain, via Wikimedia Commons
https://commons.wikimedia.org/wiki/File:American_College_of_Physicians_Logo_-_SVG.svg#/media/File:American_College_of_Physicians_Logo_-_SVG.svg

NSAIDs more effective than opioids for surgical dental pain^{1,4}

AHRQ Agency for Healthcare Research and Quality **CDC** U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION



NSAIDs first-line

ADA

https://commons.wikimedia.org/wiki/File:American_Dental_Association.png
https://commons.wikimedia.org/wiki/File:Teeth_by_David_Shankbone.jpg
I, DavidShankbone, CC BY-SA 3.0, via Wikimedia Commons

NSAIDs or muscle relaxers for low back pain^{1,4}

AHRQ Agency for Healthcare Research and Quality **CDC** U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION


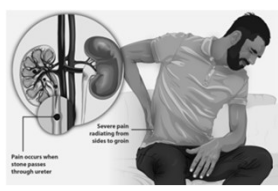


NSAIDs similarly effective to opioids for LBP

ACP American College of Physicians®
Leading Internal Medicine, Improving Lives

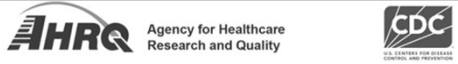
https://commons.wikimedia.org/wiki/File:Lower_back_pain.svg
Injurymap, CC BY 4.0, via Wikimedia Commons

NSAIDs for nephrolithiasis pain^{1,4}

NSAIDs first-line then acetaminophen more effective than opioids

https://commons.wikimedia.org/wiki/File:A_man_with_Kidney_Stones.png
<https://www.myupchar.com/en>, CC BY-SA 4.0, via Wikimedia Commons




Opioids for acute:

- low back pain
- postoperative pain

associated with increased likelihood of opioids long-term^{1,4}

- NSAIDs & acetaminophen have decreased risk of short-term adverse events compared to opioids




Worse Outcomes with Long-term Opioids¹

- Osteoarthritis
- Nonspecific low back pain
- Headache
- Fibromyalgia

▪ *Limited evidence improved pain or function*

Patient perceptions



“Doctor, I need a prescription”

“OTC is not as effective”

https://commons.wikimedia.org/wiki/File:An_online_prescription_being_made_on_a_mobile_phone.jpg
 Click2pharmacy.co.uk Images, CC BY 2.0, via Wikimedia Commons

Common Non-opioid Medication Classes

Acetaminophen^{1,5}



- Antipyretic, analgesic
- Well tolerated, less side effects
- MOA: Activates CNS descending serotonergic inhibitory pathways
- Inferior to NSAIDs improving knee and hip pain for OA
 - *No longer first-line for OA pain*

<https://www.uptodate.com/contents/acetaminophen-paracetamol-drug-information>

Topical Analgesics Acute and Chronic Pain⁶



Good Evidence at least 50% relief	Low Quality Evidence
<ul style="list-style-type: none"> • NSAIDs • Capsaicin • Lidocaine 	<ul style="list-style-type: none"> • Rubefaciants (Salicylates) • Clonidine

<https://upload.wikimedia.org/wikipedia/commons/9/9d/Cochrane-logo.jpg>

Topical NSAIDs⁷



- Acute muscle or joint injuries: sprains, strains
- Osteoarthritis = single or few joints near the surface of the skin
- Little systemic uptake, plasma concentrations are only a fraction (usually much less than 5%) compared to oral
- Topical NSAID levels high enough to inhibit COX-2

Topical NSAIDs⁷



- Primary outcome >50% pain relief compared to placebo
- Topical diclofenac is equivalent to oral NSAIDs in knee and hand osteoarthritis (joints close to skin surface)
- Formulation can influence efficacy
- Topical NSAIDs reduce GI adverse events compared with oral NSAIDs

Topical Capsaicin¹



- RCT studies using high-concentration ($\geq 5\%$) topical
 - Postherpetic neuralgia
 - Painful HIV-neuropathy
 - Peripheral diabetic neuropathy
- Moderate quality evidence that high-concentration (8%) capsaicin patches gives > moderate pain relief to a minority of people with postherpetic neuralgia
- Low quality evidence that it benefits those with HIV-neuropathy and peripheral diabetic neuropathy



[https://commons.wikimedia.org/wiki/File:Hot_\(365-232\)_-_Flickr_-_Robert_Couse-Baker.jpg](https://commons.wikimedia.org/wiki/File:Hot_(365-232)_-_Flickr_-_Robert_Couse-Baker.jpg)
Robert Couse-Baker from Sacramento, California, CC BY 2.0, via Wikimedia Commons

Topical Lidocaine¹



- Neuropathic pain: PHN or traumatic nerve injury
- Minimal systemic side effects
- MOA: sodium channel & N-methyl-d-aspartate (NMDA) receptor blockage
- Formulations: cream, gel, patch, spray, solution
- Oral, intranasal, transdermal



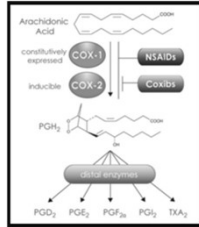
https://commons.wikimedia.org/wiki/File:Drugs_and_Treatments_-_Patch_-_Smart-Servier.png
Laboratoires Servier, CC BY-SA 3.0, via Wikimedia Commons

NSAIDs

- Analgesic, antipyretic, and anti-inflammatory effects
- Inhibition of cyclooxygenase (COX), which impairs
 - arachidonic acid \xrightarrow{X} prostaglandins, prostacyclin, thromboxanes
- COX-1 is expressed in most tissues: "housekeeping" enzyme, regulating normal cellular processes
- COX-2 expression is increased in inflammation
- Significant cardiovascular, renal, GI consequences

<https://www.uptodate.com/contents/overview-of-cox-2-selective-nsaids>

Oral NSAIDs lowest effective dose, shortest duration



https://upload.wikimedia.org/wikipedia/commons/2/2a/Tipus_de_prostaglandines.jpg

Major coronary events

- Heart failure
- Myocardial infarction

Stroke

GI bleeding / perforation

Renal failure

COX selectivity of common NSAIDs

- Nonselective COX-1 inhibitors: ibuprofen, naproxen
- “More” selective for COX-2 inhibitors: meloxicam, diclofenac, etodolac
- Selective COX-2 inhibitor: celecoxib

<https://www.uptodate.com/contents/overview-of-cox-2-selective-nsaids>

CAUTION Systemic NSAIDs⁸



- Older adults
- Previous GI bleeding / risk for peptic ulcer disease
 - (COX-2 inhibitor or + proton pump inhibitor)
- Renal insufficiency / failure
- Cardiovascular comorbidities

NSAIDs for Acute LBP⁹



- NSAIDs are effective for low-back pain without sciatica
 - *moderate evidence*
- NSAIDs are similarly effective to opioids
- Various types of NSAIDs = COX-1 versus COX-2 NSAIDs, are **equally effective** for acute low-back pain
- COX-2 NSAIDs had statistically significantly less side-effects

NSAIDs for Chronic LBP¹⁰



- Short-term use only
- NSAIDs are more effective than placebo

NSAIDs for Sciatica



- For acute sciatica, no difference between NSAIDs and placebo



- Rasmussen-Barr E, Held U, Grooten WJA, Roelofs PDDM, Koes BW, van Tulder MW, Wertli MM. Non-steroidal anti-inflammatory drugs for sciatica. *Cochrane Database of Systematic Reviews* 2016, Issue 10. Art. No.: CD012382. DOI: 10.1002/14651858.CD012382. Accessed 05 February 2025
- Hansuelli Krapf, CC BY-SA 3.0 <<https://creativecommons.org/licenses/by-sa/3.0/>>, via Wikimedia Commons

Corticosteroids for Sciatica

- **Systematic review of three studies found some benefit but only**
 - **short term (>2 weeks but <3 months)**
- No significant leg pain difference in intermediate term > 3 months
- Patients receiving steroids had more adverse effects, including epigastric symptoms, mood changes, and hyperglycemia

Pinto RZ, Maher CG, Ferreira ML, Ferreira PH, Hancock M, Oliveira VC, McLachlan AJ, Koes B. Drugs for relief of pain in patients with sciatica: systematic review and meta-analysis. *BMJ*. 2012 Feb 13;344:e497. doi: 10.1136/bmj.e497. PMID: 22331277; PMCID: PMC3278391

Muscle Relaxants Clinical Practice Guideline¹¹



- Patient population: acute, subacute, or chronic low back pain
- Most patients with acute, subacute low back pain improve over time *regardless of treatment*: **recommend NONPHARMACOLOGIC first line**
- Recommendation SECOND line: select **NSAIDs** or **skeletal muscle relaxants** (*moderate evidence; strong recommendation*)

Muscle Relaxer Clinical Outcomes		
↑ pain relief	↓ work disability	↑ patient satisfaction
↑ function and QOL	↓ # of back pain episodes	AEs: drowsiness

https://commons.wikimedia.org/wiki/File:American_College_of_Physicians_Logo_-_SVG.svg#/media/File:American_College_of_Physicians_Logo_-_SVG.svg

Antidepressants for Chronic Pain: SNRIs/TCAs¹²

- Tricyclic antidepressants (TCAs) and serotonin norepinephrine reuptake inhibitors (SNRIs) have **analgesic effects independent of antidepressant effects**
- MOA: inhibits reuptake of serotonin and norepinephrine at descending inhibitory pain pathways in spinal cord
- TCAs: sodium channel modulation in periphery & NMDA antagonism → enhances dorsal root inhibition and reduces peripheral sensitization

SNRIs for Chronic Pain¹²



- **Duloxetine standard dose (60 mg) showed a small to moderate effect for substantial pain relief, moderate certainty evidence**
- For pain intensity, **milnacipran standard dose (100 mg)** also showed a small effect, *moderate certainty evidence*
- Duloxetine showed a small effect on mood (*moderate certainty evidence*)
- Common side effects mild: fatigue, somnolence, nausea, and dizziness, mild GI distress

Duloxetine for Chronic Pain¹³



- **Diabetic peripheral neuropathy: 60 mg-120 mg daily** effective
 - *moderate quality*
- **Fibromyalgia: 60 mg** daily improves pain, mental & mood symptoms
 - *low-moderate quality*
 - Minor side effects are common with duloxetine 60 mg and particularly with 120 mg daily, than 20 mg daily, but serious side effects are rare

Venlafaxine for Neuropathic Pain¹⁴



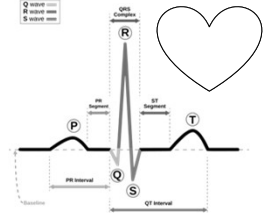
- some third-tier evidence of benefit, little compelling evidence to support use
- In the largest RCT by Rowbotham, 2004, 56% of participants receiving venlafaxine 150 to 225 mg achieved at least a 50% reduction in pain intensity versus 34% of participants in the placebo group

Tricyclic Antidepressants¹⁵

- Tertiary amines more sedation = antihistaminic and anticholinergic side effects, more potent inhibiting reuptake **5-HT** compared to NE
- *amitriptyline, doxepin, imipramine*
- Secondary amines more potent inhibiting reuptake **NE** > 5-HT
nortriptyline, and desipramine
- Caution against use >65yrs: delirium, orthostatic hypotension, falls
- Decreased seizure threshold, sexual dysfunction, diaphoresis, and tremor
- Dangerous in overdose by suicidal patients (age <25yrs)

TCA Cardiac CAUTION¹⁵

- Increased risk of cardiac side effects, contraindicated in heart failure, cardiac conduction blocks, FHx sudden death
- contraindicated QTc > 500ms
- Increased risk of sudden cardiac death at higher doses (>100mg)
- Patients > age 50 years baseline electrocardiogram (ECG)



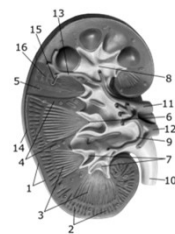
<https://www.uptodate.com/contents/tricyclic-and-tetracyclic-drugs-pharmacology-administration-and-side-effects>
<https://commons.wikimedia.org/wiki/File:SinusRhythmLabels.svg>
 Created by Agateller (Anthony Atkietski), Public domain, via Wikimedia Commons

Amitriptyline for Neuropathic Pain¹⁶



- One or more condition & > moderate pain:
 - painful diabetic neuropathy
 - postherpetic neuralgia
 - trigeminal neuralgia
 - phantom limb pain
 - postoperative/traumatic neuropathic pain
 - complex regional pain syndrome
 - cancer-related neuropathy
 - Guillain Barré
 - HIV neuropathy
 - spinal cord injury
- Only third-tier evidence
- Historically first-line successful treatment for neuropathic pain for decades
- Continue to be useful

Antiepileptic Drugs¹



- First-line therapies for neuropathic pain
 - *Gabapentin and pregabalin*
- Alpha-2-delta subunit of voltage-sensitive calcium channels → reduces release of excitatory neurotransmitters glutamate, substance P, and calcitonin gene-related peptide
- Caution: lower dose for renal disease

https://commons.wikimedia.org/wiki/File:Didactic_model_of_a_mamma_Kidney_with_numbered_parts.png
 Origin: Museum of Veterinary Anatomy FMVZ USP Photographer: Wagner Souza e Silva Modified: D6194c-1cc, CC BY-SA, via Wikimedia Commons

Gabapentin¹⁷



- Gabapentin at doses of 1200 mg to 3600 mg daily may provide good levels of pain relief for **postherpetic neuralgia** and **peripheral diabetic neuropathy**
- Around 3 or 4 out of 10 participants had at least 50% pain intensity reduction; improved QOL & function
- Over half of those treated with gabapentin will not have worthwhile pain relief
- AEs: dizziness (19%), somnolence (14%), peripheral edema (7%), and gait disturbance (14%), blurry vision, weight gain, cognitive effects

Pregabalin¹⁸



- Efficacy for **postherpetic neuralgia & painful diabetic neuropathy**
 - (moderate quality)
- Absence of efficacy in HIV neuropathy
 - (moderate quality)
- Some people will derive substantial benefit (at least >50% pain reduction)
- More will have moderate benefit at least (>30% pain reduction)
- But many will have no benefit or will discontinue treatment
- Higher doses = greater AEs

- Cohort study: rotation to pregabalin in patients who were gabapentin responders ($\geq 30\%$ relief on a visual analog scale) or gabapentin nonresponders after prolonged GBP use; compared with patients receiving continuous GBP therapy
- Both gabapentin responder and non-responder groups had >25% neuropathic pain relief following rotation to pregabalin after 6 and 12 months
- Improved QOL was identified in the gabapentin non-responder group
- Conclusion: pregabalin may provide additional pain relief and QOL compared to gabapentin

Other Antiepileptics



- topiramate: side effect weight loss
- oxcarbazepine, lacosamide
- carbamazepine, lamotrigine (US Boxed warning: life-threatening skin reactions)
- increased risks / side effects

https://commons.wikimedia.org/wiki/File:Lose_weight_now.jpg
Alan Cleaver, CC BY 2.0, via Wikimedia Commons

\$\$\$ DAILY Antiepileptic Drugs: Less Sedating! \$\$\$				
GENERIC	BRAND NAME	MANUFACTURER COUPON? (Private insurance only)	CHEAPER ONLINE PHARMACY? (TEXT COUPON)	GENERIC FORMULATION AVAILABLE?
Extended-release	Extended-release			
<u>extended release gabapentin</u>	GRALISE®	YES	N	YES
<u>topiramate ER</u>	QUDEXY® XR	NO	YES	YES
	TROKENDI XR®	YES		
<u>pregabalin CR</u>	LYRICA® CR	NO	NO	NO

Strategies for Drowsiness



- Extremely slow titrations may help, ER formulations
- AEDs, Muscle Relaxers: only take at night
 - Daytime alert & still have pain, but sleep better
 - Nighttime only dosing as long as brain fog/hangover feeling in AM
 - Take evening dose earlier (7pm) to avoid morning hangover feeling
- Instead of BID dosing:
 - try TID dosing = divide morning dose into half = take AM + afternoon; followed by PM dosing
- Schedule reminders to space medication

Jacek Halicki, CC BY-SA 4.0 <<https://creativecommons.org/licenses/by-sa/4.0/>> via Wikimedia Commons

N-methyl-D-aspartate (NMDA) Antagonists Reverse Central Sensitization

- Nonopioid drugs include:
 - ketamine
 - dextromethorphan
 - memantine
- Others: *methadone*, TCAs, *phencyclidine (PCP)*



https://commons.wikimedia.org/wiki/File:G%C3%BCcklicher_Patient.png
sOER Frank, CC BY 2.0, via Wikimedia Commons

NMDA Antagonists: Ketamine²⁰

- Continuous ketamine IV infusion reduces/reverses CNS hyperexcitability = “windup” amplification of noxious & non-noxious stimuli
- Improves pain, function, QOL
- Greatest reduction in pain scores: **high-dose ketamine therapy** or **complex regional pain syndrome patients**
- AEs: sedation, dysphoria, and dissociative episodes

Ketamine Infusions for Chronic Pain²⁰:

- **Helps all types of pain, all medical conditions**
- Three RCTs reported significant analgesic benefit favoring ketamine
 - **(at least >30% or at least >50% pain relief)**
 - Even small effect up to 2 weeks after the infusion (mean difference in pain scores, -1.83 points on 0-10 scale)
 - Proportion with a positive outcome was greater in the ketamine than in the placebo group (51.3% vs 19.4%)

Low-dose Naltrexone for Neuropathic Pain^{21,22,23}

- MOA: anti-inflammatory effect cells in brain/spinal cord (glial cells modulation)
- Chronic pain conditions: CRPS, IBD, Fibromyalgia, low back pain, RA, PDN
- 2021 RCT: Low-dose naltrexone (to 4mg) exhibited similar efficacy and a superior safety profile compared with amitriptyline (25/50mg) in **painful diabetic neuropathy**
- 2013 RCT: low-dose naltrexone (4.5mg) improved **fibromyalgia** pain, QOL, mood, sleep, fatigue
- Side effects MINIMAL: sleep disturbance/unusual dreams, headache, decreased appetite, nausea and fatigue

Common Pain Syndromes



https://commons.wikimedia.org/wiki/File:Exam_room_in_a_doctor%27s_office.jpg
Harrison Keely, CC BY 4.0, via Wikimedia Commons

Root Cause Analysis to Optimize Functional Health

- Healthy weight, proper nutrition
- Reduce toxins: sugar, alcohol, cigarettes, chemicals
- Identify poor posture/body mechanics; repetitive injury risks
- Prevent neuropathy progression with tighter glucose control
- Immune-modulating agents for rheumatoid arthritis, autoimmune
- Stress management

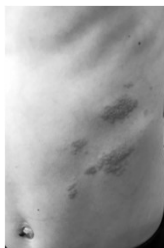
Fibromyalgia ¹		
OFF-LABEL	DRUG CLASS	FDA-APPROVED
TCAs - amitriptyline - nortriptyline - doxepin	ANTIDEPRESSANTS <i>Benefits patient with co-occurring PAIN/DEPRESSION/ANXIETY</i>	SNRIs - duloxetine - milnacipran
gabapentin topiramate	ANTIEPILEPTICS	pregabalin
low-dose naltrexone	OPIOID-ANTAGONIST	
	NSAIDs = topical, systemic	
ketamine (topical) memantine	NMDA Antagonists	
clonidine (patch, pill, topical)	Alpha-2 agonist (sympatholytic)	
tizanidine (alpha-2 agonist)	MUSCLE RELAXERS	
Vitamin D; Magnesium	micronutrients	

Central Sensitization / Abdominal Pain / Pelvic Pain	
BEHAVIOR MODIFICATION	TREATMENTS
<i>nutrition/elimination diet/water intake</i>	Opioids less than ideal
<i>AVOIDANCE OF pelvic floor dysfunction</i> • Excess idle time on toilet • Prolonged sitting on perineal region • Constipation	Avoid chronic systemic NSAIDs
<i>Healthy weight</i>	TCAs, SNRIs, AEDs
<i>Minimize stress; rehab psych; CBT, EMDR</i>	Low-dose naltrexone
<i>Regular exercise/outdoors/good sleep</i>	

Postherpetic Neuralgia

Ounce of prevention worth a pound of cure

- Vaccination for varicella-zoster virus
- Prompt antiviral for herpes zoster (shingles)
- Topicals: capsaicin, lidocaine
- Antiepileptic drugs
- SNRIs (duloxetine), TCAs
- Early aggressive multimodal pain management



[https://commons.wikimedia.org/wiki/File:Zonaz_\(herpes_zoster\).jpg](https://commons.wikimedia.org/wiki/File:Zonaz_(herpes_zoster).jpg)
Gzzz, CC BY-SA 4.0, via Wikimedia Commons

Conclusions:¹

- High quality evidence/research may not be available, expert opinion helpful
- Favorable evidence for duloxetine for diabetic peripheral neuropathy, fibromyalgia
- Consider duloxetine for chronic low back pain; autoimmune, OA & inflammatory arthritis; central sensitization; as opioid sparing, NSAID sparing technique
- Cannabis evidence is limited, AEs may limit use



Conclusions: Go case-by-case¹

- Opioids should not be first-line or routine therapy for subacute or chronic pain
- **HOWEVER some clinical contexts: opioids are appropriate first-line for serious illness:**
 - e.g., patient with poor prognosis
 - contraindications to other therapies
 - physician/patient agreement that overriding goal is patient comfort
- In other situations (e.g., headache, fibromyalgia), expected benefits of initiating opioids are unlikely to outweigh risks regardless of previous therapies

Opioids are not a failure; NSAIDs harmful too!

- Severe cerebrovascular or cardiovascular disease (CVA, MI, PVD)
- Renal disease
- Severe gastrointestinal bleeding presence or risk
- Chronically anticoagulated patient
- Certain pain populations (elderly, cancer, palliative, end-of-life)
- No surgical solution; no "easy" fix
- Procedure harm outweighs benefit
- Noncoverage of other "superior" medications or therapies
- If no contraindication, and if other treatments ineffective...

Are opioids causing a moral dilemma?

- Patients/physicians need to consider options, both of their preferences, for greatest benefit
- Set treatment goals early and often
- Identify barriers to treatment
- Bridge the gap from lack of awareness (implicit bias) to ability to recognize bias in ourselves and others
- Results in equitable, quality, & patient-centric care

Final thoughts:

- Caution to avoid synergistic risks of medications
- Combinations of medications that depress CNS = such as an opioid with gabapentin, have increased risk for overdose compared with either medication alone
- Dose reductions may lessen AEs and still have pain relief
- Start low and go slow

Goals of Care Improve Function MORE (treat pain less)

- Pain is a warning sign
- Take one pill and get two new side effects?
- Are side effects worse than actual problem?
- Medication may be a bridge to a fuller life
 - Purpose-driven life in the foreground...pain in background



https://commons.wikimedia.org/wiki/File:JoshuaTreeCA_Rainbow_20170909.jpg
Niranjan Arminius, CC BY-SA 4.0, via Wikimedia Commons

“Do the best you can
until you know better.
Then when you know
better, do better.”

- Maya Angelou

Thank You



https://commons.wikimedia.org/wiki/File:V%C3%A4imela_Ala%C3%A4rv_2012_08.jpg
Vaido Otsar, CC BY-SA 3.0, via Wikimedia Commons

1. Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. *MMWR Recomm Rep* 2022;71(No. RR-3):1–95. DOI: <http://dx.doi.org/10.15585/mmwr.r7103a1>
2. Raja SN, Carr DB, Cohen M, Finnerup NB, Flor H, Gibson S, Keefe FJ, Mogil JS, Ringkamp M, Sluka KA, Song XJ, Stevens B, Sullivan MD, Tutelman PR, Ushida T, Vader K. The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. *Pain*. 2020 Sep 1;161(9):1976–1982. doi: 10.1097/pain.0000000000001939. PMID: 32694387; PMCID: PMC7680716.
3. McDonagh MS, Selph SS, Buckley DI, Holmes RS, Mauer K, Ramirez S, Hsu FC, Dana T, Fu R, Chou R. Nonopioid Pharmacologic Treatments for Chronic Pain [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Apr. Report No. 20-EHC010. PMID: 32338847.
4. Chou R, Wagner J, Ahmed AY, Blazina J, Brodt E, Buckley DI, Cheney TP, Choo E, Dana T, Gordon D, Khandelwal S, Kantner S, McDonagh MS, Sedgley C, Skelly AC. Treatments for Acute Pain: A Systematic Review [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2020 Dec. Report No. 20(21)-EHC006. PMID: 33411426.
5. Towheed T, Maxwell L, Judd M, Catton M, Hochberg MC, Wells GA. Acetaminophen for osteoarthritis. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD004257. DOI: 10.1002/14651858.CD004257.pub2. Accessed 05 February 2025.
6. Derry S, Wiffen PJ, Kalso EA, Bell RF, Aldington D, Phillips T, Gaskell H, Moore RA. Topical analgesics for acute and chronic pain in adults - an overview of Cochrane Reviews. *Cochrane Database of Systematic Reviews* 2017, Issue 5. Art. No.: CD008609. DOI: 10.1002/14651858.CD008609.pub2. Accessed 06 February 2025.

7. Derry S, Conaghan P, Da Silva JAP, Wiffen PJ, Moore RA. Topical NSAIDs for chronic musculoskeletal pain in adults. *Cochrane Database of Systematic Reviews* 2016, Issue 4. Art. No.: CD007400. DOI: 10.1002/14651858.CD007400.pub3. Accessed 02 February 2025.
8. Roelofs PDDM, Deyo RA, Koes BW, Scholten RJP, van Tulder MW. Non-steroidal anti-inflammatory drugs for low back pain. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD000396. DOI: 10.1002/14651858.CD000396.pub3. Accessed 03 February 2025.
9. van der Gaag WH, Roelofs PDDM, Enthoven WTM, van Tulder MW, Koes BW. Non-steroidal anti-inflammatory drugs for acute low back pain. *Cochrane Database of Systematic Reviews* 2020, Issue 4. Art. No.: CD013581. DOI: 10.1002/14651858.CD013581. Accessed 05 February 2025.
10. Enthoven WTM, Roelofs PDDM, Deyo RA, van Tulder MW, Koes BW. Non-steroidal anti-inflammatory drugs for chronic low back pain. *Cochrane Database of Systematic Reviews* 2016, Issue 2. Art. No.: CD012087. DOI: 10.1002/14651858.CD012087. Accessed 05 February 2025.
11. Qaseem A, Witt TJ, McLean RM, Forcica MA; Clinical Guidelines Committee of the American College of Physicians. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. *Ann Intern Med* 2017;166:514–30. <https://doi.org/10.726/M16-2387> PMID: 28192789
12. Birkinshaw H, Friedrich GM, Cole P, Eccleston C, Serfaty M, Stewart G, White S, Moore RA, Phillipou D, Pincus T. Antidepressants for pain management in adults with chronic pain: a network meta-analysis. *Cochrane Database of Systematic Reviews* 2023, Issue 5. Art. No.: CD014682. DOI: 10.1002/14651858.CD014682.pub2. Accessed 05 February 2025.

- 13. Lunn MPT, Hughes RAC, Wiffen PJ. Duloxetine for treating painful neuropathy, chronic pain or fibromyalgia. *Cochrane Database of Systematic Reviews* 2014, Issue 1. Art. No.: CD007115. DOI: 10.1002/14651858.CD007115.pub3. Accessed 05 February 2025.
- 14. Gallagher HC, Gallagher RM, Butler M, Buggy DJ, Henman MC. Venlafaxine for neuropathic pain in adults. *Cochrane Database of Systematic Reviews* 2015, Issue 8. Art. No.: CD011091. DOI: 10.1002/14651858.CD011091.pub2. Accessed 05 February 2025.
- 15. Moraczewski J, Awozika AO, Aedma KK. Tricyclic Antidepressants. [Updated 2023 Aug 17]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK557791/>
- 16. Moore RA, Derry S, Aldington D, Cole P, Wiffen PJ. Amitriptyline for neuropathic pain in adults. *Cochrane Database of Systematic Reviews* 2015, Issue 7. Art. No.: CD008242. DOI: 10.1002/14651858.CD008242.pub3. Accessed 05 February 2025.
- 17. Wiffen PJ, Derry S, Bell RF, Rice ASC, Tolle TR, Phillips T, Moore RA. Gabapentin for chronic neuropathic pain in adults. *Cochrane Database of Systematic Reviews* 2017, Issue 6. Art. No.: CD007938. DOI: 10.1002/14651858.CD007938.pub4. Accessed 06 February 2025.
- 18. Derry S, Bell RF, Straube S, Wiffen PJ, Aldington D, Moore RA. Pregabalin for neuropathic pain in adults. *Cochrane Database of Systematic Reviews* 2019, Issue 1. Art. No.: CD007076. DOI: 10.1002/14651858.CD007076.pub3. Accessed 06 February 2025.

- 19. Toth C. Substitution of gabapentin therapy with pregabalin therapy in neuropathic pain due to peripheral neuropathy. *Pain Med.* 2010 Mar;11(3):455-66. doi: 10.1111/j.1526-4637.2009.00756.x. Epub 2010 Jan 22. PMID: 20113408.
- 20. Orhurhu V, Orhurhu MS, Bhatta A, Cohen SP. Ketamine Infusions for Chronic Pain: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *Anesth Analg.* 2019 Jul;129(1):241-254. doi: 10.1213/ANE.0000000000004188. PMID: 31082965.
- 21. Srinivasan A, Dutta P, Bansal D, Chakrabarti A, Bhansali AK, Hota D. Efficacy and safety of low-dose naltrexone in painful diabetic neuropathy: A randomized, double-blind, active-control, crossover clinical trial. *J Diabetes.* 2021 Oct;13(10):770-778. doi: 10.1111/1753-0407.13202. Epub 2021 Jun 1. PMID: 34014028.
- 22. Younger J, Noor N, McCue R, Mackey S. Low-dose naltrexone for the treatment of fibromyalgia: findings of a small, randomized, double-blind, placebo-controlled, counterbalanced, crossover trial assessing daily pain levels. *Arthritis Rheum.* 2013 Feb;65(2):529-36. doi: 10.1002/art.37734. PMID: 23359310.
- 23. Smith JP, Bingham SI, Ruggiero F, Mauer DT, Mukherjee A, McGovern CO, Zagon IS. Therapy with the opioid antagonist naltrexone promotes mucosal healing in active Crohn's disease: a randomized placebo-controlled trial. *Dig Dis Sci.* 2011 Jul;56(7):2088-97. doi: 10.1007/s10620-011-1653-7. Epub 2011 Mar 8. PMID: 21380937; PMCID: PMC3381945.