FREQUENTLY ASKED QUESTIONS
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• When should I refer patients to a specialist or pain clinic?

Coxib = COX-2 inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug
What clinical clues help distinguish between nociceptive and neuropathic pain?

<table>
<thead>
<tr>
<th>Nociceptive</th>
<th>Neuropathic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Usually aching or throbbing and well-localized</td>
<td>• Pain often described as tingling, shock-like, and burning – commonly associated with numbness</td>
</tr>
<tr>
<td>• Usually time-limited (resolves when damaged tissue heals), but can be chronic</td>
<td>• Almost always a chronic condition</td>
</tr>
<tr>
<td>• Generally responds to conventional analgesics</td>
<td>• Responds poorly to conventional analgesics</td>
</tr>
</tbody>
</table>

Common Descriptors of Neuropathic Pain

- Burning
- Tingling
- Pins and needles
- Electric shock-like
- Numbness

Can I combine treatments?

Lifestyle management

Stress management

Not all pain therapies are pharmacological

Sleep hygiene

Occupational therapy

Education

Biofeedback

Complementary therapies

Why should the treatment of chronic pain be multimodal?

- Improved analgesia
- ↓ doses of each analgesic
- ↓ severity of side effects of each drug

Coxib = COX-2 inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug

But... Patients with Chronic Pain of Just One Type of Pain Pathophysiology May be Rare

- Patients may have different pathophysiologic mechanisms contributing to their pain
  - e.g., complex regional pain syndrome has multiple potential mechanisms, including nerve injury and inflammation – “mixed pain state”

- Therapies that will work better for a particular patient are likely to depend on the mechanisms contributing to the patient’s pain

- Patients with mixed pain may benefit from combination therapy

What is the gastrointestinal risk with nsNSAIDs/coxibs?

Pooled Relative Risks and 95% CIs of Upper Gastrointestinal Complications

CI = confidence interval; coxib = COX-2 inhibitor; NSAID = non-steroidal anti-inflammatory drug; nsNSAID = non-specific non-steroidal anti-inflammatory drug

Risk Factors for Gastrointestinal Complications Associated with nsNSAIDs/Coxibs


ASA = acetylsalicylic acid; coxib = COX-2-specific inhibitor; GI = gastrointestinal; NSAID = non-steroidal anti-inflammatory drug; nsNSAID = non-specific non-steroidal anti-inflammatory drug; SSRI = selective serotonin reuptake inhibitor

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Odds Ratio/Relative Risk for Ulcer Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of GI bleeding/perforation</td>
<td>13.5</td>
</tr>
<tr>
<td>Concomitant use of anticoagulants</td>
<td>6.4</td>
</tr>
<tr>
<td>History of peptic ulcer</td>
<td>6.1</td>
</tr>
<tr>
<td>Age ≥60 years</td>
<td>5.5</td>
</tr>
<tr>
<td>Single or multiple use of NSAID</td>
<td>4.7</td>
</tr>
<tr>
<td>Helicobacter pylori infection</td>
<td>4.3</td>
</tr>
<tr>
<td>Use of low-dose ASA within 30 days</td>
<td>4.1</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>2.4</td>
</tr>
<tr>
<td>Concomitant use of glucocorticoids</td>
<td>2.2</td>
</tr>
<tr>
<td>Smoking</td>
<td>2.0</td>
</tr>
</tbody>
</table>

ASA = acetylsalicylic acid; coxib = COX-2-specific inhibitor; GI = gastrointestinal; NSAID = non-steroidal anti-inflammatory drug; nsNSAID = non-specific non-steroidal anti-inflammatory drug; SSRI = selective serotonin reuptake inhibitor

## Guidelines for nsNSAIDs/Coxibs Use Based on Gastrointestinal Risk and ASA Use

<table>
<thead>
<tr>
<th>Gastrointestinal risk</th>
<th>Not elevated</th>
<th>Elevated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not on ASA</td>
<td>nsNSAID alone</td>
<td>Coxib nsNSAID + PPI</td>
</tr>
<tr>
<td>On ASA</td>
<td>Coxib + PPI</td>
<td>Coxib + PPI nsNSAID + PPI</td>
</tr>
<tr>
<td></td>
<td>nsNSAID + PPI</td>
<td>nsNSAID + PPI</td>
</tr>
</tbody>
</table>

ASA = acetylsalicylic acid; coxib = COX-2-specific inhibitor; nsNSAID = non-selective non-steroidal anti-inflammatory drug; PPI = proton pump inhibitor
What is the cardiovascular risk with nsNSAIDs/coxibs?

Composite includes non-fatal myocardial infarction, non-fatal stroke, or cardiovascular death compared with placebo; chart based on network meta-analysis involving 30 trials and over 100,000 patients.

Coxib = COX-2 inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug

Do nsNSAIDs/coxibs interfere with bone healing?

• Some animal and *in vitro* studies suggest nsNSAIDs may delay bone healing, though results are contradictory

• However, clinical experience and most *in vivo* studies do not substantiate this

• Balance of evidence suggests short-duration nsNSAID/coxib use is safe and effective for post-fracture pain control

*Coxib = COX-2 inhibitor; nsNSAID = non-specific non-steroidal anti-inflammatory drug*  
What is the risk of addiction with opioids?

- One review of 24 studies (involving 2507 chronic pain patients) indicated there is a 3.3% risk of developing addiction to prescription opioids.

What are the side effects to be expected with opioids?

<table>
<thead>
<tr>
<th>System</th>
<th>Adverse effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td>Nausea, vomiting, constipation</td>
</tr>
<tr>
<td>CNS</td>
<td>Cognitive impairment, sedation, lightheadedness, dizziness</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Respiratory depression</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Orthostatic hypotension, fainting</td>
</tr>
<tr>
<td>Other</td>
<td>Urticaria, miosis, sweating, urinary retention</td>
</tr>
</tbody>
</table>

CNS = central nervous system

Why should antidepressants be used to treat pain?

Inhibiting reuptake of serotonin and norepinephrine enhances descending modulation.

When should I refer patients to a specialist or pain clinic?

Evaluate for patients presenting with pain the presence of red flags!

Initiate appropriate investigations/management or refer to specialist

Look for Red Flags for Musculoskeletal Pain

- Older age with new symptom onset
- Night pain
- Fever
- Sweating
- Neurological features
- Previous history of malignancy
Clinical Approach to Suspected Neuropathic Pain

Are verbal descriptors and history suggestive of neuropathic pain?¹

Yes

Can you detect sensory abnormalities using simple bedside tests?¹,²

Yes

Can you identify the responsible somatosensory nervous System lesion/disease²

Yes

Neuropathic pain is likely: initiate treatment³

No

Probable nociceptive pain

No

Consider specialist referral and if neuropathic pain is still suspected, consider treatment in the interim period³

No

Whenever possible, treat the underlying cause/disease