Management of neuropathic cancer pain

We read with interest the recent ESMO clinical recommendations on ‘management of cancer pain’ by Jost and Roila on behalf of the ESMO Guidelines Working Group [1]. As adequately outlined by these recommendations, neuropathic cancer pain, which may be related to tumor infiltration or complications of treatments of cancer, cannot be treated according to the World Health Organization recommendations because there is no evidence that it responds to step I or II analgesics that are recommended for mild or moderate cancer pain [1]. Therefore, the authors propose that neuropathic cancer pain should be treated not only by the co-analgesics, including tricyclic antidepressants, pregabalin, gabapentin, but also by the selective serotonin reuptake inhibitor fluoxetine up to very high dosages (80 mg/day), neuroleptics (haloperidol, chlorpromazine), and the antiepileptic carbamazepine. However, although tricyclic agents, gabapentin, and pregabalin have indeed been found efficacious in various neuropathic pain conditions, and amitriptyline and gabapentin have specifically shown efficacy in trials of neuropathic cancer pain [2–4], neuroleptics have been found ineffective in neuropathic pain on the basis of good quality randomized controlled trials and are therefore considered inadvisable in such conditions [2]. Although fluoxetine has sometimes been found to induce antinociception in animal models of neuropathic pain, it has no or little analgesic effect on its own and has been found effective only in patients with
Finally, carbamazepine is recommended as a first choice only in classical trigeminal neuralgia [5], while its level of evidence for efficacy in other neuropathic conditions is insufficient and its tolerability profile is poorer than that of newer antiepileptic drugs [4]. We are also concerned by the recommendations of potentially high dosages of fluoxetine, which have not been tested in neuropathic pain patients and should not be used in combination with the weak opioid analgesic tramadol due to increased risk of serotonin syndrome [3, 4]. Evidence-based therapeutic algorithms for the treatment of neuropathic pain have been published in recent years [2–4]. It is regrettable that ESMO did not take notice of them in their recommendations regarding neuropathic cancer pain.

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Disclosure

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References


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