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Topics in pain management: part 3 in a series

Targeting localized pain of postherpetic neuralgia (PHN)

A mechanism-based approach to treatment

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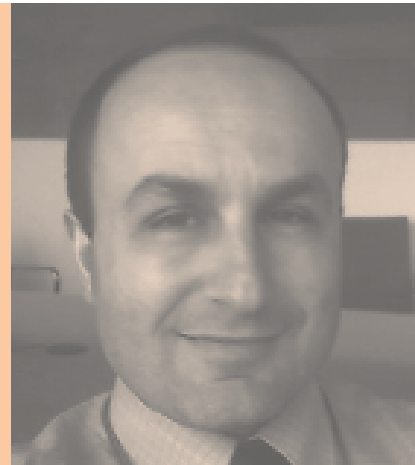
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“The advantage of targeted peripheral analgesia is its mechanism of peripheral desensitization that allows the local analgesic to inhibit impulses directly at the site of hyperexcitable cutaneous nerve endings.”



Christopher Gharibo, MD, is the Director of the New York University/Hospital for Joint Diseases (NYU/HJD) Pain Management Center, Assistant Professor of Anesthesiology at NYU School of Medicine, and also maintains a full-time pain medicine practice at NYU Pain Management Center and HJD Comprehensive Pain Treatment Center. Prior to coming to NYU, Dr Gharibo served 5 years as Director of the Bellevue Pain Treatment Center. He is a Diplomate of the American Board of Anesthesiology and American Board of Pain Medicine and holds Special Qualifications in Pain Medicine.

Dr Gharibo earned his medical degree from New Jersey Medical School in 1992, followed by an anesthesiology residency at NYU Medical Center. After his residency, he completed his Pain Medicine fellowship at Thomas Jefferson University Hospital in Philadelphia.

His clinical expertise includes low back and neck pain of musculoskeletal and spinal origin, cancer pain, and neuropathic pain syndromes such as peripheral neuropathies, postherpetic neuralgia, and reflex sympathetic dystrophy. He also possesses specific pharmacological and clinical experience in acute and perioperative pain management.

In addition to serving as principal investigator and co-investigator for many studies, Dr Gharibo has published abstracts, articles, and chapters in his field. He has also been invited to speak at several domestic and foreign conferences.

Dr Gharibo is a member of the American Academy of Pain Medicine, American Pain Society, American Society of Regional Anesthesia, International Anesthesia Research Society, and American Society of Anesthesiologists.

Targeting localized pain of PHN A mechanism-based approach to treatment

How can LIDODERM® address the mechanisms of PHN?

“PHN is a complex process resulting from a combination of peripheral and central sensitization. The peripheral nervous system generates abnormal impulses that travel to the spinal cord and fuel the central sensitization responsible for pain, allodynia, and hyperalgesia.

“Patients with PHN often report constant, burning pain that they may describe as superficial *and* deep. They also experience jabs or attacks of pain that are lancinating and uncomfortable. Patients may also describe their pain as tingling, stabbing, shooting, hot, and searing.

“These painful descriptions are rooted in both peripheral and central neuropathic pain mechanisms caused by abnormal impulse generation. These underlying mechanisms can be helped by continued use of LIDODERM®. For patients without sensitivity to lidocaine or other local anesthetics, initiating treatment with LIDODERM® at the diagnosis of PHN pain can dampen the development of peripheral sensitization by inhibiting peripheral impulses that can also contribute to central sensitization.”

Does the local delivery of LIDODERM® contribute to its efficacy in PHN?

“The advantage of targeted peripheral analgesia is its mechanism of peripheral desensitization that allows the local analgesic to inhibit impulses directly at the site of hyperexcitable cutaneous nerve endings. LIDODERM® blocks peripheral sodium channels, thereby reducing the peripheral impulses that barrage the area of central sensitization in the spinal cord. The net effect is believed to be a reduced number of painful impulses traveling to the brain and less PHN pain for the patient.

“LIDODERM® is a noninvasive way to target analgesia directly to the site of localized PHN pain, and when it is properly applied on intact skin to the area of abnormal nerve activity, there is a reduced risk of systemic side effects due to the small amount of lidocaine absorbed. The end result is effective analgesia via controlled neural targeting.”

How can LIDODERM® benefit PHN patients who also suffer from allodynia?

“Since approximately 90% of PHN patients suffer from allodynia, establishing the area of allodynia in PHN is an important part of the initial patient evaluation. Allodynia can interfere profoundly with a patient’s overall comfort,

and this sensitivity is often one of the first features to emerge during a medical interview. Clinically, allodynia is often detected dermatome-by-dermatome using gentle touch or a brush-stroke exam. The area of allodynia is typically generalized to the dermatomes above and below the original dermatome where acute herpes zoster and, later, the pain of PHN occurred.

“In addition to reducing the number of ectopic impulses that promote pain, when applied to intact skin, LIDODERM® forms a physical barrier between the allodynic area and the external environment, dampening mild external stimuli such as a tap over the painful area or the feeling of clothing. This results in less impulse production in the area of the peripheral sensitization and, therefore, less pain. The reduction in intensity of allodynia can also serve as an effective outcome marker in the treatment of PHN.”

Why is it important to give LIDODERM® an adequate trial?

“Continued use of LIDODERM® would suppress peripheral neuropathic impulses, thus producing a gradual “wind-down” of painful peripheral and central mechanisms. In my experience, the use of LIDODERM® would need to be maintained for at least 2 weeks to provide sustained analgesia. I believe that steady treatment with LIDODERM® can also decrease the intensity of allodynia. For breakthrough pain, a physician might also consider adding another analgesic to the LIDODERM® treatment regimen.”

How important is mechanism-based treatment? Where might LIDODERM® fit into this approach?

“Trial and error and stepwise analgesic prescribing are outdated practices that ignore the various pain states and mechanisms. In the case of PHN, patients suffer from more than just one type of pain. The current state of pain medicine is rational pharmacotherapy or co-analgesia, where several agents with different mechanisms of action may be used to provide the best *quality* of analgesia. Regardless of whether an analgesic is used first line, as a single agent, or as part of combination therapy, treatment should not only focus on efficacy, but also on safety, tolerability, and titratability. However, I use LIDODERM® cautiously with patients on Class I antiarrhythmics because the toxic effects are additive and potentially synergistic.

“Based on my clinical experience, I’ve found that LIDODERM® is effective, generally well tolerated, and easy to use. It is easy to prescribe, and due to its targeted mechanism, it does not need to be titrated to attain effectiveness. These factors make it an obvious first-line analgesic of choice for treatment of PHN that can be used alone or as part of combination therapy.”

Important Safety Information

LIDODERM® is indicated for relief of pain associated with post-herpetic neuralgia. Apply only to **intact skin**.

LIDODERM® is contraindicated in patients with a history of sensitivity to local anesthetics (amide type) or any product component.

Even a *used* LIDODERM® patch contains a large amount of lidocaine (at least 665 mg). The potential exists for a small child or pet to suffer serious adverse effects from chewing or ingesting a new or used LIDODERM® patch, although the risk with this formulation has not been evaluated. It is important to **store and dispose of LIDODERM® out of the reach of children, pets, and others**.

Excessive dosing, such as applying LIDODERM® to larger areas or for longer than the recommended wearing time, could result in increased absorption of lidocaine and high blood concentrations leading to serious adverse effects.

When LIDODERM® is used concomitantly with local anesthetic products, the amount absorbed from all formulations must be considered.

Avoid contact of LIDODERM® with the eye. If contact occurs, immediately wash the eye with water or saline and protect it until sensation returns.

Immediately discard used patches or remaining unused portions of cut patches in household trash in a manner that prevents accidental application or ingestion by children, pets, or others.

Patients with severe hepatic disease are at greater risk of developing toxic blood concentrations of lidocaine, because of their inability to metabolize lidocaine normally. LIDODERM® should be used with caution in patients receiving Class I antiarrhythmic drugs (such as tocainide and mexiletine) since the toxic effects are additive and potentially synergistic. LIDODERM® should also be used with caution in pregnant (including labor and delivery) or nursing mothers.

Allergic reactions, although rare, can occur.

During or immediately after LIDODERM® treatment, the skin at the site of application may develop blisters, bruising, burning sensation, depigmentation, dermatitis, discoloration, edema, erythema, exfoliation, irritation, papules, petechia, pruritus, vesicles, or may be the locus of abnormal sensation. These reactions are generally mild and transient, resolving spontaneously within a few minutes to hours. Other reactions may include dizziness, headache, and nausea.

Before prescribing LIDODERM®, please refer to the accompanying full Prescribing Information.

Although Dr Gharibo received compensation for his participation, the opinions expressed herein are his own. Results reported are based on individual experiences and may not be typical of all patients.

Inside: A clinician perspective on mechanism-based treatment

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Treating localized PHN pain at the source — Part 3 in a series