Reply

We thank Dr Main for his valuable comments regarding the use of antidepressants as analgesics. As Dr Main has correctly mentioned, most of the clinical trails on the effectiveness of duloxetine in chronic pain management were performed by the manufacturers of duloxetine, which is a funding bias. Lunn, Hughes and Wiffen have concluded that there is moderate-quality evidence in managing pain in diabetic peripheral neuropathy with a dose of 60 mg and 120 mg of duloxetine.[1]

Serotonin (5-hydroxytryptamine) and noradrenaline have been implicated in the mediation of endogenous pain-inhibitory mechanisms via the descending pain-inhibitory pathways in the brain and spinal cord. In view of this, duloxetine was evaluated in neuropathic pain, widespread pain syndrome (WSPS), chronic pain due to osteoarthritis (OA), and chronic lower back pain. There is wide inter-individual variation in response to duloxetine. The beneficial and harmful responses to treatments cannot be predicted for individuals with chronic pain condition.

A recent systematic review published by Finnerup et al showed serotonin–noradrenaline reuptake inhibitors to be moderately effective in managing neuropathic pain with a number needed to treat (NNT) of 6.40 (5.2–8.4). Duloxetine has been recommended as first-line management for neuropathic pain.[2] In WSPS, there is lower quality evidence. The effect in WSPS may be achieved through a greater improvement in psychological symptoms than in somatic physical pain.

WSPS is a chronic pain condition in which the main features are widespread musculoskeletal pain and tenderness accompanied by a number of non-specific symptoms that include fatigue, headache, low mood, unrefreshed sleep, abdominal pain and cognitive symptoms.[3,4] Pathophysiological hypotheses for WSPS are neuroendocrine dysfunction, neurotransmitter dysfunction and neurosensory dysfunction.[4] Complete resolution of symptoms is, unfortunately, almost never achieved, but significant improvement can be obtained through adequate pharmacological and non-pharmacological management. The European League Against Rheumatism (EULAR) published a series of recommendations in 2007.[5] They stress the importance of a multidisciplinary approach to treatment of WSPS. Biopsychosocial, cultural and spiritual management with lifestyle changes, such as improving quality and quantity of sleep, avoiding emotional and physical stress, improving posture and body mechanics, eating nutritiously, building a strong support system, developing and maintaining a positive attitude, are recommended. Antidepressants are often used as they decrease pain and improve function. Specific EULAR recommendations on non-pharmacological management include heated pool treatment with or without exercise and, in some cases, individually tailored exercise programs (aerobic exercise and strength training). On the basis of the patient's specific needs, relaxation, rehabilitation, physiotherapy and psychological support are also beneficial.[5]

It is also essential to consider the possibilities of hypothyroidism, polymyalgia rheumatica, systemic lupus erythematosus, Sjögren's syndrome, vitamin D deficiency and autoimmune conditions, as these may complicate the clinical presentation and remain a significant challenge for assessment and management.

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Letters to the editor

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