Journal of Pain & Relief
ISSN: 2167-0846

Mini Review Open Acces

Keywords: Cardiac-related events; Liver toxicity; Pain syndromes; Ibuprofen; In ammation; Acute pain

Introduction

Non-selective NSAIDs can be associated with gastritis, gastric ulcers, and gastrointestinal bleeding. Conversely, COX-2 inhibitors have fewer GI adverse e ects. e use of NSAIDs may be associated with renal insu ciency, hypertension, and cardiac-related events. Anticonvulsants are medications originally developed to treat seizures, but they are also commonly used to treat di erent pain syndromes, including post therapeutic neuralgia, peripheral neuropathy, and migraine. ey are o en used as part of a multimodal approach to the treatment of perioperative pain. Some of these agents can e ectively treat the neuropathic components of pain syndromes. Anticonvulsants, which include gabapentinoids such as gabapentin and pre-gabalin, may cause signi cant sedation and have recently been associated with a possible risk of misuse. Antidepressants are commonly used in various chronic pain conditions. TCAs are e ective in a variety of chronic pain conditions, including neuropathic pain [1]. As with other medications, they have risks and adverse e ects, including dry mouth, dizziness, sedation, memory impairment, orthostatic hypotension, urinary retention, and cardiac conduction abnormalities. Trials with di erent TCAs should be initiated at a low dose and gradually titrated to optimal e ect. SNRIs, such as venlafaxine and duloxetine, are e ective for a variety of chronic pain conditions, including musculoskeletal pain, bromyalgia, and neuropathic pain conditions, but have markedly fewer adverse e ects than TCAs. ere have been some reports of withdrawal reactions when these medications are suddenly stopped. Although selective serotonin reuptake inhibitors, such as uoxetine, sertraline, citalopram, and paroxetine, are e ective antidepressants; they have less analgesic e ect compared with other anti-depressant classes [2]. Overall, the analgesic actions of antidepressants occur even in patients who are not clinically depressed, and their analgesic e ect typically occurs sooner and at lower doses than those required for the treatment of depression. Musculoskeletal agents commonly used for pain treatment include baclofen, tizanidine, and cyclobenzaprine. Carisoprodol is metabolized to meprobamate, which is both sedating and possibly addictive, so the use of carisoprodol is not recommended; particularly because alternatives are available. Antianxiety medications are o en prescribed to treat the anxiety that accompanies acute pain as well as anxiety resulting from uctuations in chronic pain. ey may also be prescribed for co-morbid anxiety disorders such as generalized anxiety disorder, panic disorder, post-traumatic stress disorder, and agoraphobia, which as a group have a prevalence estimated in the range of 30% in patients with chronic pain [3]. SSRIs and SNRIs may also help manage the anxiety associated with co-morbid depression. It is important to recognize and treat anxiety e ectively because it can

medications vary in the ratio of their analgesic potency and their potential for respiratory depression, the major cause of opioid overdose death.107 For example, synthetic fentanyl and fentanyl analogues are