

involves not only a sensory aspect, but also a considerably complex psychological aspect [9].

Interestingly, the administration of low-dose APZ and amitriptyline in our two cases resembles the treatment strategy for obsessive-compulsive disorder (OCD) [10,11], an illness quite different from BMS. BMS patients not only complain of tongue pain but constantly ruminate about the pain—its etiology, relief, and cause—analogue to the way in which OCD patients obsess about their anxieties. Furthermore, delayed diagnosis and treatment [12] of BMS may exacerbate the “suffering” rather than the pain sensation itself. Therefore, an obsessive, anxiety-based thinking process might be a clinical attribute shared by patients with BMS and those with OCD, and the neural circuits of the two diseases might at least partially overlap. In case 2, the patient said that she felt slight pain but did not care about it, indicating that the augmentation treatment might have resolved her obsession with pain, in addition to reducing the pain. In conclusion, low-dose APZ augmentation can be an effective treatment for BMS when an adequate response is not achieved via amitriptyline monotherapy.

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# LETTER TO THE EDITOR

*Pain Medicine* 2017; 18: 815–817  
 doi: 10.1093/pm/prw220

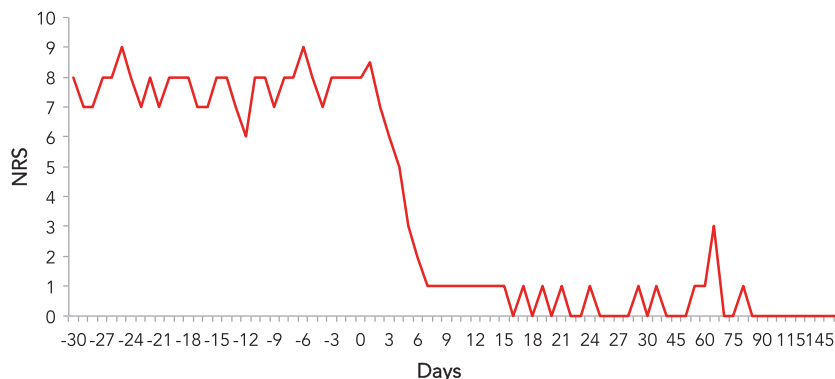
OXFORD

## Efficacy and Safety of Long-Term Administration of Tapentadol in Relieving Chronic Pancreatitis Pain

Dear Editor,

Chronic pancreatitis (CP) is a condition associated with severe pain frequently refractory to common analgesics,

leading to multiple hospital admissions [1–3]. A novel, centrally acting analgesic has been recently commercialized for the treatment of chronic pain, and several studies demonstrated promising results in the management



**Figure 1** Mean daily Numeric Rating Scale (NRS) of pain before and during tapentadol administration.

**Table 1** Time-course of patient's self-recorded graphic extension pain scores according to tapentadol administration

Day left	t <sub>2</sub> = -30	t <sub>1</sub> = -15	t <sub>0</sub>	t <sub>1</sub> = 10	t <sub>2</sub> = 15	t <sub>3</sub> = 20	t <sub>4</sub> = 25	t <sub>5</sub> = 35	t <sub>6</sub> = 45	t <sub>7</sub> = 55	t <sub>8</sub> = 65	t <sub>9</sub> = 68	t <sub>10</sub> = 95	t <sub>11</sub> = 125	t <sub>12</sub> = 155
Score drawing	11	10	12	1	0	1	0	0	2	1	3	1	0	0	0

of both nociceptive and neuropathic pain, as well as a good tolerability profile as compared with traditional opioids [4]. Here we present the case of a Caucasian female age 62 years with CP and pain refractory to endoscopic and surgical management, in which tapentadol administration resulted in a good pain relief. Pain control was checked by means of the Numeric Rating Scale (NRS) [5] and the graphic extension of pain [6]. Genomic DNA was purified from the fresh blood sample following standard method. The two single-nucleotide polymorphisms (SNPs) rs1799853 and rs1057910 identifying the two main alleles \*2 and \*3 of CYP2C9 and the two SNPs rs4244285 and rs12248560 identifying the two main alleles \*2 and \*17 of CYP2C19, as well as the 16 clinical relevant polymorphisms in the CYP2D6, were detected as previously described [7–9]. No variants were identified, suggesting a normal tapentadol metabolism. Accordingly, tapentadol-based treatment was prescribed at 150 mg daily (50 mg in the morning and 100 mg at bedtime). Starting 30 days before the first day of intake, the patient was asked to report a mean daily NRS score (Figure 1) and a graphic extension of pain (Table 1). Blood chemistry was performed before drug intake and every 10 days thereafter. On days 37 and 64, creatinine levels increased 0.5 mg/dl over the previous value, which normalized after an appropriate water assumption; no dose reduction of tapentadol was deemed necessary. NRS score was significantly reduced from 8 to 1 (Figure 1), and surface of referred pain was reduced up to 95% (Table 1).

CP-associated pain may persist for the patient's lifetime, and a multitude of available treatments still prove

to be elusive. Thus, pain management in CP represents a major challenge for the attending physicians. Concomitant drug treatments are a further option, but undesirable drug interactions may lead to significant and potentially dangerous side effects such as sedation, respiratory depression, and constipation. Tapentadol use in the management of pain has been shown to be effective in pain relief at a dosage of 300 mg daily. Safety evaluation did not report any increase in renal and liver cytotoxic parameters throughout the treatment period, which exceeded three months. To our knowledge, this is the first description of pancreatic pain treated with tapentadol in which a pharmacogenetic test was also used a priori to assess the metabolic phenotype of the patient.

Funding sources: This work was supported by "Ministero della Salute," the IRCCS Research Program, Ricerca Corrente 2015–2017, and by the "5 x 1000" voluntary contribution.

Disclosure and conflicts of interest: The authors have no conflict of interest or support to disclose.

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**Acknowledgments**

We thank Mrs C. Gravina and M. Urbano for their skilled technical works.

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## LETTER TO THE EDITOR

*Pain Medicine* 2017; 18: 817–819  
doi: 10.1093/pm/pnw224


**An 84-Year-Old Woman with a Rare Cause of Constipation**

Dear Editor,

Acute colonic pseudo-obstruction (ACPO)—also known as Ogilvie's syndrome—was first described in 1948 in two patients with retroperitoneal malignancy who experienced acute onset of nonobstructive massive colonic distension, probably resulting from invasion of the celiac plexus. Abnormalities in the autonomic nervous system, characterized by sympathetic dysfunction, parasympathetic dysfunction, or a combination of both, have been considered responsible for ACPO [1–3].

The most severe complication of ACPO syndrome is cecal perforation. It occurs more commonly when the cecal diameter is greater than 14 cm. Moreover, advancing age is associated with increased risk of complications and mortality.

ACPO can often be managed using conservative therapy. However, persistent colonic distension can lead to bowel perforation requiring surgery. The mortality rate of ACPO is around 40% [4–7].

We present the case of a woman age 84 years who suffered from diabetes and chronic obstructive pulmonary disease and was admitted with a 10-day history of constipation. Two days preceding the onset of

her constipation, the patient sustained a fracture of her right ilium and ischium after a fall that was managed conservatively and required treatment with tramadol 37.5 mg every eight hours. Physical examination revealed a distended tympanitic abdomen with no bowel sounds.

An abdominal x-ray and a CT scan revealed massive colonic dilatation without mechanical obstruction.

At first, the patient was managed with decompression using both a nasogastric tube and a rectal tube. Erythromycin and metoclopramide were initiated, and tramadol was discontinued. After 72 hours with no improvement, intravenous neostigmine (1 mg) was administered, but the patient was unable to tolerate the drug (due to hypotension and dyspnea); therefore, the treatment could not be repeated. After five days of marked clinical deterioration and given the high surgical risk, adrenergic blockade treatment was initiated after infusing bupivacaine at a 0.25% concentration (2.5 mg/mL), which was administered at doses of 3 mL per hour through an epidural catheter at T6 for 12 days. The patient's clinical condition improved after 24 hours, and she passed two liquid stools. During the next 10 days, the colonic distension decreased and the patient's bowel movement frequency returned to normal