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Current management of pain associated with multiple sclerosis

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Abstract

While pain is a common problem in patients with multiple sclerosis (MS), it is not frequently mentioned by patients and a more direct approach is required in order to obtain information about pain from patients. Many patients with MS experience more than one pain syndrome; combinations of dysaesthesia, headaches and/or back or muscle and joint pain are frequent. For each pain syndrome a clear diagnosis and therapeutic concept needs to be established. Pain in MS can be classified into four diagnostically and therapeutically relevant categories: (i) neuropathic pain due to MS (pain directly related to MS); (ii) pain indirectly related to MS; (iii) MS treatment-related pain; and (iv) pain unrelated to MS. Painful paroxysmal symptoms such as trigeminal neuralgia (TN), or painful tonic spasms are treated with antiepileptics as first choice, e.g. carbamazepine, oxcarbazepine, lamotrigine, gabapentin, pregabalin, etc. Painful 'burning' dysaesthesias, the most frequent chronic pain syndrome, are treated with TCAs such as amitriptyline, or antiepileptics such as gabapentin, pregabalin, lamotrigine, etc. Combinations of drugs with different modes of action can be particularly useful for reducing adverse effects. While escalation therapy may require opioids, there are encouraging results from studies regarding cannabinoids, but their future role in the treatment of MS-related pain has still to be determined. Pain related to spasticity often improves with adequate physiotherapy. Drug treatment includes antispastic agents such as baclofen or tizanidine and in patients with phasic spasticity, gabapentin or levetiracetam are administered. In patients with severe spasticity, botulinum toxin injections or intrathecal baclofen merit consideration. While physiotherapy may ameliorate malposition-induced joint and muscle pain, additional drug treatment with paracetamol (acetaminophen) or NSAIDs may be useful. Moreover, painful pressure lesions should be avoided by using optimally adjusted aids. Treatment-related pain associated with MS can occur with subcutaneous injections of interferon-beta or glatiramer acetate, and may be reduced by optimizing the injection technique and by local cooling. Systemic (particularly 'flu-like') adverse effects of interferons, e.g. myalgias, can be reduced by administering paracetamol, ibuprofen or naproxen. A potential increase in the frequency of pre-existing headaches after starting treatment with interferons may require optimization of headache attack therapy or even prophylactic treatment. Pain unrelated to MS, such as back pain or headache, is common in patients with MS and may deteriorate as a result of the disease. In summary, a careful analysis of each pain syndrome will allow the design of the appropriate treatment plan using various medical and nonmedical options (multimodal therapy), and will thus help to improve the quality of life (QOL) of the patients.

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