Neuropathic cancer pain: What are we dealing with? How to manage it?

Abstract: Cancer pain is a serious health problem, and imposes a great burden on the lives of patients and their families. Pain can be associated with delay in treatment, denial of treatment, or failure of treatment. If the pain is not treated properly it may impair the quality of life. Neuropathic cancer pain (NCP) is one of the most complex phenomena among cancer pain syndromes. NCP may result from direct damage to nerves due to acute diagnostic/therapeutic interventions. Chronic NCP is the result of treatment complications or malignancy itself. Although the reason for pain is different in NCP and noncancer neuropathic pain, the pathophysiologic mechanisms are similar. Data regarding neuropathic pain are primarily obtained from neuropathic pain studies. Evidence pertaining to NCP is limited. NCP due to chemotherapeutic toxicity is a major problem for physicians. In the past two decades, there have been efforts to standardize NCP treatment in order to provide better medical service. Opioids are the mainstay of cancer pain treatment; however, a new group of therapeutics called coanalgesic drugs has been introduced to pain treatment. These coanalgesics include gabapentinoids (gabapentin, pregabalin), antidepressants (tricyclic antidepressants, duloxetine, and venlafaxine), corticosteroids, bisphosphonates, N-methyl-D-aspartate antagonists, and cannabinoids. Pain can be encountered throughout every step of cancer treatment, and thus all practicing oncologists must be capable of assessing pain, know the possible underlying pathophysiology, and manage it appropriately. The purpose of this review is to discuss neuropathic pain and NCP in detail, the relevance of this topic, clinical features, possible pathology, and treatments of NCP.

Keywords: neuropathy, cancer pain, coanalgesics

Introduction
Cancer pain is a serious health problem, and imposes a great burden on the lives of patients and their families. Pain can be encountered in every stage of cancer until the end of life, and may interfere with the patient’s treatment process, lead to treatment refusal, and substantially impair quality of life. Today, although many treatment options for cancer are available, there is still no cure for some malignancies; therefore, a peaceful end of life is a privilege. All practicing oncologists must be capable of assessing pain, know the possible underlying pathophysiology, and manage it appropriately.

Methodology
A literature search was conducted on November 3, 2013 on the PubMed and Cochrane databases using the following keywords: neuropathy, pain, cancer, neuropathic pain (NP), cancer pain, oncology, chemotherapy, pharmacology, non-pharmacologic treatment, genetic mechanisms, resistance, opioid, coanalgesic. Articles reporting data for...
cancer and noncancer patients and neuropathy and NP were chosen to be eligible for our review. Abstracts of the articles were reviewed independently by the two authors (EE and SY). The original articles and reviews for which we could obtain full texts were chosen. All of the references cited were agreed upon by the two authors.

**Pain-related definitions**

The International Association for the Study of Pain (IASP) defines NP as an unpleasant, multidimensional, sensory, and emotional experience associated with actual or potential tissue damage or described in relation to such damage. Pain can be described in two major categories: adaptive pain and maladaptive pain. Adaptive pain is a protective mechanism that provides survival benefit or contributes to the healing process. In contrast, maladaptive or chronic pain is a disorder that represents pathology of neural structures. Chronic pain has been defined as a pain that lasts beyond the duration of insult to the body or beyond the duration of the healing process. Pain can be categorized as two main types: noxious pain, which is developed by a noxious stimulus to a tissue (somatic nociceptive pain) or to a visceral organ (visceral nociceptive pain), and NP, which arises from abnormal neural function as a result of direct damage or indirect insult to a neural tissue involved in pain processing. Pain can be also be described according to the response given to underlying altered sensation. This terminology is summarized in Table 1.

Neuropathy is the result of pathological change or functional disturbance in nerves. If only one nerve is affected, it is called mononeuropathy. When only a few nerves are affected, this is described as mononeuropathy multiplex; if nerves are affected diffusely and bilaterally, than it is called polyneuropathy. Although the IASP first published its pain terminology in 1979, neuropathy was included in this list only after 1994. The original definition of NP involves both lesion and dysfunction. In a broader sense, this could easily define the neuropathy, but the term “dysfunction” created some arguments in the literature in 2002 and 2004. The definition was narrowed by the IASP so that neuropathy consists of a lesion either in the peripheral nervous system (PNS) or the central nervous system (CNS) or both. As the nature of this type of pain is studied further, the excitability and plasticity of the nervous system become increasingly important, so treatment approaches have focused on pathophysiology rather than etiology. The Neurology and Pain Community introduced a new definition in 2008 in order to clarify the issue, which defines neuropathy as a pain arising as a consequence of either a lesion or disease affecting the somatosensory system. This definition is good in terms of classification of neurological diseases, but NP is a condition that involves multiple specialties.

Generally speaking, NP can be subdivided into three categories: sympathetically mediated pain, peripheral NP pain, and central pain. Sympathetically mediated pain arises in a PNS tissue, but is associated with autonomic changes (formerly known as reflex sympathetic dystrophy). Peripheral NP occurs due to damage to PNS components without the involvement of the autonomic system. Central pain stems from abnormal CNS activity.

The current National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines for Adult Cancer Pain (version 1.2013) follows the IASP definition, but also broadens and specifies the assessment of cancer patients, since this category may include more pathophysiologic pathways than others. The NCCN guidelines describe a detailed assessment regarding both etiology and pathophysiology, as well as specific cancer-related syndromes. These guidelines are also important in that they draw attention to NP as a medical emergency.

Still, there is no consensus on the definition and assessment strategies of NP. Future studies are thus needed to find a better definition to standardize language in the literature.

**Etiopathogenesis of neuropathic pain**

Over the past decade, the pathophysiologies of neuropathic syndromes and NP have been the subject of extensive preclinical and clinical research. Neuropathy syndromes are disorders of the CNS or PNS, whether or not they are associated with a demonstrable lesion. NP is a part of these syndromes. The etiologic condition can be a primary lesion of a nerve or it can indirectly involve the function or conduction pathway of that nerve. Sometimes, the first etiology disappears with time, but pain continues. The most commonly considered theory is that pain is potentially a learned condition. Today, this notion is widely accepted, although it was originally introduced in an evolutionary way. Peripheral and central mechanisms can play role in NP. Under normal conditions, unmyelinated C fibers and thinly myelinated Aδ fibers are responsible for

<table>
<thead>
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<th>Table 1 Terms used for classification of pain-related symptoms</th>
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<tr>
<td><strong>Hyperalgesia</strong></td>
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<tr>
<td><strong>Hypoalgesia</strong></td>
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<td><strong>Allodynia</strong></td>
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<td><strong>Dysesthesia</strong></td>
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the transmission of painful stimuli. They are responsive to high thresholds, but in neuropathic conditions their physiology changes. Spontaneous activity is evident in injured-area neurons. In animal models, ectopic neuronal activation related to malfunctioning sodium or possibly potassium channels in peripheral nerves and dorsal root ganglia have been reported.\textsuperscript{13–15} Peripheral lesions can induce central changes at spinal cord levels or higher in the CNS.\textsuperscript{10} Every step from signal transduction from primary painful stimulus and peripheral nerve plasticity to microglial activation, central stimulus organization, and central neural plasticity can be involved in pathophysiology.\textsuperscript{11,16,17} Central neuronal plasticity and hyperexcitability are probably sensitive to intracellular protein-concentration changes. These changes can be induced by activation of N-methyl-D-aspartate (NMDA) receptors by excitatory neurotransmitters. Because of the multiplicity of mechanisms, each of the painful symptoms may correspond to distinct mechanisms, and thus respond to specific treatments. NP syndromes are not typically isolated; most of the time, they are accompanied by nociceptive pain, such as visceral pain, ischemia-induced pain, and inflammatory pain. Conditions associated with NP are summarized in Table 2.

### Cancer pain syndromes and neuropathic cancer pain: causes and forms

Pain can be the presenting symptom of cancer in an otherwise healthy patient or emerge as disease progresses. It may also develop as a treatment complication. It is estimated that 50%–90% of cancer patients encounter pain in their lifetime.\textsuperscript{18,19} In a recent study from Europe, 670 of 1,051 patients were recorded as having pain.\textsuperscript{20} Pain in cancer patients can result from the tumor itself invading or destroying bodily structures, from side effects of treatment modalities, and from comorbid diseases.

Cancer pain syndromes can be either acute or chronic. Acute pain is most frequently associated with diagnostic or therapeutic interventions related to cancer. Diagnostic approaches directly harm tissues, especially nerves, resulting in pain. Chemotherapy/radiotherapy induces acute pain at the beginning of treatment or as a side effect (Table 3).

Chronic pain in cancer can be directly tumor-related or due to treatment strategies.\textsuperscript{21} Chronic cancer pain syndromes are summarized in Table 4. In the acute setting, cancer pain is troublesome but easier to handle. Pain becomes more disturbing and disappointing for patients and physicians as time passes. Whether cancer pain is either acute or chronic, it must be identified, assessed, and treated dynamically.

Bennett et al estimated that 18.7%–21.4% of cancer patients have neuropathic cancer pain (NCP). According to

### Table 2 Etiopathogenic disorders associated with neuropathic pain syndromes\textsuperscript{8}

<table>
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<tr>
<th>Category</th>
<th>Causes</th>
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<tr>
<td>Toxicity</td>
<td>Chemotherapy, radiotherapy, arsenic/lead exposure, statin and isoniazid usage</td>
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<tr>
<td>Trauma</td>
<td>Phantom limb pain, postmastectomy pain, postthoracotomy pain, or any pain in major surgical regions</td>
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<tr>
<td>Compression</td>
<td>Nerve-entrapment syndromes like carpal tunnel syndrome, direct tumor compression, especially in tumor metastasis</td>
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<tr>
<td>Ischemia</td>
<td>Pain in diabetic food ulcers, vasculitis-associated neuropathy, Buerger’s disease</td>
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<tr>
<td>Infection</td>
<td>Postherpetic neuroma, human immunodeficiency virus-associated neuropathy, herpes zoster-associated leprosy</td>
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<tr>
<td>Congenital diseases</td>
<td>Storage diseases, Fabry’s disease, amyloidosis</td>
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<tr>
<td>Autoimmune disorders</td>
<td>Chronic inflammatory demyelinating polyneuropathy, multifocal motor neuropathy, vasculitic neuropathy, and paraneoplastic syndromes like Eaton–Lambert syndrome, multiple sclerosis</td>
</tr>
<tr>
<td>Metabolic disorders</td>
<td>Diabetic neuropathy, uremic neuropathy, alcohol toxicity, beriberi</td>
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**Note:** Some of these mechanisms usually coexist in neuropathic pain syndromes.
On their systematic review, the prevalence of pain syndromes associated with NCP is 19%–39.1%.

Recognition of NCP is especially important, since different treatment strategies may be required to successfully overcome it.

NCP is characterized by patients as a spontaneous burning-like sensation and/or intermittent sharp, stabbing-like pain mostly felt at night. Also, patients report burning-like pain sensations in a stocking-and-glove pattern. NCP can be seen in conjunction with motor deficits, deep sensory loss, loss of proprioception and also with dysmotility of enteric organs, bladder dysfunction, pupillomotor abnormalities and orthostatic hypotension. These additional symptoms worsen the quality of life more, since daily life requirements like dressing and combing hair are affected in addition to functionality. The relationship between the etiology and type/pattern/symptomatology of pain is complex and not well understood. NCP is a multistep process, which explains the presence of diverse clinical presentations. This is why combination-treatment options are necessary for effective pain relief. Besides cancer-related pathologies, disorders like diabetes that already exist can lead to NP or worsen the situation. Psychological conditions, mood disorders, and personality type may influence pain perception and intensity.

NCP arises from physical or chemical damage to peripheral or central neurons or in the neural conduction system. Direct nerve damage by tumor pressure, invasion of nerve structure and resulting entrapment, hypoxia, or chemical changes in the tumor microenvironment like inflammatory signaling, proinflammatory cytokine production, and release of tumor algogens can result in NCP. There is a growing body of information on the subject of inflammation in relation to cancer. Inflammatory cells and cytokines are accused of having a role in the development of cancer complications, in addition to carcinogenesis, tumor progression, and metastasis. The neuropathic process and NCP is the intersection of complications of cancer and inflammation. Macrophages and microglia were investigated in the plasticity of visceral neural plexuses, dorsal root ganglion, spinal cord, and CNS broadly. Mast cells were found to be increased in pancreatic cancer with NP. Autonomic and enteric neuropathies (eg, in gastric paresis or NCP in pancreatic cancer) have an association with inflammatory signals and neuritis. Neural plasticity could have a role in the CNS and PNS, and may interact with other carcinogenetic mechanisms. These changes are more unique to NCP than noncancer NP. Bone metastasis is an important part of NCP. Bone is a prevalent metastasis site, and related pain
mechanisms are diverse. NCP related to bone metastasis is time- and energy-consuming for patients and physicians. The afferent sensory fibers of bone, periosteum, osteoclasts, and bone-remodeling balance are important in the development of NCP. Metastatic cancer cells can invade the sensory fibers and initiate pain. Increased osteoclastic activity diminishes bone strength, and thus pathological microfractures can happen, resulting in pain. Mechanical distortion and pressure to the periosteum is the third factor that leads to pain.33–35

NCP can be broadly categorized as peripheral (tumor infiltration/pressure, pain due to treatment complication) or central (spinal cord or CNS involvement or treatment-complication pain). NCP can also be divided into subgroups, such as pain directly related to tumor involvement, pain associated with chemotherapy, neuropathic syndromes associated with paraneoplastic syndromes, and pain associated with radiotherapy or surgery related NCP. Surgery results in physical damage to afferent neurons, and may cause phantom pain. Radiotherapy creates a hypoxic environment, and hypoxic nerves are more vulnerable. In the long term, chronic hypoxia leads to fibrosis in perineural tissues and causes late onset NP and NCP even in cancer-free survivors.25,36

Paraneoplastic neuropathies can be encountered during various malignancies, such as small-cell lung cancer, thymoma, and hematological malignancies, ie, lymphomas. Although the classical feature of paraneoplastic neuropathy is a subacute sensory neuropathy, it can present as sensorimotor neuropathy, brachial plexopathy, vasculitic neuropathies, and autonomic neuropathies also.37 These paraneoplastic neuropathies may be related to onconeural antibodies, a term used to describe the antibody secreted from neoplasm or its metastasis that reacts to normal nervous tissue components. Voltage-gated potassium and calcium channels and the collapsin response-mediator protein 5 can be potential targets, and anti-Hu antibodies are responsible most of the time. However, most of the time, none of the known antibodies can be identified. The diversity of symptoms of paraneoplastic neuropathy ranges from paresthesias, pain, and muscle weakness to limbic encephalitis, dysautonomic motility problems (gastric or enteric pseudo-obstruction), and orthostatic hypotension.25,38 These paraneoplastic neuropathies may be associated with pain. Paraneoplastic neuropathies can be confused with other types of malignancy-associated NP syndromes and complicate the treatment process. These definitions make NCP easier to understand and recognize in the clinical setting, but generally they do not differ in relation to treatment. Common NCP syndromes are summarized in Table 5.

<table>
<thead>
<tr>
<th>Table 5 Common neuropathic syndromes associated with cancer</th>
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<tr>
<td>Chemotherapy-induced neuropathy</td>
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<td>Tumor invasion: leptomeningeal metastases</td>
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<td>Neuralgias: trigeminal neuralgia or postherpetic neuropathy</td>
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<tr>
<td>Glossopharyngeal neuralgia</td>
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<tr>
<td>Radiculopathies and plexopathies: lumbosacral radiculopathy/plexopathy</td>
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<tr>
<td>Cervical radiculopathy/plexopathy</td>
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<tr>
<td>Brachial plexopathy</td>
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<tr>
<td>Painful peripheral mononeuropathies</td>
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<tr>
<td>Paraneoplastic sensory neuropathies</td>
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<tr>
<td>Horner’s syndrome</td>
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<tr>
<td>Enteric neuropathies</td>
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<tr>
<td>Eaton–Lambert myasthenic syndrome</td>
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<tr>
<td>Postsurgery neuropathies</td>
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<tr>
<td>Postradiotherapy neuropathies</td>
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<tr>
<td>Paraneoplastic motor neuropathy</td>
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<td>Paraneoplastic visceral neuropathy</td>
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Pain associated with infectious neuropathies is a main concern during cancer treatment. Infectious neuropathies are a group of disorders mainly encountered with leprosy, hepatitis C virus, and human immunodeficiency virus (HIV) infections, Lyme disease, and varicella zoster virus (VZV) infections.

VZV reactivation is the most common infectious disease associated with increased risk of neuropathy. It poses a 10%–20% lifetime risk of ganglionitis in the general population.39 VZV is a neurotropic virus of the human α-herpes virus family. It can cause chickenpox as a primary disease, and can stay latent in neurons of autonomic ganglia, dorsal root ganglia, and ganglia of cranial nerves. Also, the inactivated viruses in VZV vaccine can become dormant. The latent viruses become important as cellular immunity decreases naturally (ie, the aging process) or as a complication of treatment (ie, cancer patients). Reactivation of viruses results in the development of a maculopapular pruritic rash and dermatomal distributed pain.

VZV infection may be followed by multiple neurological complications (encephalitis, meningitis, vasculitis, motor radiculopathies, necrotizing ocular disease, and most commonly postherpetic neuralgia [PHN]).40–42 PHN is an NP syndrome that is persistent after 30–90 days of the healing of a zoster-infection rash. The replication process of viruses destroys the neurons in ganglia and causes the pain syndrome in diverse clinical presentations from allodynia to dysesthesia.42 PHN risk can be estimated from the intensity of pain in the acute zoster-infection period. However, antiviral therapy to slow down the pathophysiologic mechanism of ganglia injury has not yet been proven.41,43 The latent zoster infection and the PHN associated with VZV pose a great burden, especially in immunocompromised patients (hematological malignancies, solid-tumor patients treated with chemotherapy, solid-organ
transplant patients, and HIV patients), who have higher reactivation rates.\textsuperscript{,39,40,41–46}

The VZV-reactivation rate is as high as 50% in hematopoietic stem cell transplant patients without a prophylactic regimen,\textsuperscript{44} and is also higher in patients treated with purine analogs and novel agents like proteasome inhibitors or alemtuzumab.\textsuperscript{44} PHN can be treated with tricyclic antidepressants (TCAs), gabapentin, pregabalin, long-acting opioids, or tramadol; moderate evidence supports the use of capsaicin cream or a lidocaine patch as a second-line agent. The details of treatment options will be discussed later.

Among all mechanisms, it is estimated that a greater proportion of NCP will be caused by cancer chemotherapy.\textsuperscript{5,22} In a recent European survey, the proportion of chemotherapy-induced NP (CINP) pain among other NCP types was 32.6%.\textsuperscript{47} There are several reports showing that CP and NCP were diagnosed and treated inefficiently.\textsuperscript{20,22,48} Special attention should be given to common mechanisms of NCP in order to understand better and treat accordingly.

**Chemotherapy-induced neuropathy**

The development of more sophisticated chemotherapeutics and optimal-use older drugs enables cancer patients to have excellent outcomes, with more cure potential, and a longer survival chance even if no cure is possible. On the other hand, this improvement may result in serious acute or chronic side effects for “survivors”. Neuropathy is one of those side effects that is encountered frequently. The vague symptomatology, indeterminate terminology to define it, and lack of really adjustable and applicable diagnostic criteria lead to underreported NCP by patients and physicians.\textsuperscript{49,50} Still, CINP is the main syndrome among the NCP types.\textsuperscript{20} Chemotherapy-induced neuropathy and CINP depend on the agent used, duration and dosage of treatment and also coexisting other neuropathic disorders.\textsuperscript{51} Although the risk of NP complication is specific to the drug itself, the clinical symptoms and signs of neuropathy and NP are very similar between drugs. Sometimes, the effects are seen as acute or subacute onset, but insidious development is more frequent. The main chemotherapeutic drugs responsible for NCP and CINP are shown in Table 6.\textsuperscript{25,36,52,53}

| Table 6 Common chemotherapeutic agents involved in neuropathy process |
|--------------------------|-----------------|-----------------|
| **Drug** | **Type** | **Onset, duration, recovery** |
| Cisplatin | Chronic | 1–6 months for onset, Years for recovery (more than 80%) |
| Carboplatin | Chronic | Years for recovery (more than 80%) |
| Oxaliplatin | Acute or chronic | Acute: even during infusion, Chronic: same as cisplatin |
| Taraxanes | Chronic, rarely acute | Onset within weeks |
| Vincristine | Subacute | Recovery after 3 months |
| Vinblastine | Subacute | Recovery after 3 months of drug cessation |
| Bortezomib | Onset any time, mainly subacute or chronic | Dose reduction is recommended |
| Thalidomide | Dose-dependent | Recovery at 2 years or no recovery |
| Ixabepilone | Subacute or chronic | Onset is acute or subacute |
| Eribulin | Subacute or chronic | Quick recovery in mild cases |

Cisplatin is a mainstay of many chemotherapy regimens for diverse cancer types, such as lymphoid malignancies, lung cancer, and genitourinary cancer. When utilized, the rate of curing testicular cancer rapidly increased. However, neuropathy is the dose-limiting adverse effect of treatment in some of these patients. Cisplatin causes axonal neuropathy, which mostly affects large sensory fibers. Although the primary involved site is the dorsal root ganglion, the peripheral nerve may be involved. Patients complain of paresthesias and some degree of motor loss. Temperature sensation is spared, although proprioception and reflexes are lost. Autonomic neuropathy is encountered less often than sensory and motor neuropathies. The onset can be subacute or chronic; usually, NP and NCP occur months later (3–6 months), or sometimes the symptoms become evident after the chemotherapy cycles have finished.\textsuperscript{54} Although cisplatin neurotoxicity is dose-related, NP is more common with increasing dosages, and there is substantial variability among individuals for sensitivity.\textsuperscript{54} Cisplatin-associated electrolyte imbalance can contribute to the neurotoxic process. On pathological examination, both demyelination and axonal loss can be evident. Symptoms may continue with decreasing intensity after months or even years.\textsuperscript{24,25,33} Although there are some data about the prevention of cisplatin neurotoxicity with utilization of vitamin E and amifostine, a Cochrane meta-analysis could not find any beneficial effects of preventive strategies.\textsuperscript{55}

Oxaliplatin is a new type of platinum-class drug. It is effective mainly in colon cancer as well as in other gastrointestinal malignancies. It has a different NP profile than cisplatin. It can cause acute dysesthesia within hours, even during infusion and/or painful abdominal pain. Similar to cisplatin, it can cause cumulative sensory NP in a chronic setting. The acute symptomatology consists of painful
muscle cramps, paresthesias in distal extremities and the perioral region and rarely priapism. These symptoms can be aggravated by cold exposure. Acute toxicity is believed to be the result of calcium chelation, leading to activation of low-calcium voltage-gated channels in peripheral nerves. The dose-limiting neurotoxicity is the late onset, cumulative, sensory, symmetric distal axonal neuropathy. There is no motor involvement. Similar to cisplatin, oxaliplatin forms deoxyribonucleic acid adducts, especially in the neurons of dorsal root ganglia. The main problem with oxaliplatin NP is that it also affects proprioception and can cause urinary retention. Therefore, quality of life is further decreased. In contrast to cisplatin, oxaliplatin neurotoxicity may be reversible after discontinuation of treatment.

Gemcitabine is a purine analog used for treatment of pancreatic cancer, lung cancer, and bladder cancer. Neuropathies in a wide spectrum can be encountered with gemcitabine therapy, from mild paresthesias to severe peripheral and autonomic neuropathies. Taxanes as microtubule inhibitors are another major group of drugs responsible for NCP, but their role in oncology practice is also incontrovertible. They are used mainly in breast cancer, lung cancer, and ovarian neoplasms. They give patients the chance to survive longer and remain mostly disease-free. However, NP and NCP significantly decrease their quality of life. In general, taxanes affect sensory neurons related to vibration sensation and proprioception. The symptomatology of neuropathy associated with taxanes includes peripheral burning-like sensations and numbness, paclitaxel-associated acute pain syndrome (which is characterized by arthralgias, myalgias, and numbness that begins within 1–2 days following treatment and lasts 4–5 days), motor neuropathies, and rarely autonomic neuropathy. Neurotoxicity is dose-related. Coexisting neurotoxic diseases and chemotherapeutic agents that are used in combination are also important in the NCP process. Taxane and platinum compound neurotoxicity is synergistic. Both taxanes and platinum-group drugs can cause axonopathy and neuronopathy (damage to neurons in dorsal root ganglia). The difference between them is important for NP prognosis. Neuronopathy is accepted as a more progressive, irreversible process compared to axonopathy. Docetaxel causes both sensory and motor neuropathy, though these are less frequent. Nab-paclitaxel is a new member of the taxane group of drugs for which clinical experience is low. There are studies showing that its neurotoxicity profile is similar to docetaxel both in prevalence and intensity. The acute painful neuropathy syndrome can be observed more frequently with nab-paclitaxel. Cabazitaxel is another new drug that is approved for the treatment of castration-resistant prostate cancer. NP was reported as 13%–17%, with severe NP less frequent.

Vinca alkaloids are effective anticancer agents due to their antimicrotubule activities. Vincristine is the most neurotoxic drug of the available drugs in the vinca alkaloid class. Both sensory and motor neuropathies can be encountered. It can cause NCP, painful paresthesias in hands and feet, and muscle cramps. The onset of NP can be acute or subacute, and NP can last even after discontinuation of the drug. Comorbid neuropathic diseases and concurrent use of hematopoietic colony-stimulating factors can increase the NP and NCP. It is important to note that autonomic neuropathies can be encountered with vincristine. Abdominal pain, constipation, and even paralytic ileus may develop. Impotence, atonic bladder, and postural hypotension may develop, but are far less common. Vincristine can cause focal cranial mononeuropathies, as seen in oculomotor neuropathy, or in the optic nerve and facial nerve. Patients with mild neuropathy may continue with standard doses of treatment, but if symptoms increase in intensity, the dose should be reduced or the drug must be totally canceled from the regimen. The recovery process takes more time. There are data suggesting glutamic acid use for prophylaxis of vincristine NP, but the evidence level is not strong enough to apply in clinical practice. Although there is a risk of NCP with vinblasteine and vinorelbine, the severity is less than compared to vincristine.

Ixabepilone (an epothilone-class microtubule inhibitor) and eribulin (derived from a marine sponge) are two new drugs with antimicrotubule inhibitor effects. Both of them were reported to be associated with NP. Ixabepilone may cause autonomic NP in addition to sensory NP. Grade 3–4 NP with ixabepilone occurs in 6%–24% of cases, and dose reductions are advised in such cases.

Thalidomide is a potent antiangiogenic agent that is used especially for multiple myeloma. It has a cumulative, dose-dependent NP side effect. The neuropathy of thalidomide presents as symmetrical distal sensory NP and motor NP. The underlying pathology is suggested to be toxic axonopathy. The dose-limiting toxicity is the NP, but NP is only partially reversible, even after the discontinuation of therapy. Autonomic NP is also common, especially in senior adults. This can complicate the treatment process of myeloma in the elderly, since NP may present as bradycardia and also constipation and impotence. Lenalidomide is a second-generation drug with more potency but less neurotoxicity.

Bortezomib is a member of a new class of chemotherapeutics called proteasome inhibitors. It is a reversible 20S
proteasome-complex inhibitor, acting by disrupting the cell-signaling process, leading to cell-cycle arrest, apoptosis, and inhibition of angiogenesis. In 2003, it was approved by the US Food and Drug Administration for refractory multiple myeloma. Later, bortezomib gained importance in the treatment of early stages of myeloma and other hematologic malignancies (ie, mantle-cell lymphoma). There are ongoing investigations in the treatment of solid malignancies with bortezomib in combination with other chemotherapeutic agents. Peripheral neuropathy is a dose-limiting toxicity of bortezomib, usually presenting as length-dependent axonal neuropathy distributed in a stocking-and-glove pattern. In addition, patients may develop demyelinating polynuropathy and sensory ganglionopathy. The effects on neurons or axons are dose-dependent, usually evident with the first cycle of chemotherapy, and increase in severity as treatment continues. Reversibility of neuropathy has been shown to be up to 80% in various trials. Ixazomib, marizomib, and carfilzomib were developed as irreversible proteasome inhibitors. In clinical trials, they are associated with less neuropathy risk than observed with bortezomib.

Clinical assessment of cancer patients with neuropathic pain

The diverse heterogeneity of pain syndromes in cancer patients makes them also difficult to assess, score, and handle. Therefore, a detailed patient history and a meticulous clinical examination are necessary steps to confirm the diagnosis of NP and NCP. Past history with particular attention to comorbidities and family history of any neurological diseases are important in terms of the risk of developing NP. Medication history should always be kept in mind, as drug interactions and cumulative neurotoxicities are common in NCP treatment. It is important to assess the severity of pain by a pain-assessment scale (visual analog scale, brief pain inventory or its short form [BPI-SF], memorial pain assessment). Particular attention should be given to location, radiation, frequency, and aggravating factors of pain. Standardized screening tools, such as the NP questionnaire, PainDetect, and ID-Pain have been developed. Although these screening tools cannot identify 10%–20% of patients with NCP, they offer guidance to clinicians. Moreover, the impact of pain on patients’ daily living, functional status, emotions, social functions, and sleep should be assessed.

A bedside examination should include the examination of components that include touch, pinprick, pressure, temperature, vibration sensation, and temporal summation. Touch can be assessed by gently applying cotton wool to the skin, pinprick sensation by the response to sharp pinprick stimuli, deep pain by gentle pressure on muscle and joints, and cold and heat sensation by measuring the response to a thermal stimulus (eg, by burettes filled with hot and ice-cold water). Vibration can be assessed via a tuning fork. Abnormal temporal summation is the clinical presentation of neuronal activity after repetitive noxious stimuli, which can be evoked by mechanical and thermal stimuli. There are several different electrophysiological methods to quantify neurologic dysfunction that can help to identify patients with NP and NCP. Nerve-conduction and electromyography studies, provocative nerve testing, functional brain imaging, and skin biopsy for nerve-ending pathologies are tests that are beneficial. However, none of these modalities has been validated in cancer patients, and they are not in widespread use. Their use needs physician expertise and special resources, and they are not practical to use in everyday practice.

Pharmacologic treatment of neuropathic cancer pain

The first approach for a patient at risk of NP is the prevention of NP. However, there is no strong evidence in favor of agents that are used for prevention of NCP. Since the pathophysiology of NCP is complex, long-term management of NCP is challenging for physicians dealing with cancer patients.

Decades after the publication of the World Health Organization (WHO) analgesic ladder, cancer pain is still a burdensome symptom for patients. NCP is even more complicated, since the pain mechanisms are complex and integrated with one another. Today, many of the guidelines accept data extrapolated from nononcological pain studies as evidence for treatment of oncological patients with pain and NCP. European and NCCN guidelines follow the revised WHO orders to treat pain in cancer. The WHO recommends starting the treatment in a stepwise manner and following the patient for symptom relief and side effects. There are opioid and nonopioid treatment options for pain relief in cancer patients. In the following section, pharmacological treatment options will be briefly discussed, and detailed information of adjuvant analgesics will be provided.

Mild cancer pain (eg, pain-intensity rating as 1–3) is treated with nonopioid analgesics. Paracetamol and/or nonsteroidal anti-inflammatory drugs (NSAIDs) are the drugs of choice. They are beneficial for bone and soft-tissue pain. Hepatic toxicity should be kept in mind for paracetamol, while cardiac, gastric, and renal side effects and thrombocytopenia/platelet dysfunction are important considerations.
in the use of NSAIDs. There is no evidence to support a particular NSAID over any other in terms of safety and efficacy.⁹⁵ Even if the pain is not alleviated with NSAIDs, these drugs should be continued with opioids.⁹⁶

Opioids are the mainstay of therapy in cancer patients. Treatment of pain beyond mild intensity needs the implementation of opioids to treatment. Weak or short-acting opioids (e.g., codeine, dihydrocodeine, and dextropropoxyphene), drugs with mixed effects (tramadol, tapentadol), and partial opioid agonists (transdermal buprenorphine) are advised if the result with nonopioid analgesics was not satisfactory.⁹,⁹² There are some controversies about this approach. To start, there is not enough evidence that adding a short-acting opioid is better than a nonopioid treatment.⁹² Second, the use of low-dose strong opioids or low-dose morphine can be more effective than short-acting opioids.⁹,⁹⁷ Codeine is a prodrug, and has to be changed into morphine-6-glucuronide in order to show its effect. Due to genetic polymorphism in the metabolism of this drug, it may not be effective in 10%–30% of the population.⁹⁸ Regarding drugs used for moderate-intensity pain, tramadol deserves special interest. It is a centrally acting drug, with both opioid activity and monoaminergic properties. Tramadol has good bioavailability and has been proven effective in the treatment of strong pain and NP.⁹⁹ The risk of serotonin syndrome prevents its use in combination with monoamine-oxidase inhibitors. The side-effect profile is similar to other opioids, except constipation incidence is less. Even at maximum doses, its effects are less than other opioids.⁹ Tapentadol is a µ-opioid analgesic with a norepinephrine reuptake-inhibitory effect.¹⁰⁰ Although most of the data about the efficacy of tapentadol comes from nononcological trials, it has been shown to have a moderate analgesic effect.¹⁰¹ The gastrointestinal side effects of tapentadol may be lessened.⁹ Once the pain cannot be modified any further, rather than combining short-acting or weak opioids with each another, it is recommended that longer-acting and strong opioids be used. In each step of pain treatment, coanalgesics may be added to treatment, as will be discussed further in detail.

The strong opioids are used in severe pain syndromes alone or in combination with nonopioid analgesics and/or coanalgesics. These drugs include morphine, hydromorphone, methadone, and fentanyl. Pethidine was used for this intent, but is no longer recommended, because of the accumulation of a neurotoxic metabolite.⁸ Morphine, oxycodone, and hydromorphone are effective drugs for pain management. Each of these could be the first choice of drug in personalized treatment of cancer pain. Morphine used to be the standard choice for pain treatment in cancer patients for decades. It is available in a wide variety of formulations, and can be used via oral, rectal, and intravenous routes. There is a risk of active metabolite accumulation in patients with renal failure.¹⁰¹ Oxycodone is a synthetic opioid that can be used orally or parenterally. It has no active metabolite, and is therefore safe to use in comorbid kidney disorders. Additionally, it has clinical efficiency in NCP and visceral pain.¹¹ Naloxone is a peripheral µ-receptor antagonist used in combination with oxycodone to overcome constipation, one of the most common and refractory side effect of opioids.¹⁰² Safety and efficacy of this combination was shown in a recent trial.¹⁰³ Hydromorphone is a semisynthetic opioid with three- to fivefold the potency of morphine. Similar to morphine, it has an active metabolite that is dialyzable, allowing its use in patients on dialysis.

Transdermal fentanyl is a potent, effective alternative to oral, slow-release opioids that is preferred by oncologic patients incrementally. The bioavailability depends on absorbance through the skin, since cachexia can reduce its efficacy.¹⁰⁴ Transdermal fentanyl should not be used as a first line drug in patients, for whom their pain may be clinically stabilized with other opioids. It is typically the treatment of choice when a patient has difficulty in swallowing or poor compliance, and it should be used in caution in patients with risk of sedation.

Methadone is an NMDA antagonist. Although it has a bad reputation for being used in drug abuse, it is a useful drug when applied by experienced pain physicians. Its unpredictable half-life and risk of accumulation and toxicity prevents the use of methadone in everyday practice.⁸ One of the main barriers to effective pain management for oncologic patients is the fear of drug addiction and/or common and worrisome side effects. Although most of the mentioned opioid drugs proved to be addictive in an otherwise painless individual, that fear was shown to be unfounded in oncologic patients suffering from moderate-to-severe pain.¹⁰⁵ The classical side effects of opioids vary, and are listed in Table 7. Constipation is the most common continuing adverse effect, and is related to blockage of peripheral µ-receptors. Laxatives

<table>
<thead>
<tr>
<th>Table 7 Adverse effects of opioids</th>
<th>Bronchoconstriction</th>
<th>Respiratory depression</th>
<th>Delirium</th>
<th>Seizures</th>
<th>Noncardiogenic pulmonary edema</th>
<th>Immunodeficiency</th>
<th>Allodynia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emesis</td>
<td>Constipation</td>
<td>Sedation</td>
<td>Cough suppression</td>
<td>Sedation</td>
<td>Pruritus</td>
<td>Dry mouth</td>
<td></td>
</tr>
</tbody>
</table>
should be applied with the first few days of opioid institution. Stimulating laxatives are necessary to prevent and overcome the constipation. Naloxone in combination with oxycodone is effective in this setting. Mild drowsiness is also common, but generally dissipates or decreases in severity with the development of tolerance. If treatment is prolonged, an opioid switch should be considered. Emesis is a side effect of opioids to which tolerance develops within first few days of opioid initiation. Emesis can be managed with antiemetics. If the emesis continues, a change of route of administration can help or an opioid switch can be considered.9 Opioid-dose reduction and combination with coanalgesics may improve the adverse effects. Guidelines recommend use of the opioids with nonopioid analgesics and adjuvant analgesic or coanalgesics.9,88,92 The term “coanalgesic” means that a drug is intended to play another role in the pharmaceutical market but potentially useful when added to opioids in pain management.106

Coanalgesics should be utilized when opioid response is poor or no more titration of the dose is possible because of inevitable side effects. The addition of a second analgesic makes the control of both the pain and side effects easier. Coanalgesics can be used at every step of the WHO ladder, but are generally added by physicians when difficulties occur during pain management concurrent with increased severity or side effects.

Management of NP is a challenge. Control of NCP usually requires higher doses of opioids then what is tolerable, thus the need for adjuvant analgesics or coanalgesics. The coanalgesic drug group include gabapentinoids (gabapentin, pregabalin), antidepressants (TCAs, duloxetine, and venlafaxine), corticosteroids, bisphosphonates, NMDA antagonists, and cannabinoids.9,92,107,108 Although it is criticized frequently, the most common approach to compare clinical trials is to compare the number-needed-to-treat and number-needed-to-harm values of drugs. These coanalgesic drugs have number-needed-to-treat values of 3–5, which are within the therapeutic interval.88,109 In the following section, coanalgesic drugs will be described in detail.

Coanalgesics
Antidepressants

Tricyclic antidepressants
TCAs are well-known drugs that inhibit norepinephrine and serotonin reuptake in the CNS, modulating sodium channels and augmenting dorsal root ganglion blockage by the inhibition of NMDA receptors.11,108 The efficacy of TCAs is established mainly in PHN.111,112 Antidepressive effects create a double hit to NP mechanism, since pain perception is highly increased with depression. TCAs are thought to have analgesic effects at dosages lower than required for depression. Drug toxicity can be dose-limiting for TCA, since they are strongly anticholinergic drugs. The most common side effects are the result of their anticholinergic activity, which are dry mouth, constipation, blurred vision, cognitive impairment, and orthostatic hypotension.11 Therefore, they should be started cautiously in patients with cardiac problems and especially in the elderly. A baseline electrocardiogram should be obtained and repeated as necessary. There is large pharmacokinetic variability in the metabolism of this class of drugs, so personalized treatment is important. Imipramine, desipramine, and nortriptyline are accepted as safer than amitriptyline.11 Further data on dosage of analgesics, coanalgesics, and warnings are summarized in Table 8.

Other antidepressants

The analgesic effects of selective serotonin-reuptake inhibitors are not well established, as there is not enough clinical evidence.9,109 The selective serotonin–norepinephrine inhibitors (SNRIs) venlafaxine and duloxetine are the drugs of choice in NCP, although the main evidence of their effectiveness in NP was established in studies on diabetic neuropathy. Venlafaxine is the first SNRI to be effective in NP. In a well-designed study comparing venlafaxine and imipramine, both were found to be equally effective.113 The dosage is important, since lower dosages (<75 mg) are ineffective in NCP, and higher doses are required (>150 mg).114 Acute oxaliplatin toxicity can be successfully treated with venlafaxine.115 Elevation of blood pressure is a risk during venlafaxine treatment, and regular monitoring is necessary. The main side effects are gastrointestinal disturbances, but rarely result in drug discontinuation. Venlafaxine dose should be reduced in severe hepatic and renal insufficiency. In comparison with duloxetine, venlafaxine was found to be more effective but with more side effects.116

Duloxetine is a relatively new agent in the SNRI family. It has been found to be more effective than placebo.117,118 Dose titration of duloxetine should be done in no less than 2 weeks, as the effect of drug begins in that period.119 It is a better agent, since no cardiotoxicity has been reported yet. Doses of 60–120 mg are efficient, but lower doses are not.120 Venlafaxine has been found to be effective in postmastectomy pain syndrome after breast cancer surgery.121 In respect to CINP, duloxetine is more effective than placebo, and can be considered in first-line therapy.122

Bupropion is an antidepressant with norepinephrine and dopamine reuptake-inhibitory effect. It acts both centrally
<table>
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<tr>
<th>Drug group</th>
<th>Drug</th>
<th>Level of recommendation</th>
<th>Dose and titration</th>
<th>Common side effects</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioids</td>
<td>Morphine</td>
<td>First-line</td>
<td>10–30 mg po in opioid-naïve patients every 4 hours</td>
<td>Constipation, nausea, vomiting, pruritus, sedation, somnolence, micturition problems, dizziness, myoclonus</td>
<td>Respiratory arrest, Opioid-induced hyperalgesia, Hepatic insufficiency, Renal insufficiency, Methadone: high variability in half-life and pharmacodynamics; highest risk among opioids in terms of overdose, accumulation</td>
</tr>
<tr>
<td></td>
<td>Oxycodone</td>
<td>First-line</td>
<td>5–15 mg po every 4–6 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hydrocodone</td>
<td>First-line</td>
<td>2–4 mg every 3–4 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transdermal fentanyl</td>
<td>First-line</td>
<td>12–25 µg every 72 hours, not recommended for opioid-naïve patients or acute pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Methadone</td>
<td>Second-line/third-line</td>
<td>2.5–10 µg po every 4–8 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tramadol</td>
<td>Second-line</td>
<td>50–100 mg every 4–6 hours (IR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Codeine/acetaminophen</td>
<td>Second-line, not recommended in chronic cancer pain</td>
<td>30–60 mg po every 4–6 hours (according to codeine content)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tapentadol</td>
<td></td>
<td>50–100 mg every 6 hours (IR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants – tricyclic</td>
<td>Nortriptyline</td>
<td>First-line</td>
<td>Start as 10–25 mg bedtime</td>
<td>Dry mouth, constipation, dizziness, urinary retention</td>
<td>Cardiac disease, Glaucema</td>
</tr>
<tr>
<td></td>
<td>Desipramine</td>
<td>First-line</td>
<td>Start as 10–25 mg at bedtime</td>
<td>Titrations should be done no less than every few days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amitriptyline</td>
<td>Second-line/third-line</td>
<td>Start as 10–25 mg at bedtime effective as 50–150 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressants – SNRIs</td>
<td>Duloxetine</td>
<td>First-line, effective in prevention of oxaliplatin-associated neuropathic pain</td>
<td>Start as 20–30 mg daily, usually effective in 60–120 mg daily doses</td>
<td>Nausea, sedation, dizziness, edema</td>
<td>Hepatic dysfunction, Renal insufficiency</td>
</tr>
<tr>
<td></td>
<td>Venlafaxine</td>
<td>First-line</td>
<td>225 mg twice daily, 37.5–75 mg daily increase after toleration</td>
<td>Nausea</td>
<td>Hepatic dysfunction, Renal insufficiency</td>
</tr>
<tr>
<td>Antidepressants – norepinephrine–dopamine inhibitors</td>
<td>Buproprion</td>
<td>Third-line</td>
<td>Start as 75 mg twice daily, usually effective in 300–450 mg three times daily doses</td>
<td>Weight loss</td>
<td>Seizures</td>
</tr>
<tr>
<td>Antiepileptics – gabapentinoids</td>
<td>Gabapentin</td>
<td>First-line</td>
<td>Start as 100–300 mg twice daily, usually effective in 300–1,200 mg three times daily doses</td>
<td>Sedation, dizziness, edema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pregabalin</td>
<td>First-line</td>
<td>Start as 25–75 mg twice daily, usually effective in 150–300 mg three times daily doses</td>
<td>Sedation, dizziness, edema</td>
<td>Renal insufficiency</td>
</tr>
<tr>
<td>Topical antineuralgics</td>
<td>Topical lidocaine</td>
<td>First-line in cases with allodynia (level B)</td>
<td>1–3 patches daily, 2 weeks</td>
<td>No systemic side effects</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Topical capsaicin</td>
<td>Second-line/third-line</td>
<td>8% capsaicin, 1 patch daily, usually effective – 3–4 patches daily</td>
<td>Local irritation</td>
<td>Application-related severe pain</td>
</tr>
<tr>
<td>Cannabinoids</td>
<td>Nabiximols</td>
<td>Third-line</td>
<td>Start as 0.5–1 mg once a day, titration maximum to 3 mg</td>
<td>Dizziness, somnolence, and dry mouth</td>
<td></td>
</tr>
</tbody>
</table>

Note: It should be kept in mind that most of the analgesic trials on pain were for nonmalignant pain syndromes.

Abbreviations: po, per os (by mouth); IR, immediate release; ER, extended release; SNRIs, serotonin-norepinephrine reuptake inhibitors.
and peripherally. Bupropion is distinguished from other antidepressants in its efficacy for stimulation in the CNS. It can be used as a first-line drug in patients who are suffering from fatigue or somnolence in addition to NCP. This drug should be used with caution in patients prone to seizures. Bupropion can have a negative effect on cancer patients who are already prone to cancer cachexia.

Antiepileptic drugs – gabapentinoids

Nowadays, physicians dealing with pain focus on disease-modifying therapies rather than simply modifying the symptoms. One of the main pathophysiologic mechanisms of NP is hyperexcitability. Understanding of the importance of hyperexcitability enabled the use of antiepileptic drugs in NCP. The main antiepileptic drugs employed in NCP are gabapentinoids (gabapentin and pregabalin). They act by inhibiting calcium channels on terminals of afferent nociceptors. Both drugs have established efficacy, mainly in diabetic NP and PHN, but pregabalin trials are more focused on central mechanisms.

Gabapentin

Dorsal root ganglia have a central role in NP, since the downregulation of their action results in the inhibition of transduction of spontaneous peripheral nociceptive signals. γ-Aminobutyric acid is an important neurotransmitter of dorsal root ganglia. Gabapentin acts by decreasing the release of glutamate, norepinephrine, and substance P, with ligands on the α,δ subunit of voltage-gated calcium channels. Gabapentin is effective in NCP and specific CINP. Clinical trial data comparing gabapentin and TCA showed equivocal results. It diminishes both tumor- and chemotherapy-induced pain, as well as iatrogenic hot flashes and nausea/vomiting and pain syndromes associated with mucositis. Gabapentin needs several weeks before achieving a steady-state plasma level; therefore, its onset of action is late. One of the main advantages of gabapentin is its effective combination with opioids in the treatment of NCP, especially for allodynia, which is a less responsive type of pain to other combinations of drugs. The most common side effects include dizziness and somnolence, peripheral edema, weight gain, asthenia, and dry mouth.

Pregabalin

Pregabalin has the same mode of action as gabapentin, but has a greater affinity for voltage-gated calcium channels. Its onset of action is faster than gabapentin. Pregabalin improves sleep, quality of life, and daily living abilities to the same extent as gabapentin. Recent trials in NCP showed that pregabalin use is effective in combination with opioids and enables the downtitration of the opioid dose. Somnolence and dizziness are the dose-limiting side effects.

Other antiepileptics

Lamotrigine was thought to be effective, but the results of a new Cochrane review showed that in the presence of highly proven therapies like gabapentinoids and TCAs, lamotrigine is not a beneficial drug for NP. Second-generation anticonvulsants (levetiracetam, oxcarbazepine, tiagabine, topiramate) are used in seizure disorders frequently, since their side effects are reduced and drug interactions are fewer. Carbamazepine and oxcarbazepine have been used in trigeminal neuralgia, but recent studies do not advise their use in PHN or NCP.

NMDA antagonists: ketamine, dextromethorphan, amantadine, magnesium

NMDA is an excitatory neurotransmitter. Its role is significant in chronic NP, since the balance is disrupted between excitation and inhibition. Ketamine is a potent NMDA antagonist among the family, and acts by inhibiting dorsal root ganglia. It is also known to have anti-inflammatory effects; theoretically, it should be a good agent for NCP relief. Its analgesic effect is at subanesthetic doses. However, at lower doses, its serious side effects limit its use. In two recent prospective trials, it was not found to be effective as an adjunct analgesic to opioids, although some controversies exist. The use of ketamine should be reserved for resistant NCP patients, and only applied by pain professionals. There are insufficient data regarding the efficacy and safety of other NMDA antagonists.

Magnesium is an economical and effective approach for the prevention of CINP of oxaliplatin. Especially when infused with calcium, it may decrease resulting numbness, cramps, and difficulty in swallowing. In a recent review, magnesium and calcium infusions were found to be effective in the prevention of CINP.

Topical antineuralgics: lidocaine, capsaicin

Topical analgesia has the potential to be a useful adjunct to treatment of NCP with opioids and/or coanalgesics. The main two groups of drugs that are in use for NP are lidocaine and capsaicin. Lidocaine relieves pain through nonspecific blocking of sodium channels on afferent fibers. Its use is convenient, since no systemic absorption occurs, and only local side
effects are seen. Topical lidocaine is available as a 5% patch or gel. Topical lidocaine is effective in peripheral neuropathic syndromes with allodynia. 143–145 It has been used in CINP and postsurgery in breast cancer patients. 109 Topical lidocaine treatment achieved a sufficient level of analgesia in 50% of patients in a 2-month to 4 year-period. 124 Although absorption is minimal, it should not be used with oral class I antiarrhythmic drugs.

Capsaicin is a natural product found in chili peppers, and is a special ligand of transient receptor potential vanilloid 1 (TRPV1). When capsaicin binds to TRPV1 receptors, calcium influx occurs on heat-receptor membranes and leads to desensitization, and in the long term results in depletion of substance P. 146 There are topical low–moderate dose (0.075%–0.04%) capsaicin preparations, but insufficient data and inconsistent results. 146 The high-dose patch contains 8% capsaicin. The benefits of high-dose preparations have been shown in NP and HIV neuropathy. 147 Common side effects include local erythema, edema, itching, and initial pain necessitating opioids. High blood pressure can be the result of intense pain associated with the drug, and it should be monitored closely. 109

Other drugs: tapentadol, cannabinoids, vitamins

Tapentadol is a new synthetic opioid drug that has an inhibitory effect both on µ-opioid receptors and central norepinephrine uptake. 148 It has a lower affinity for µ-receptors than strong opioids have. In Phase II and III studies, the efficacy of tapentadol has been proved in comparison to placebo and oxycodone. 149,150 Regarding safety, it has been hypothesized that due to low µ-receptor affinity, the drug could have fewer opioid side effects. In 2012, Merker et al published a meta-analysis of reported adverse effects in tapentadol in randomized clinical trials. 151 Typical gastrointestinal side effects (emesis and constipation) were found to be significantly lower, although xerostomia was higher in the tapentadol-received group of patients (relative risk 1.79, 95% confidence interval 1.40–2.29). Those randomized controlled trials were all nononcological trials. Mercadante et al conducted a tapentadol trial in opioid-naive cancer patients. At the end of the study, patients all had a response, with decreases in pain intensity and with no increment of adverse effects. 109 Although the evidence regarding tapentadol is not conclusive yet, its use holds promise.

Cannabinoids are compounds that are effective for pain relief, appetite enhancement, and suppression of emesis via acting on endogenous cannabinoid receptors by imitation of endogenous ligands. 152,153 There are two types of endogenous cannabinoid receptors (CBs): CB1 is active on the CNS, and CB2 is prevalent in the periphery. 8–9-Tetrahydrocannabinol is a partial CB1 and CB2 agonist. The therapeutic potential of cannabinoids has been investigated in chronic pain extensively. In animal models, cannabinoids and opioids were shown to be synergistically effective. 154,155 The oromucosal cannabinoid form is effective in NP associated with multiple sclerosis and peripheral nononcological NP. 11,88,110 In 2012, a novel cannabinoid agent, nabiximols, was studied in a double-blind study of cancer patients. 152 Although the effect on pain intensity was better, the effect size was small, and the incidence of adverse effects and dropout rate were high. Despite the promising results of previous studies, the use of cannabinoids in NCP is not established yet.

Mainstream “natural living” is a popular topic regarding the prevention and treatment of cancer and its related adverse effects. Many studies have examined the roles of vitamin E, vitamin C and α-lipoic acid. 55,112,156,157 There are controversies concerning the results of those studies: although a particular decrease in incidence of NP with the use of vitamin E was shown, 122,158 the results could not be replicated in a large Phase III randomized controlled trial. 159

Combination therapy

The WHO recommends managing pain in a stepwise manner to achieve better pain relief with fewer side effects. However, the efficacy of a single agent is limited, due to both complicated pain mechanisms and dose-limiting adverse effects. There have been many efforts to develop better drugs or favorable combinations of available drugs. Berger et al showed that nearly half of NP patients receive more than two analgesic drugs concomitantly. 160

Ideally, combination treatment should focus on maximum efficiency with less toxicity and minimum drug interaction, and synergistically different mechanisms of action. 161 Nowadays, although there are scarce data, the most common prescribed combinations of analgesics are fixed-dose combinations of NSAID + opioids, NSAID + tramadol, antidepressants + anticonvulsants, and antidepressants + opioids. 161

Chaparro et al analyzed 21 randomized controlled trials (gabapentin + nortriptyline, opioid + TCA, fluphenazine + TCA, opioid + gabapentin/pregabalin) in a Cochrane review. 162 They concluded that many good-quality trials showed the superiority of combination therapy to monotherapy, but a particular combination was not specified. They emphasized the intensification of adverse effects with combinations, particularly sedation. After this Cochrane
review, a few promising studies have been published. The combination of pregabalin and oxycodone has been shown to be operative and safe in previous studies. Garassino et al conducted a study to investigate the practical dose escalation of a pregabalin–oxycodone combination. They showed that the pregabalin dose can be escalated safely, in contrast to recent applications in clinical practice. They showed that if the pregabalin dose is increased slowly, higher doses can be achieved. In 2013, Nishihara et al investigated the impact of mirtazapine on pain in combination with pregabalin in a refractory NP syndrome. Although mirtazapine did not relieve pain when used alone, based on the results of this study, the combination had additive/synergistic effects compared to a doubled dose of pregabalin. One of the interesting points of this study was that the onset of action of the combination was as early as 1 week. A third study from Lazzari et al showed that the addition of low-dose oxycodone–naloxone to the gabapentin–pregabalin combination treated patients successfully, with fewer gastrointestinal side effects.

Nonpharmacological therapy of neuropathic cancer pain

Every cancer patient is unique, with individual presentations of pain. NCP is more complicated than other pain syndromes. It is not always possible to manage pain appropriately and sufficiently by means of drugs, NCP remains refractory, and more techniques or approaches are needed. Nonpharmacological therapies are needed for NCP when drug effects are not adequate or not applicable. The primary nonpharmacological therapies are the treatment approaches targeting the etiology of pain (eg, radiotherapy), invasive symptomatic therapies (eg, nerve blocks), and noninvasive symptomatic therapies (Table 9). Some of these approaches are considered specifically for refractory pain, and some of them are suitable as adjuncts to conventional treatment. Celiac plexus block and splanchnic neurolysis are the most accepted interventions. There are surgical ablative methods, such as cordotomy, myelotomy, and dorsal root entry-zone lesioning. There have been few studies conducted to prove the efficacy of interventional approaches, since it is difficult and unethical to find and apply a sham procedure. Palliative radiotherapy to a specific region (abdominal) or bony metastasis is beneficial. In a recent trial, intrathecal infusion therapy was not found to be beneficial. Cognitive–behavioral interventions and mind–body therapies (relaxation, imagery, hypnosis, and biofeedback) may have a role to play. It is hypothesized that the mechanism of NCP intersects with the pain-relieving mechanism of acupuncture. However, in a recent meta-analysis, Garcia et al emphasized that the results of acupuncture trials in NCP were questionable. Little evidence exists about the effects of psychological therapies. However, cancer pain is multidimensional, and patients may perceive some benefit from physical, rehabilitative, and integrative therapies as well.

Future aspects – conclusion and perspectives

According to the new definition of the IASP, neuropathic pain is defined as “pain arising as a direct consequence of a lesion or disease affecting the somatosensory system”. Although this definition narrows and simplifies NP for physicians, NCP is still underreported, underdiagnosed, and not treated efficiently. Therefore, NCP remains an open area where new treatment approaches are needed urgently. Several treatment options have been studied in randomized controlled trials to shift the paradigm of NP treatment towards more targeted and multimodal agents, and may contribute to treatment of NCP in the future.

Recently, there has been a dramatic increase in efforts to reveal a genetic contribution to the mechanism of perception of pain and a genetic impact on the efficacy and safety of drugs. Genetic polymorphisms that are linked to alterations of pain and a genetic impact on the efficacy and safety of drugs. Genetic polymorphisms that are linked to alterations of pain perception are generally single-nucleotide polymorphisms of genes coding for receptors, ion channels, transcription factors, cytokines, and enzymes. Personal variations in opioid requirements and toxicity have been investigated heavily. The strongest link was found to be the p450 cytochrome 2D6 gene variations. However, there are associations of

### Table 9 Nonpharmacological treatment approaches in neuropathic pain

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<th>Intervventional approaches</th>
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<th>Psychological approaches</th>
<th>Neurostimulation</th>
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<td>Neural blockade – neurolysis</td>
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<td>Hydrotherapy</td>
<td>Relaxation therapy, guided imagery, other types of stress management</td>
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<tr>
<td>Injection therapies</td>
<td></td>
<td>Psychoeducational interventions</td>
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<td>Radiotherapy-ablation therapies</td>
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the catechol-O-methyl transferase, melonocortin-1 receptor, and μ-1 opioid receptor genes in the response to analgesics. 175,178 Another contribution to pain treatment by genetic mechanisms is targeted drug delivery to the PNS using gene therapy. Preclinical studies have been done with nonreplicating virus vectors injected into skin to transduce neurons in the dorsal root ganglion in animal models with neuropathic pain and NCP. Wolfe et al conducted a Phase I trial of gene therapy with herpes simplex virus vectors expressing human preproenkephalin. 179 The primary outcome was safety; pain modulatory effects were shown in moderate–higher doses. A Phase II trial is now underway. In the future, better outcomes will be achieved by the application of further understanding of genetics and molecular biology of pain.

Animals have evolutionary mechanisms for defense and hunting via assorted small molecules. These have attracted the attention of investigators for a long time. One of these is cobratoxin, a nicotinic acetylcholine receptor antagonist, which is analgesic at lower doses, although lethal in higher doses. This molecule in combination with opioids and NSAIDs was investigated in 230 cancer patients with severe pain, and was found to be superior to NSAIDs or analgesic monotherapy. 180 Cone snails have natural substances called conopeptides, and one of these is ziconotide, which was found to be effective in chronic pain. 181–184 It acts via blocking N-type voltage-sensitive calcium channels in the dorsal horn. 185 In 2004, the US Food and Drug Administration approved the intrathecal application of ziconotide in refractory pain conditions. Tetrodotoxin is a sodium-channel antagonist derived from puffer fish. In animal models and in cancer clinical trials, it was found to be beneficial in pain relief. 186–190 In the future, results of these and further studies will have had an impact on pain-management strategies.

CINP is detrimental, besides decreasing the quality of life of cancer patients it interferes with the treatment process and may lead to drug cessations. There is emerging information indicating that proinflammatory cytokines are important in the pathogenesis of CINP. 191,192 Macrophages are accused of being involved in the neuroinflammatory process of the axons and neurons of dorsal root ganglion (DRG) in CINP. In response to chemotherapy-induced hypoxic injury, macrophages secrete or organize other inflammatory cells to produce cytokines (tumor necrosis factor-α, interleukin [IL]-1β, IL-6, IL-8), chemokines (CCL2, CXC family), growth factors, and inflammatory mediators, such as bradykinin, prostaglandins, serotonin, and nitric oxide. 178,191,193 These small molecules have been investigated both as potential targets for treatment and as potential biomarkers of estimation or early diagnosis of NP. Further elucidation of underlying mechanisms of CINP may yield a new vision for targeted therapy of NCP.

There is a rapidly growing body of evidence demonstrating that spinal microglia play an important role in the NP process. Under normal circumstances, microglia are resident macrophages derived from yolk-sac macrophages, and responsible for monitoring of the local environment and protection. 194,195 After a peripheral nerve injury, they transform into active states by hypertrophy, new gene expression (purinergic cell-surface receptors), and proinflammatory cytokines in DRG. 16,196 There are growing numbers of studies trying to elucidate the role of microglial activation and also the astrocyte role in the NP mechanism. 17,197 Inhibition of microglia suppresses hypersensitivity to pain to innocuous stimuli (alldynia), which is one of the hallmarks of NP. In animal models, microglia–neuronal interaction was tested in CINP. 25 It was shown that in rats treated with oxaliplatin, microglia reactivation occurred in the CNS; additionally, astrocytes proliferated and migrated to certain areas of the brain, supporting the hypothesis of astrocyte-related long-term pain persistence. 26 Spinal microglia might be a promising target for treating NCP and CINP.

Ceramide is a proinflammatory and proapoptotic molecule derived from sphingomyelin and by de novo synthesis from serine palmitodyltransferase. 198 In addition to established roles in inflammation and cancer, there are emerging data of their modulatory role in the peripheral and central sensitization of pain processing. 199 Preclinical and clinical pharmacological studies will provide fundamental information about the role of ceramide in pain, and may offer a multilevel approach for the development of analgesics.

Cancer pain includes both the nociceptive and NP components. Cancer itself may be the cause of pain, or treatment processes and pharmaceuticals may lead to pain. NCP is resistant to treatment, and may continue to be present in patients even when the cancer is cured. WHO guidance is still valid for cancer pain, and there is a growing body of evidence for the addition of coanalgesics to treatment. Diagnosis of NCP is burdensome, since most of the time, pain is underreported by patients unless they are asked, and NCP is underrecognized by physicians. Doctors other than pain specialists are afraid of pain and NCP as an esoteric topic. There are no well-established diagnostic tools that can be used by practitioners easily to make the differential diagnosis of NP in everyday practice. Once a diagnosis of NCP is made, opioids, antidepressants, and anticonvulsants should be prescribed. The clinical beneficence of opioids and coanalgesics outweighs the adverse effects.
The armory of NCP is broad and is getting broader as interest in pain mechanisms increases. In accordance with WHO guidelines, appropriate induction of coanalgesics should be recommended. Combination therapies with different pathophysiologic mechanisms are especially supported. This kind of polypharmacy may effectively relieve pain with acceptable side effects. Basic scientific developments and findings have shown new pathophysiologic pathways in NP and NCP. More clinical studies are needed to understand NCP and treat patients accordingly. In the future, new specific disease-modifying agents are expected.

Disclosure
The authors report no conflicts of interest in this work.

References


Neuropathic cancer pain


