PainWeek

Pain Pathways Made Simple

David M Glick, DC, DAAPM, CPE

1

Disclosures

- Nothing to Disclose

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Learning Objectives

- Differentiate between nociceptive and neuropathic pain
- Describe the process of pain transmission
- Identify the specific pain pathways that can be acted upon by common pharmacotherapy classes

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Classification of Pain

- Good pain vs. Bad Pain

Clinical Pearl

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Good Pain

- **Nociceptive Pain**: Purposeful Pain
  - **Eudynia** - being pain linked to normal tissue function or damage
  - Non-maldynic Pain
  - Adaptive

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Bad Pain

- **Neuropathic Pain**: Non-purposeful Pain
  - **Maldynia** - pain linked to disorder, illness or damage
  - i.e may be abnormal, unfamiliar pain, assumed to be caused by dysfunction in PNS or CNS

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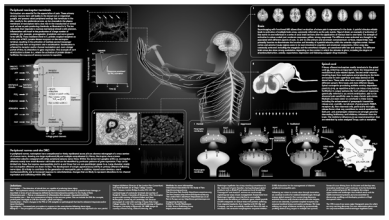
Pain Mechanisms



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Adapted from Nature Reviews – Neuroscience, Stephen McMahon & David Bennett, 2007.

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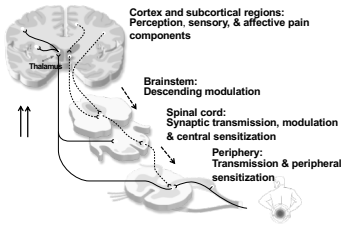
General Anatomy of Pain



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- Adapted from Von Hehn CA, Baron R, Woolf CJ. Deconstructing the neuropathic pain phenotype to reveal neural mechanisms. *Neuron*. 2012; 73(4):638-652.

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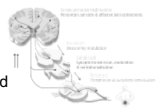
Pain Roadmap:
Peripheral and Central Nervous System Landmarks

- Physiologic process involving multiple areas of the nervous system
- Bidirectional
- Involves normal as well as pathological processes
- A sensory experience associated with affective and cognitive responses
- Dynamic (i.e. occurring in real time)
- Adapts or changes in response to function – "**Neuroplasticity**"



1. Gardner EP, et al. In: Kandel E, et al, eds. *Principles of Neural Science*. 4th ed. McGraw-Hill Medical; 2000; chapters 21-23.

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Pathophysiologic Classification of Pain

- **Nociceptive -** Purposeful pain
  - Somatic or visceral linked to normal tissue function or commensurate with identifiable tissue damage
- **Inflammatory Pain –** Usually involves tissue damage
  - **Localized chemical soup of inflammatory mediators**
- **Neuropathic -** Non-purposeful pain
  - May be abnormal, unfamiliar pain, probably caused by dysfunction in PNS or CNS
- **Functional Pain -** Dysfunctional pain
  - Non-neuropathic, non-inflammatory, often ill defined

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changes 2008. http://www.iasp-pain.org/AM/Template.cfm?Section=General&Template=/CM/ContentDisplay.cfm&ContentID=5693. Published November 2007. Accessed May
Pain pathways and acute pain processing. In: Sinatra RS, et al, eds. *Acute Pain Management*. New York, NY: Cambridge University Press; 2009:3-20.

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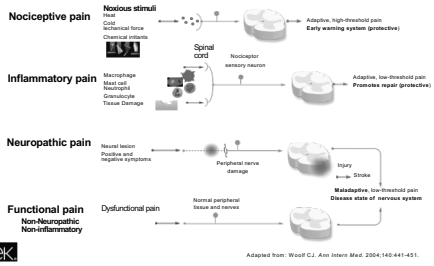
Classification of Pain



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Adapted from: Woolf CJ. *Ann Intern Med*. 2004;140:441-451.

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Nociceptive vs Neuropathic Pain

1. Portenoy RK, Kanner RM. In: Portenoy RK, et al, eds. *Pain Management: Theory and Practice*. Philadelphia, PA: FA Davis Company;1996:4.
Galer BS, Dworkin RH. *A Clinical Guide to Neuropathic Pain*. Minneapolis, MN: McGraw-Hill Companies Inc; 2000:8-9.

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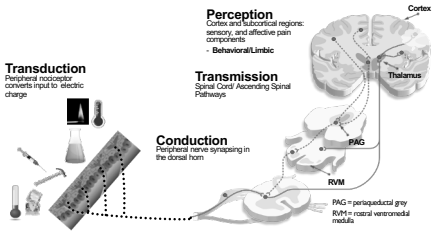
Pain Pathway Steps



Adapted from Scholtz J, Woolf CJ, Nat Neuroscience, 2002;5:1062-1067

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Transduction: Processing at Peripheral Nerve Endings

- Conversion of mechanical, thermal or chemical stimuli into an electric charge
- Involves
  - receptors activated directly by stimuli
  - injury/inflammatory response

Adapted from Dougherty PM, et al. Neurochemistry of somatosensory and pain processing. In: Benzon H, et al, eds. *Essentials of Pain Medicine*. Philadelphia, PA; Saunders; 2011: chapter 2.

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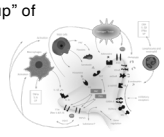
Peripheral Sensitization

After injury, a peripheral nervous system neuron becomes abnormally sensitive to stimuli, resulting in either or both

- Decreased threshold for activation
- Increased rate of firing

Mechanism of action*

- Tissue damage releases sensitizing "soup" of cytokines & neurotransmitters
- COX-mediated PGE2 release
  - These events are thought to be based on a number of changes at the cellular/molecular level, including changes in receptors and ion channels.



1. Baron R. Mechanisms of disease: neuropathic pain--a clinical perspective. *Nat Clin Pract Neurol*. 2006;2(2):95-106.
Figure: Adapted from Dougherty PM, et al. Neurochemistry of somatosensory and pain processing. In: Benzon H, et al, eds. *Essentials of Pain Medicine*. Philadelphia, PA; Saunders; 2011: chapter 2

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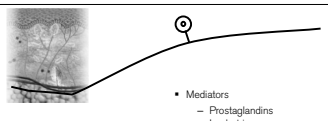
How is Pain Transduced?



- Nociception
  - Mechanical
  - Thermal
  - Chemical
- Mediators
  - Prostaglandins
  - Leukotrienes
  - Substance P
  - Histamine
  - Bradykinin
  - Serotonin
  - Hydroxyacids
  - Reactive oxygen species
  - Inflammatory cytokines and chemokines

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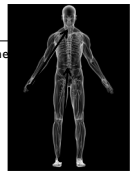
Conduction

Transfer of noxious impulses from primary nociceptors to cells in the spinal cord dorsal horn along the peripheral nerve.



Primary Nociception Fibers

Aδ – Fast/First Pain
Large diameter
C-fibers – Slow/second pain
Small diameter

Non- Nociception Fibers
(Proprioception)
Aβ – Muscle spindle, touch & kinesthesia
Larger diameter, myelinated

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Pain pathways and acute pain processing. In: Sinatra RS, et al, eds. *Acute Pain Management*. New York, NY: Cambridge University Press; 2009:3-20.
Figure adapted from Binder A, et al. Disease mechanisms in neuropathic itch. *Nat Clin Pract Neurol*. 2008;4(6):329-333.

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Primary Nociception

- **A-delta fibers**
  - Small receptive fields
  - Thermal & mechanical
  - Myelinated
  - Rapidly conducting
    - 10-30 m/sec
  - Large diameter

- **C-fibers**
  - Broad receptive fields
  - Polymodal
  - Unmyelinated
  - Slower conducting
    - .5-2.0 m/sec
  - Cross sensitized
  - Small diameter

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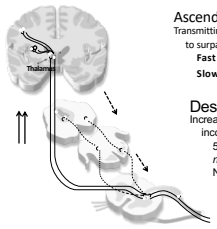
Transmission & Modulation



Ascending nociceptive pathways
Transmitting nociceptive impulses from the dorsal horn to surpaspinal targets
Fast *(green)* Neospinalthalamic
Slow *(yellow)* Paleospinalthalamic

Descending inhibitory tracts *(blue)*
Increased activation leads to a decrease in volume control of incoming nociceptive signals reaching the brain
5-HT – **Serotonin - both excitatory & inhibitory*** (*may not lead to pain relief*)
NE – **Norepinephrine - Inhibitory**

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* Adapted from Von Hehn CA, Baron R, Woolf CJ. Deconstructing the neuropathic pain phenotype to reveal neural mechanisms. *Neuron*. 2012; 23;73(4):638-652.

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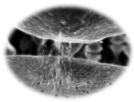
Transmission & Modulation

- **Excitatory Transmitters**
  - Substance P
  - Calcitonin gene related peptide
  - Aspartate, Glutamate
- **Inhibitory Transmitters** *(Descending Inhibitory Pathways)*
  - GABA
  - Glycine
  - Somatostatin
  - α_2 agonists



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Role of Neuronal Plasticity in Pain

- Nervous system changes in
  - Neuronal structure
  - Connections between neurons
  - Quantity/properties of neurotransmitters, receptors, ion channels
- Decreases body's pain inhibitory systems (Increased Pain)
- Injury, inflammation, and disease are culprits
- Produces short-term and permanent changes
- Pivotal to the development of hypersensitivity of inflammatory pain

- Enables NS to modify its function according to different conditions or demands placed upon it.

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How Acute Pain Becomes Chronic

- Peripheral Sensitization
  - Tissue damage releases sensitizing "soup" of cytokines & neurotransmitters
  - COX-mediated PGE2 release
  - Sensitized nociceptors exhibiting a decreased threshold for activation & increased rate of firing
- Central Sensitization –Resulting from noxious input to the spinal cord
  - Resulting in hyperalgesia, & allodynia

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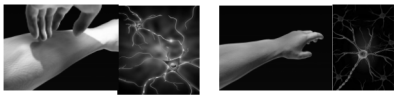
Definitions

- **Hyperalgesia**
  - Lowered threshold to different types of noxious stimuli
- **Allodynia**
  - Painful response to what should normally be non-painful stimuli



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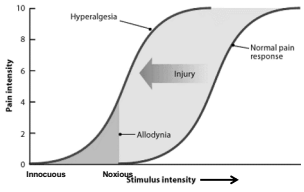
Neuroplasticity in Pain Processing



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1. Woolf CJ, Salter MW. Science. 2000;288:1765-1768.
2. Ringkamp M, Meyer RA, Raja SN, Campbell JN. Peripheral mechanisms of cutaneous nociception. In: Wall and Melzack's Textbook of Pain. 5th ed. Edinburgh: Elsevier Churchill Livingstone; 2006:11-26.
3. Cervero F, Laird JMA. Pain. 1996;68:13-23.

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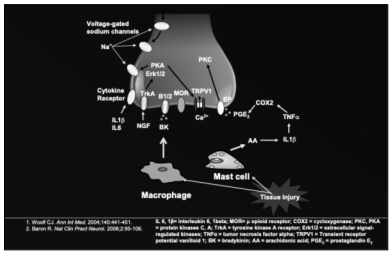
Neuroplasticity in Peripheral Pain Transmission



1. Woolf CJ. *Ann Int Med.* 2004;140:441-451.
2. Baron R. *Nat Clin Pract Neurol.* 2006;2:95-106.

IL 6, 1β= interleukin 6, 1beta; MORr = opioid receptor; COX2 = cyclooxygenase; PKC, PKA = protein kinases C, A; TrkA = tyrosine kinase A receptor; Erk1/2 = extracellular signal-regulated kinases; TNFα = tumor necrosis factor alpha; TRPV1 = Transient receptor potential vanilloid 1; BK = bradykinin; AA = arachidonic acid; PGE_2 = prostaglandin E_2

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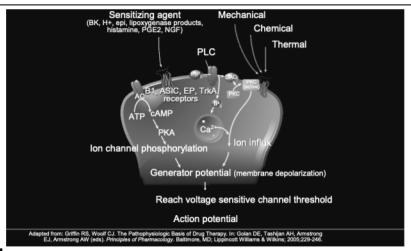
Peripheral Sensitization



Adapted from: Griffin RS, Woolf CJ. The Pathophysiologic Basis of Drug Therapy. In: Golan DE, Tashjian AH, Armstrong EJ, Armstrong AW (eds). *Principles of Pharmacology.* Baltimore, MD: Lippincott Williams & Wilkins; 2005:229-246.

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Central Sensitization

- Activation
  - "Wind up" of dorsal horn nociceptors
- Modulation
  - Excitatory/Inhibitory neurotransmitters
- Decreased central inhibition of pain transmission
  - NE/5HT

Prime role in chronic pain, particularly neuropathic pain

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Definitions

- Wind Up
  - Causes long-term changes in nociceptive neurons, which become hyperexcitable such that they respond to lower stimuli
    - NMDA-type glutamate receptors play an important role in this process 1,2,3,4
  - Prolonged opening of the ion channels enables greater influx of calcium and sodium across the post-synaptic membrane and greater excitation of nociceptive neurons 2,3

1. Kandel ER, Schwartz JH, Jessell TM , editors. Principles of Neural Science (Fourth Edition). New York: McGraw Hill (Health Professions Division). 2000;A72-491.
2. Millan MJ. Progress in Neurobiology 1999;57:1-164.
3. Dickenson AH. Brit J Anaesthesia 1995;75:193-200.
4. Suzuki R and Dickenson AH. Neuroreport 2000;11:R17-21.

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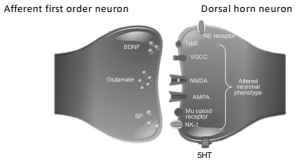
First Order Synapse – Dorsal Horn



NK-1 = Neurokinin 1 receptor; AMPA = alpha-amino-3-hydroxy-5-methyle 4-isoxazolepropionic acid; NMDA = N-methyl-D-aspartic acid; VGCC = voltage gated sodium channel; TrkB = tropomyosin receptor kinase B; BDNF = Brain derived neurotrophic factor; SP = substance P

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Adapted from Schlotz J, Woolf CJ. Nat Neuroscience. 2002;5:1062-1067

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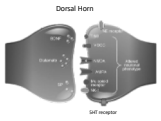
Central Sensitization



Key Influences upon signal propagation

- Excitatory Neurotransmitters
  - Substance P, CGRP, Glutamate
- NMDA Channel Activity
  - Glutamate binding
  - Altering channel activity
- Descending inhibitory tracts
  - NE/Serotonin (5HT)
- Mu opioid receptor

NK-1 = Neurokinin 1 receptor; AMPA = alpha-amino-3-hydroxy-5-methyle 4-isoxazolepropionic acid; NMDA = N-methyl-D-aspartic acid; VGCC = voltage gated sodium channel; TrkB = tropomyosin receptor kinase B; BDNF = Brain derived neurotrophic factor; SP = substance P; CRGP = Calcitonin gene related peptide

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Adapted from Schlotz J, Woolf CJ. Nat Neuroscience. 2002;5:1062-1067

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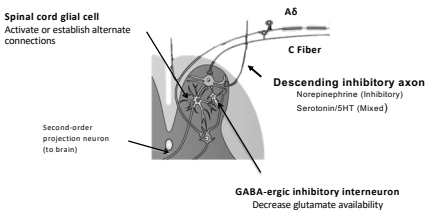
Dorsal Horn of the Spinal Cord Serves as a Relay Station in Pain Processing [1,2]



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Adapted from: 1. Baron R. Mechanisms of disease: neuropathic pain-a clinical perspective. *Nat Clin Pract Neurology*. 2006;2:95-106.
2. Woolf CJ. Pain: moving from symptom control toward mechanism-specific pharmacologic management. *Ann Int Med*. 2004;140:441-451.

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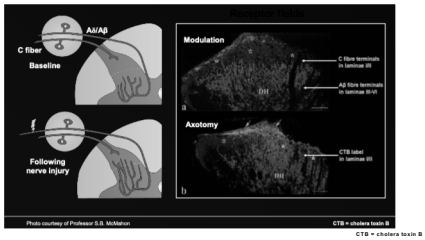
Neuroplasticity: Neural Reorganization



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CTB = cholera toxin B

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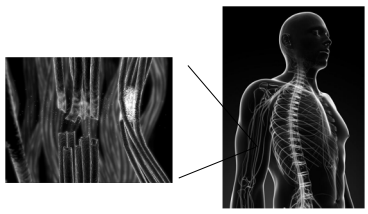
Neuroplasticity: Cross Talk



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CTB = cholera toxin B

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Central Sensitization:
Neuroplasticity in Spinal Cord Processing

- Definition: Altered function of neurons or synaptic activity
- Mechanisms of central sensitization may include:
  - Changes effecting glutamate / NMDA receptors activity
    - Reduced threshold for activation
    - Increased availability of Glutamate
    - Increased influx of Na^+/Ca^+ (receptor open longer)
  - Modulation – Excitatory/Inhibitory neurotransmitters
  - Decreased tone - descending inhibitory pathways[2]
  - Activation/migration of glial cells into the spinal cord[3]
  - Changes in the thalamus and primary somatosensory cortex[4]

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1. Mannion RJ, Woolf CJ. *Clin J Pain*. 2000;16(3):S151-S153. 2. Ossipov MH, et al. *Ann NY Acad Sci*. 2000;909:12-24.
3. Wieseler-Frank J, et al. *Neurosignals*. 2005;14:166-174. 4. Guilbaud G, et al. *Exp Brain Res*. 1992;92:227-245.

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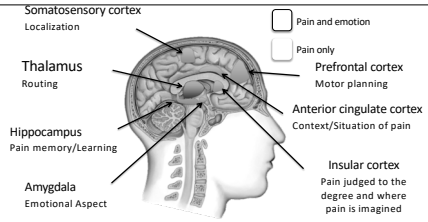
Brain Regions Involved in Pain Processing



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Apkarian AV et al, Eur J Pain 2005;9:463-484

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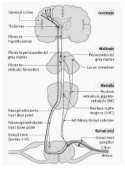
Analgesics That Modify Pain Processes



- Transduction
  - NSAIDs
  - Antihistamines
  - Membrane stabilizing agents
  - Local anesthetic cream
  - Opioids
  - Bradykinin & Serotonin antagonists
- Transmission/Modulation
  - Spinal opioids
  - α_2 agonists
  - NMDA receptor antagonistic
  - NSAIDs
  - NO inhibitors
  - K^+ channel openers
- Conduction
  - Local anesthetics
    - Peripheral nerve, plexus, epidural block
- Perception
  - Parenteral opioids
  - α_2 agonists
  - General anesthetics

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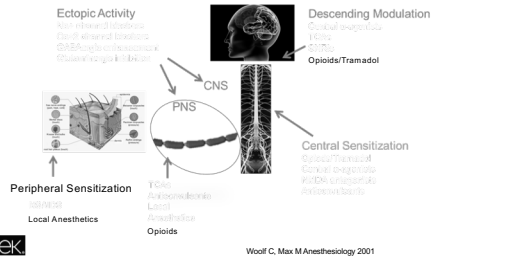
Pharmacological Targets in Pain



Woolf C, Max M Anesthesiology 2001

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Non-Pharmacologic Treatments Reliant Upon Pain Pathways

- Classic Neuromodulation (Implantable spinal and extraspinal)
- External devices (Transcutaneous)
  - Quell (NeuroMetrix) – Musculoskeletal Pain (neck, back, etc.)
  - Nerivio Migra (Theranica Bio-Electronics) – Acute Migraine
  - Cefaly (Cefaly US) – Acute migraine without aura
  - Livia (iPulse Medical) – Menstrual cramps
  - ActiPatch (BioElectronics) – Musculoskeletal pain

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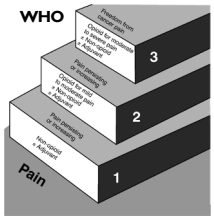
The Chronic Pain Armamentarium

Nonopioids
- Acetaminophen
- NSAIDs
- COX-2 inhibitors

Opioids
- Mu-opioid agonists
- Mixed Agonist-antagonists

Adjuvant analgesics
- Antidepressants
- Anticonvulsants
- Topical agents/local anesthetics



IC Ballegooie Oncologist 2001;6(6):567-75. © AlphaMed Press; WHO, 2005

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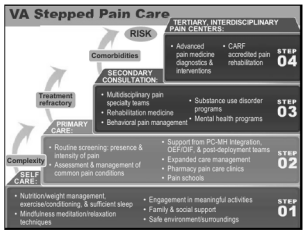
VA DoD Stepped Pain Care Model



PCSS-O Webinar Implementation of the National Pain Strategy and Safer Opioid Prescribing: A Military Perspective, Buckenmaier C (COL) ret, Aug 24, 2016

JAMA Intern Med. 2015;175(5):682-689. doi:10.1001/jamainternmed.2015.97

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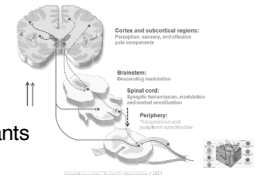
Common Pharmacologic Therapies

- Acetaminophen
- NSAIDS
- Antiepileptics
- TCAs
- SNRIs
- Topicals
- Muscle Relaxants
- Opioids



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Nonopioids: Acetaminophen

Example
- Acetaminophen

Mechanism of Action
- Inhibits prostaglandin production in CNS; antipyretic activity
- No effect on blocking peripheral prostaglandin production; no anti-inflammatory or antirheumatic activity

FDA Warning
- Potential severe liver damage if over-used
- Stevens-Johnson Syndrome & toxic epidermal necrolysis

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Nonopioids: NSAIDs

Examples
- Acetylated (aspirin); nonacetylated (diflunisal); acetic acid (diclofenac); propionic acid (naproxen); fenamic acid (mefenamic acid); enolic acids (piroxicam); nonacidic (nabumetone); ibuprofen, selective COX-2s (celecoxib)

Mechanism of Action
- Exhibit both peripheral and central effects; antiinflammatory and analgesic effects
- Inhibition of cyclooxygenase and prostaglandin production
- Inhibition of leukotriene B4 production
- Lipoxins (signaling resolution of inflammation)

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Opioids

Examples
- Morphine, hydromorphone, fentanyl, oxycodone, oxymorphone, meperidine, codeine, methadone, tramadol

Mechanism of Action
- Bind to opioid receptors in the central nervous system (CNS) to inhibit transmission of nociceptive input from periphery to spinal cord
- Activate descending pathways that modulate transmission in spinal cord
- Alter limbic system activity; modify sensory and affective pain aspects

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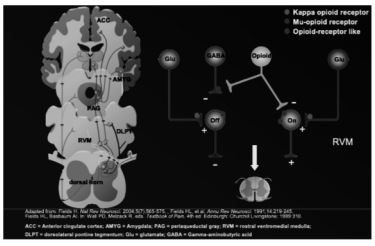
Overview of Descending Pain Inhibitory Pathways and Modulation of Pain Response



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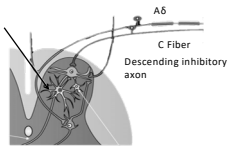
Modulation of Central Sensitization by 5-HT & NE Descending Pathways



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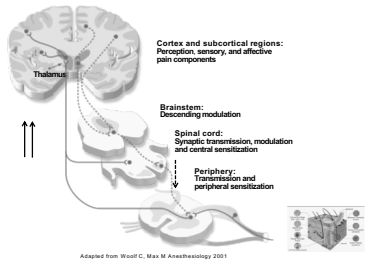
Mechanism of Action - Opioids



Adapted from Woolf C. Max M Anesthesiology 2001

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Adjuvant Analgesics: Tricyclic Antidepressants

Examples
- Amitriptyline, desipramine, doxepin, imipramine, nortriptyline

Mechanism of action
- Reduction in action potential firing of sodium channel activity
- Inhibition of reuptake of NE and 5-HT
- Analgesia is independent of antidepressant function
- High side effect profile (tolerability),
  - cardiotoxic (overdose)

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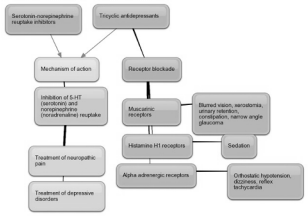
TCAs and SNRIs Pharmacological Properties



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http://pharmacologycorner.com

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SSRIs (Selective Serotonin Reuptake Inhibitors)

Examples

– Citalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline

Mechanism of action

– Selectively inhibit 5-HT reuptake without affecting NE

Therefore, no pain relief expected!

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Serotonin

- **International Union of Pure and Applied Chemistry nomenclature**
  - **5-Hydroxytryptamine (5-HT)**
  - monoamine neurotransmitter, biochemically derived from tryptophan
  - **receptors** are a group of G protein-coupled receptors (GPCRs) and ligand-gated ion channels (LGICs) found in the central and peripheral nervous systems

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Serotonin/5-HT Receptors

Family	Type	Mechanism	Potential
5-HT$_1$	G_i/G_o-protein coupled.	Decreasing cellular levels of cAMP.	Inhibitory
5-HT$_2$	G_q/G_{11}-protein coupled.	Increasing cellular levels of IP$_3$ and DAG.	Excitatory
5-HT$_3$	Ligand-gated Na^+ and K^+ cation channel.	Depolarizing plasma membrane.	Excitatory
5-HT$_4$	G_s-protein coupled.	Increasing cellular levels of cAMP.	Excitatory
5-HT$_5$	G_i/G_o-protein coupled.[4]	Decreasing cellular levels of cAMP.	Inhibitory
5-HT$_6$	G_s-protein coupled.	Increasing cellular levels of cAMP.	Excitatory
5-HT$_7$	G_s-protein coupled.	Increasing cellular levels of cAMP.	Excitatory

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http://en.wikipedia.org/wiki/5-HT_receptor

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Serotonin/5-HT Receptors

- 5-HT1a (Blood Ves/CNS)
  - Addiction
  - Aggression
  - Anxiety
  - Appetite
  - BP
  - Cardiovascular function
  - Emesis
  - Heart Rate
  - Impulsivity
  - Memory
  - Mood
  - Nausea
  - Nociception
  - Penile Erection
  - Pupil Dilatation
- 5-HT1a *(cont)*
  - Respiration
  - Sexual Behavior
  - Sleep
  - Sociability
  - Thermoregulation
- 5-HT5a & 5-HT6 (CNS)
  - Locomotion
  - Sleep
  - Anxiety
  - Cognition
  - Learning
  - Memory
  - Mood

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http://en.wikipedia.org/wiki/5-HT_receptor

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SNRIs (Serotonin/Noradrenaline Reuptake Inhibitors)

Examples

–duloxetine, milnacipran, and venlafaxine

Mechanism of action

–Block reuptake of 5-HT and NA

- (better tolerated, lower tendency for drug-drug interactions, better overdose safety)

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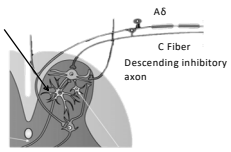
Modulation of Central Sensitization by 5-HT & NE Descending Pathways



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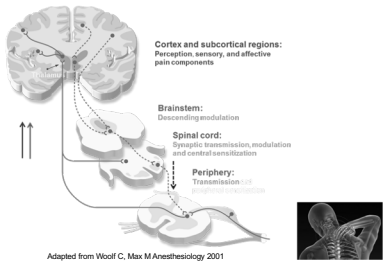
Site of Action - SNRIs



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Adapted from Woolf C, Max M Anesthesiology 2001

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Adjuvant Analgesics: Antiepileptics

Examples

- Gabapentin, pregabalin*, carbamazepine, phenytoin, divalproex sodium, clonazepam, levetiracetam, topiramate, lamotrigine

Mechanism of action

- Suppress neuronal hyperexcitability via
  - Reducing neuronal influx of sodium (Na+) and calcium (Ca+ +)
  - Direct/indirect enhancement of GABA inhibitory effects
  - Reduce activity of glutamate and/or blocking NMDA receptors
  - Binds the α2δ subunit of voltage gated Ca+ channels, inhibit NT release

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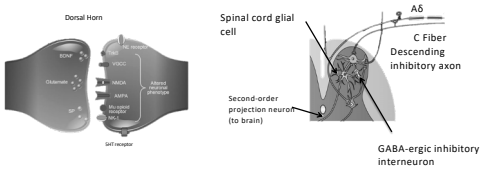
Site of Action - Antiepileptics



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Adjuvant Analgesics: Topicals

Examples
- Lidocaine Patch 5% , eutectic, mixture of lidocaine and prilocaine
- capsaicin cream/patch
- Diclofenac (cream/liquid/gel/patch)

Mechanism of action
- Block sodium channels and inhibit generation of abnormal impulses by damaged nerves
- Depletion of peripheral small fibers and therefore Substance P release from sensory nerve endings
- Target local inflammatory response

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Muscle Relaxants

- Decrease tone of skeletal muscles
- Subclasses
  - Neuromuscular blockers
    - Act at the neuromuscular junction
    - Often used in surgery to cause temporary paralysis
  - Spasmolytics
    - Centrally acting

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Muscle Relaxants - Spasmolytics

- Enhancing the level of inhibition
  - mimicking or enhancing the actions of endogenous inhibitory substances, such as GABA
- Reducing the level of excitation.
- Common examples
  - cyclobenzaprine (TCA) methocarbamol, carisoprodol (barbiturate like effects), tizanidine (α-2 agonist), baclofen (GABA agonist), orphenadrine (diphenhydramine/antihistamine)
- Common adverse effects
  - sedation, lethargy & confusion (cyclobenzaprine), dependence (carisoprodol)

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Case Study

- 54 year-old with three year history of neck, shoulder and upper extremity pain following a lifting injury
  - Current Medications
    - Fluoxetine
    - Milnacipran
    - Gabapentin
    - Clonazepam
    - Alprazolam
    - Methocarbamol
    - Tapentadol
    - Acetaminophen and propoxyphene
    - Zolpidem
    - Diclofenac topical
    - Acetaminophen

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Importance for Understanding Pain Mechanisms

- Allow for rational rather than empirical approach to pain control
- Foster the development of diagnostic tools to identify specific pain mechanisms
- Facilitate pharmacotherapies that act on specific pain pathways and mechanisms
- Reduce the number of pharmacotherapies and incidence of drug-related adverse events (rationale polypharmacy)
- Enhances use of non-pharmacologic treatments
- Improve overall patient care and outcome
  - Tailoring treatment based on the individual patient and pain type
- Do not forget to look for the spear

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