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## Pregabalin in Postherpetic Neuralgia A Viewpoint by Robert W. Johnson

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Gabapentin has deservedly become a standard, if relatively expensive, therapy for postherpetic neuralgia (PHN). In a systematic analysis of published studies, the NNT (number needed to treat) with gabapentin for a 50% reduction in pain was approximately 4.39; the NNH (number needed to harm) was 4.07 for minor harm and 12.25 for major harm.<sup>[1]</sup> Tricyclic antidepressants (e.g. amitriptyline), opioid analgesics (e.g. oxycodone) and topical agents (e.g. lidocaine [lignocaine]) remain the main alternatives (or adjuvants) to gabapentin. That improved therapy is required to manage PHN is undoubted.

Pregabalin is assumed to have a similar mode of action compared with gabapentin, but may have characteristics that make its use preferable. Tested in various doses against placebo, it was shown to be effective and well tolerated, with a similar (dose dependent) adverse event profile to that of gabapentin. Ultimately, only head-to-head studies and wider clinical experience will reveal whether pregabalin is

advantageous compared with its older (now generic) and well tried cousin. Easier dose prescription with better compliance may prove to be a deciding factor. It should always be remembered that dose adjustment and compliance in clinical practice are unlikely to match those under the conditions of a clinical trial; hence, in clinical practice, results may not be as good (effectiveness versus efficacy). A drug that has a clear target dose to be achieved in a fixed time period may improve this compliance and compensate for poor monitoring.

In conclusion, pregabalin is a new treatment for PHN that appears safe and effective and has a relatively rapid onset of action. It remains conjectural whether a combination of drugs, such as tricyclic antidepressants with gabapentin-like drugs, offers added benefit to PHN sufferers, or whether such drugs administered during active herpes zoster afford any protection against PHN.

## Reference

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