

Pregabalin-misuse

OP Kapoor

Gabapentin was brought in the market to be used, wherever Carbamazepine type of drugs were indicated.

Recently the market is flooded with preparations of Pregabalin with or without Vitamin B₁₂ etc. This drug is recommended for 'neuropathic' pain. A capsule of 150 mg costs nearly Rs. 80/-! Recently, I suffered a prolapsed disc while playing tennis and developed severe root pain of sciatica for which I was prescribed bed rest and Pregabalin! I did not take it. I am writing this article after I saw a Rajasthani housewife last week, who had a thoracic backache (unusual site) and was prescribed Pregabalin in a small Rajasthani town (may be village). The investigations showed a malignancy in the lung with secondary deposits in the bones!

Pharmaceutical industry is the richest industry in the world. The easy way to make money is to lure the family physicians and practitioners to prescribe and earn life time pension as in the case of a product like Colgate tooth paste! Here I must emphasize that the word 'neuropathic' pain is more of a layman's diagnosis and not of an allopathic one. For example, if the pain is in the area of the root, more often the cause is compression like that in the cervical spondylosis or lumbar disc disease and pain is due to 'radiculopathy'.

Coming to 'peripheral neuropathy' or 'neuritis', the most common cause is diabetes and/or alcohol, and a very long list of rare causes. In my practice, it is one disease, where

Ex. Hon. Physician, Jaslok Hospital and Bombay Hospital, Mumbai. Ex. Hon. Prof. of Medicine, Grant Medical College and JJ Hospital, Mumbai 400 008.

I ask for maximum investigations including nerve conduction studies and a nerve biopsy in the end! The other tests I ask for are blood tests for connective tissue disorder, liver, kidney diseases, Vitamin B₁₂ blood levels (and other B complex), H.I.V., HBs Ag, Toxi A and B (to exclude iatrogenic causes or addictions), tumour markers, porphyrins, etc.

Therefore, ascertaining the cause of 'neuritis' pain and treating it is the proper treatment. And in the end, if the nerve biopsy shows involvement of the blood vessels supplying the nerve, may be large doses of steroids may be the proper treatment. In short, investigate a 'case of peripheral neuritis' as much as possible. But all over the world in 30% of the cases, no cause can be detected. In idiopathic neuropathy (Neuritis) patients (who form 30% of chronic neuropathy in whom all investigations are normal) alternative medicine may be tried, but certainly not a drug, which costs Rs. 100/- to Rs. 200/- per day, and which is recommended for 'Neuropathic' pain (a layman's word). Homoeopathic, ayurvedic, acupuncture or 'passage of time' will work as well as Pregabalin!

Then there is a common neuralgia-which is post herpetic neuralgia-an age old entity – very difficult to treat. Now that acyclovir is used in full doses during the attack of Herpes Zoster, the incidence of this neuralgia is becoming less. But surely yes, any drug like amitriptyline, carbamazepine, gabapentin and now pregabalin may be used. If cost effectiveness is a problem, surely amitriptyline is preferable, because at the cost of pregabalin, the amount of relief should be

like magic!

The rest of the indications advocated for pregabalin are surely enough not vague backaches (where GP cannot exclude neuropathy!) for which GPs have started prescribing this drug and wasting patient's precious money.

Finally, (it is not playing on the word), though, peripheral neuritis can be called as peripheral 'neuropathy' when we say porphyria can cause poly-neuritis, it sounds as if it was an organic disease like-Beri-Beri – but the use of 'neuropathy' sounds as if you are introducing the subject to R.M.P or quack

doctors. Yes, if the representatives show the published reports from a leading well known medical journal with a 'peer review' – then one would accept the use of such a costly drug even in non-affording patients. Years back, the word 'neuritis' was more often used but recently 'neuropathy' is being used in all text books. Neuritis sounds more like an organic illness.

The pharmaceutical industry takes advantage of it and uses the word 'pain' for neuropathic pain. In neuropathy the patient complains of paraesthesia and burning rather than pain complained of a 'backache' patient.

METABOLICALLY HEALTHY BUT OBESE INDIVIDUALS

A subset of obese individuals seems to be protected against obesity-related metabolic complications. The metabolic profiles of metabolically healthy but obese individuals are almost indistinguishable from those of young lean individuals. Furthermore, a longitudinal study reported that the protective metabolic profile of these individuals was associated with low incidences of type 2 diabetes and cardiovascular diseases.

Upto 30% of obese people seem to be metabolically healthy, and a recent study of US adults 20 years and older reported that 31.7% of obese adults (about 19.5 million people) were metabolically healthy. However, metabolically benign obesity is not without risk. Obesity is associated with other non-metabolic complications (e.g., osteoarthritis and obstructive sleep apnoea).

The following methods have been used to identify such individuals: the hyperinsulinaemic-euglycaemic clamp (infusion of glucose $> 8 \text{ mg min}^{-1} \text{ kg}^{-1}$ of lean body mass, upper quartile of glucose disposal rates), the upper quartile of an insulin sensitivity index derived from oral glucose-tolerance tests, fewer than two cardiometabolic abnormalities (systolic/diastolic $\geq 130/85$ mm Hg, triglycerides, ≥ 1.7 mmol/L, glucose ≥ 5.6 mmol/L, homoeostasis model assessment [HOMA] > 5.13 , high-sensitivity C-reactive protein > 0.1 mg/L, HDL < 1.3 mmol/L); and meeting four of five metabolic factors (HOMA ≤ 2.7 , triglycerides ≤ 1.7 mmol/L, HDL ≥ 1.3 mmol/L, LDL ≤ 2.6 mmol/L, high-sensitivity C-reactive protein ≤ 3.0 mg/L). Despite the differences in the methods used to distinguish between metabolically healthy but obese and at-risk obese people, we observe some recurrent characteristics, such as a favourable lipid profile and lower visceral fat content.

An important question that seems to be unresolved is whether metabolically healthy but obese individuals would gain any metabolic benefit from dietary or exercise intervention.

A better understanding of metabolically benign obesity has important implications.

The Lancet, 2008; : 372 : 1281-1282.