Conclusion: the combination of duloxetine (60 mg/d) and pregabalin (300 mg/d) is possibly no more likely than either high-dose duloxetine (120 mg/d) or high-dose pregabalin (600 mg/d) to improve pain. (SMD -0.10; 95% CI, -0.33 to 0.13, low confidence, 1 Class II study).

Duloxetine vs nortriptyline

One new Class II study[73] was identified. In this Class II study, participants were randomized to duloxetine (n = 61) 30–60 mg daily vs nortriptyline (n = 57) 25–75 mg/d.[73] At 6 weeks, a significant large reduction in pain favoring duloxetine compared with nortriptyline was observed (SMD 1.64; 95% CI, 0.63–2.65).

Conclusion: duloxetine is possibly more likely than nortriptyline to improve pain (SMD 1.64; 95% CI, 0.63–2.65; large effect, low confidence; 1 Class II study).

Pregabalin and N-acetylcysteine vs pregabalin alone

One new Class II study[74] was identified. In this Class II study, participants were randomized to pregabalin (150 mg/d) and N-acetylcysteine (600 mg twice per day) (n = 43) vs pregabalin alone (n = 47) 150 mg/d. At 8 weeks, a significant large reduction in pain favoring pregabalin and N-acetylcysteine compared with pregabalin alone was observed (SMD 1.00; 95% CI, 0.56–1.44).

Conclusion: pregabalin and N-acetylcysteine is possibly more likely than pregabalin alone to improve pain (SMD 1.00; 95% CI, 0.56–1.44; large effect, low confidence; 1 Class II study).

γ-linolenic acid vs α-lipoic acid

One new Class II study[75] was identified. In this Class II study, participants were randomized to γ-linolenic acid (n = 35) 320 mg daily vs α-lipoic acid (n = 38) 600 mg/d. At 12 weeks, a significant difference in pain reduction was not observed (SMD 0.34; 95% CI, -0.12 to 0.80).