

The management requires a holistic approach with biological, psychological and social components. Few studies have specifically looked at medications used in CPPPS [431]; therefore, a wider look at the literature has been undertaken and further specific research is required. The agents concerned are divided for ease of description. Combinations often provide a greater benefit than individual agents [432]. They may also allow lower individual dosages and thus minimise side-effects. The aim of using these drugs is to allow patients to improve their QoL. This is best measured by assessing their function as well as pain severity. If the use of these agents does not allow this, then they should be withdrawn. Unfortunately, the failure of one agent does not exclude potential benefit of an alternative. If the benefit is limited by side-effects, then the lowest effective dose should be found (by dose titration). Sometimes, patients will prefer a higher level of pain and have fewer side effects.

5.2.2.1 *Mechanisms of action*

Mechanisms of action are discussed as appropriate under the drug headings below.

5.2.2.2 *Comparisons within and between groups in terms of efficacy and safety*

Paracetamol (acetaminophen)

Paracetamol is a well-tolerated analgesic in a class of its own. This is an antipyretic analgesic with a central mechanism of action [433]. It is often available over the counter without prescription. A review questions its routine use as a first-line analgesic based on inadequate evidence of efficacy in many pain conditions including dysmenorrhoea [434]. It will not be effective for all patients and individual responses should be reviewed when deciding on longer term use.

Non-steroidal anti-inflammatory agents

These agents are anti-inflammatory, antipyretic analgesics that act by inhibiting the enzyme cyclooxygenase (COX). They have a peripheral effect, hence their use in conditions involving peripheral or inflammatory mechanisms. They are commonly used for pelvic pain; many are available over the counter and are usually well-tolerated. There is insufficient evidence to suggest one NSAID over another for pelvic pain. Guidelines for use of NSAIDs and COX-2 selective agents have been developed. They have more side-effects than paracetamol, including indigestion, headaches and drowsiness.

The evidence for their benefit in chronic pelvic pain is weak or non-existent and is often limited by side-effects. For pelvic pain in which inflammatory processes are considered important, such as dysmenorrhoea [435], NSAIDs are more effective than placebo and paracetamol, but with a higher incidence of side-effects. For pelvic pain in which central mechanisms may be incriminated, such as endometriosis [436] then the evidence is lacking for NSAIDs despite their common use.

At a practical level, if NSAIDs are considered for use, they should be tried (having regard for the cautions and contraindications) and the patient reviewed for improvement in function as well as analgesia. If this is not achieved, or side-effects are limiting, then they should be withdrawn.

Neuromodulators

These agents are not simple analgesics but used to modulate neuropathic or centrally mediated pain. There are several classes commonly used with recognised benefits in pain medicine. They are taken on a regular basis and all have side-effects that may limit their use and have the potential to be dependence-forming. In the UK, NICE has reviewed the pharmacological management of neuropathic pain [437]. The evidence for treatment of CPPPS is lacking but is present for other painful conditions. For this chapter, most of the evidence is from non-pelvic pain sources. The general method for using these agents is by titrating the dose against benefit and side-effects. The aim is for patients to have an improvement in their QoL, which is often best assessed by alterations in their function. It is common to use these agents in combination but studies comparing different agents against each other, or in combination, are lacking. Some of these agents are also used for specific conditions. Early identification of neuropathic pain with a simple questionnaire could facilitate targeted therapy with neuromodulators [58].

Antidepressants

Tricyclic antidepressants

The tricyclic antidepressants (TCAs) have multiple mechanisms of action and are frequently limited by their side-effects. Tricyclic antidepressants have a long history of use in pain medicine and have been subjected to a Cochrane review [438], suggesting that they are effective for neuropathic pain. Amitriptyline is the most commonly used at doses from 10-75 mg/day (sometimes rising to 150 mg/day). This is titrated against benefit or side-effects and should be taken at night [437]. Nortriptyline and imipramine are used as alternatives.