Gabapentin in Painful Ophthalmoplegia

To the Editor:

Tolosa-Hunt syndrome has been defined as orbital pseudotumor or painful ophthalmoplegia. This syndrome may be characterized by repeated attacks of gnawing retro-orbital pain that is responsive to steroid treatment. The pathology involves a sterile granulomatous reaction in the cavernous sinus or the superior orbital fissure, which explains the cranial nerve involvement. Local tumors, metastatic disease, and inflammatory and infectious conditions may mimic Tolosa-Hunt syndrome. The preferred radiologic method for assessment of the Tolosa-Hunt syndrome is magnetic resonance (MR) imaging. The diagnosis may be not well recognized, leading to serious mistakes. To illustrate this, and the value of analgesic therapy, a patient is described who developed a severe painful condition and had undergone enucleation, but was successfully treated with gabapentin.

Case Report

A.A., a 58-year-old woman, was referred to a pain center for consultation regarding pain in her retro-orbital area. After a series of analgesic interventions, she had undergone multiple biopsies, which revealed an inflammatory infiltrate, composed primarily of lymphocytes. As her pain worsened over the years, she consulted with an eye surgeon. Ultimately, it was decided to perform a left eye enucleation. However, pain persisted and worsened after operation. At the time of pain consultation, the patient reported a continuous pain in the retro-orbital area scored as 8 on a 0–10 scale. She frequently described lancinating breakthrough events (almost every hour, each lasting 10–15 minutes). She also presented with cutaneous hyperesthesia and a painful facial expression. Her mood was flat and she had suicidal ideation. Sleep was impaired.

Amtriptiline up to 50 mg daily, phenytoin 100 mg three times a day, and mexiletine 200 mg twice daily were unsuccessful. Sphenopalatine ganglion blocks were uneventful. Methadone in doses of 3 mg three times a day was started. Doses were increased up to 15 mg daily, yielding partial pain relief (intensity 6/10). Gabapentin in increasing doses was started and effective pain relief was achieved at doses of 1200 mg daily. The patient did not complain of pain anymore. The use of steroids did not influence the outcome, despite a partial reduction in volume of inflammatory infiltrate, as evidenced by MR imaging. The discontinuation of treatment caused a worsening in pain symptomatology, and therapy with gabapentin at the previous dosage was started again. Pain was controlled and methadone could be discontinued. The patient was seen on several occasions and is reporting complete pain relief 3 years after starting gabapentin.

Comment

Anticonvulsant drugs can reduce or prevent pathologically altered neurons from excessive discharge, and can reduce the spread of excitation from abnormal foci to normal neurons. Gabapentin is a relatively new oral antiepileptic medication with an uncertain mechanism of action. It is a structural analogue of gamma amnobutyric acid. Gabapentin has been used for different neuropathic pain states, including refractory sympathetic dystrophy, postherpetic neuralgia, spinal pain, trigeminal and diabetic neuralgia, post-surgical neuropathies, peripheral nerve injuries, and head and neck painful syndromes. It does not affect the metabolism of other medications and is well tolerated. Despite the serious clinical problem and a severely compromised psychological status, our patient experienced complete pain relief using gabapentin, without reporting any adverse effects, for several years. The patient was started on a relatively small dose of gabapentin and titrated over 9 days. She experienced recurrence...
of pain after discontinuation of gabapentin, and again a positive response was achieved after re-starting the drug, supporting the relationship between the drug use and the positive outcome.

This case illustrates the challenge involved in the diagnosis and treatment of painful ophthalmoplegia. Gabapentin appears to be a very useful drug in individual cases presenting with unbearable chronic pain of neuropathic origin, including cases such as these.

Sebastiano Mercadante, MD
Anesthesia and Intensive Care Unit
Pain Relief and Palliative Care Unit
La Maddalena Cancer Center
Palermo, Italy
PII S0885-3924(02)00490-6

References

Involvement of Medical Staff in the Assessment of Pain

To the Editor:

Although much effort has been made recently to increase the involvement of care providers in pain management, some reports suggest that the prevalence and the intensity of pain are inadequately assessed.1–3 We conducted a study to examine how aware registrars are of the prevalence of pain among their patients.

The study was carried out in a 2,068-bed Parisian teaching hospital in February and May 2000. The first part of the study consisted of a cross-sectional, exhaustive survey to determine the prevalence of pain reported by patients in each ward. All patients hospitalized for at least 24 hours were asked if they had suffered any pain during the last 24 hours. The second part of the study consisted of asking the registrars to estimate the proportion of patients who had suffered from pain in their ward over a period of 24 hours. We examined the difference between the prevalence of pain estimated by registrars and that reported by patients for each ward. The degree of concordance was measured using the intra-class correlation coefficient (ICC). An intra-class correlation coefficient of zero indicates that there is no concordance between patients’ self-assessment of pain and the registrars’ estimation.4

Nine hundred and twenty-nine patients participated in this study, which was conducted in 33 departments of our hospital (114 wards). Of the 76 registrars, 58 (76%) answered the questionnaire. Thirty-eight (66%) had a medical specialty, 20 (34%) had a surgical specialty.

Seventy-four percent (n = 43) of the registrars underestimated the prevalence of pain and 26% (n = 15) overestimated it. Few registrars estimated the pain prevalence correctly (6 within 10%). The difference between the prevalence of pain and its estimation by registrars is shown in Figure 1. This figure shows that there may be two different populations of registrars, a predominant population underestimating pain prevalence and a smaller population overestimating it. There was no concordance between the prevalence of pain estimated by the registrars and that reported by the patients (ICC = 0.06). There was no difference be-

![Fig. 1. Difference between the prevalence of pain estimated by registrars and reported by patients.](image)