Results: There was no difference between the 2 groups under basic variables. Pain reported by the first group who received magnesium sulfate was significantly less at the 1st, 3rd, sixth, and 12th hour after the operation in comparison to the group who received placebo. At the 18th and 24th hour post operation, there was no significant difference between the 2 groups.
Conclusions: Receiving intravenous magnesium sulfate following lower extremities orthopedic surgery significantly reduced pain in the first few hours after the surgery.

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RAPID PAIN RELIEF AFTER BUNIONECTOMY WITH TAPENTADOL, A NOVEL CENTRALLY ACTING ANALGESIC

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Background and Aims: Tapentadol is a new potent centrally acting analgesic with a dual mode of action: μ-receptor agonism and noradrenaline reuptake inhibition. The analgesic efficacy of tapentadol was assessed in a validated pain model, postsurgical pain after bunionectomy. Compared with oral morphine sulfate 60 mg, the equianalgesic dose of tapentadol HCl is between 100 and 200 mg (total pain relief over 8 hours). This analysis further characterizes the pain relief profile of tapentadol by assessing onset of pain relief.
Methods: Single oral doses of tapentadol HCl (25, 50, 75, 100, or 200 mg), morphine sulfate (60 mg), ibuprofen (400 mg), and placebo were evaluated in a double-blind, randomized, phase II clinical trial of 517 patients with moderate-to-severe pain following bunionectomy. Pain parameters assessed included peak pain relief (PPR), time to PPR, and onset of analgesia. PPR was measured by assessing pain relief on a 5-point scale (0 = none to 4 = complete).
Results: Onset of analgesia was more rapid for tapentadol HCl 200 mg than any other study treatment. While there was no difference in time to PPR (1.5 hours each), the mean PPR score was greater ($P \leqslant 0.05$) for tapentadol HCl 200 mg compared with morphine sulfate 60 mg. Compared to morphine sulfate 60 mg, tapentadol HCl 200 mg showed lower rates of nausea and dizziness and similar rates of somnolence and vomiting.
Conclusions: Tapentadol shows the efficacy of a strong opioid with a rapid onset of action, and has an improved tolerability profile compared to morphine.

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COMBINED PARACETAMOL AND TRAMADOL FOR POSTOPERATIVE PAIN CONTROL

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Aim of investigation: To evaluate the effect of adding Paracetamol to Tramadol for postoperative pain management.
Methods: 90 Patients of similar age and weight that have been subjected to moderate surgical procedures in the hand (day cases) were divided into two equal groups according to the type of analgesic used postoperatively. All operations were done under local i.v. anaesthesia using lidocaine 1% 3 mg/kg (250–300 mg). All patients were given 50 mg Tramadol tablets preoperatively. In the immediate postoperative period patients of group I were given Tramadol 50 mg orally, while patients of group II were given 50 mg Tramadol + 500 mg Paracetamol orally. Repeated doses of the same medication were given 8 hourly for 36 hours. Patient's satisfaction regarding analgesia was assessed and graded, good, fair and poor.
Results: Most patients in each group were satisfied. 36 patients (80%) in group I and 40 patients (87%) in group II reported good postoperative pain relief. The remaining patients in each group asked for more analgesia, they were given 50 mg Tramadol orally and excluded from the study. Nausea, Vomiting and drowziness were less in group II, 40% compared to 57.7% in group I.
Conclusion: Combination of Paracetamol with Tramadol is more effective than Tramadol alone for postoperative pain relief following hand surgery in day cases.

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OXICODONE: EVALUATION IN THE TREATMENT OF CHRONIC NON-ONCOLOGICAL PAIN

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Introduction: Oxicodone is a pure opioid agonist for μ and κ receptors, with no therapeutic ceiling, and with an analgesic action similar to morphine and a lower incidence of adverse effects. It is useful for treating chronic oncological, non-oncological, or neuropathic pain.
Objective: To evaluate the efficacy and tolerability of Oxicodone in the treatment of chronic non-oncological pain.
Method: A prospective study was carried out on a total of 50 patients with chronic non-oncological pain (lumbalgia, arthrosis, vertebral bruising, etc.), who were treated at the start of the study with Oxicodone 10 mg/12 hours, with Efferalgan as rescue 1 g/8 hours. The patients were evaluated on their 1st visit, at 15 days (telephone consultation), and at 3 months, evaluating the EVA, adverse effects and quality of sleep.
Results: Some provisional results were achieved over 41 patients included up to that point. 56.09% of the patients had previously been taking minor opiates, 41.46% had been taking major opiates and the rest had been with AINES. 75.60% of the patients presented severe pain on the first visit, which dropped to 13.88% on the second consultation. 61.11% of the patients reported slight pain during the telephone consultation. The most frequent adverse effect was constipation (12.19%), followed by nausea (11.11%), dizziness (2.7%) and itching (2.7%). 5 patients have left the study on account of dizziness and nausea.
Conclusions: Oxicodone is useful in the treatment of chronic non-oncological pain with very few adverse effects.

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BOTULINUM NEUROTOXIN IN CERVICAL MYOFASCIAL PAIN SYNDROM

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Myofascial pain is a non-inflamatory syndrom that is defined by the presence of a well-localized pain, rigidity and trigger points with a twich response (taut band). Its phisiopathology is not completly understood although most known theories are "energetic crisis" and "central and peripheric sensibility". Diagnosis of myofascial pain is based primarily on finding the trigger points by patient history and physical muscle examination. Treatment is based on normalisation of excessive muscle spindle activity on the trigger points and the muscle reeducation. Botulinum neurotoxin blocks cholinergic neuromuscular transmission.
Methods: Patients with cervical and shoulder myofascial pain were included on a prospective non-comparative study. Botolinum neurotoxin type A were injected in four trigger points (25 units in each point), with two sessions in an interval of three months. Pain was assessed, using Visual analog Scale, at baselin, 1month and 3 month after injection.
Results: 22 patients were included, 73% females and 27% males, with an average age about 60 years. 59% of patients responded to botulinum toxin injections, with a pain relif over 50%. Cervicoarthrosis was the pathology with better response (5 patients), and cervical discal hernia had the worst response (7 patients). No severe adverse effects were refered.
Conclusion: The safety of Botulinum toxin type A is well established and represents a new option for patients with chronic myofascial pain syndroms with a excellent tolerability and feww side effects.