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Cymbalta for Diabetic Neuropathy

Five criteria are needed to establish the diagnosis of diabetic polyneuropathy.

- The patient has diabetes mellitus by the criteria of the National Diabetes Data Group.
- Diabetes mellitus has caused prolonged chronic hyperglycemia.
- The patient has predominantly distal sensorimotor polyneuropathy in the lower extremities.
- Other causes of sensorimotor polyneuropathy have been excluded.

Diabetic polyneuropathy typically develops as generalized asymptomatic dysfunction of peripheral nerve fibers. The first clinical sign that usually develops with abnormal nerve conduction is decrease or loss of ankle jerk reflexes or decrease in vibratory sensation over the great toes. With more severe involvement, the patient may develop varying degrees and modalities of pain; sensory loss of the toes, feet, and distal legs; deep tendon reflex abnormalities; and weakness of small foot muscles.

Cymbalta is a SSNRI. It was the first FDA-approved treatment for the management of pain associated with diabetic peripheral neuropathy. More than 18 million Americans have been diagnosed with diabetes and of all of these, 10 percent to 20 percent have painful symptoms.

In clinical studies with Cymbalta, improvements in pain levels developed as early as the first week of treatment. It was also effective in relieving pain at night, which usually interferes with sleep. Clinical trials also show Cymbalta to be more efficacious than Neurontin for diabetic polyneuronpathy.

Cymbalta comes in a capsule and can be taken once or twice a day. The recommended daily dose for Cymbalta is 60 mg and is available in 20 mg, 30 mg and 60 mg capsules. Cymbalta is not recommended for those under 18 and should not be used with other antidepressants. Common adverse effects include dry mouth and nausea. Abrupt discontinuation may cause mania and hypertension.

For Information and Referrals:

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