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(54) **ADMINISTRATION OF CAPSAICINOIDS**

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(57) **ABSTRACT**

Disclosed in certain embodiments is a method for relieving
pain at a site in a human or animal in need thereof,
comprising administering by injection or infiltration, a dose
of a capsaicinoid and coadministering a non-anesthetic
sodium channel blocker.

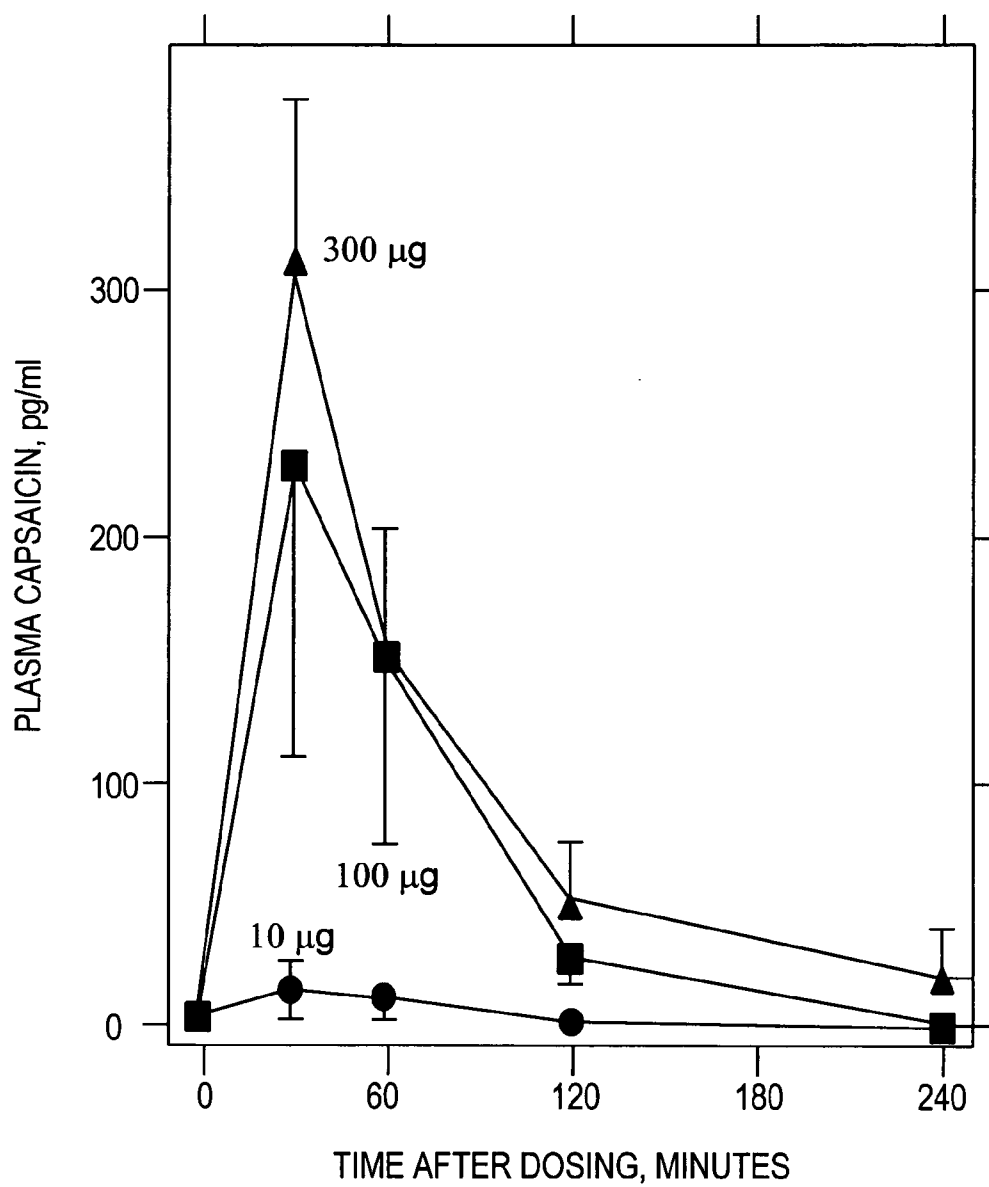


FIG. 1

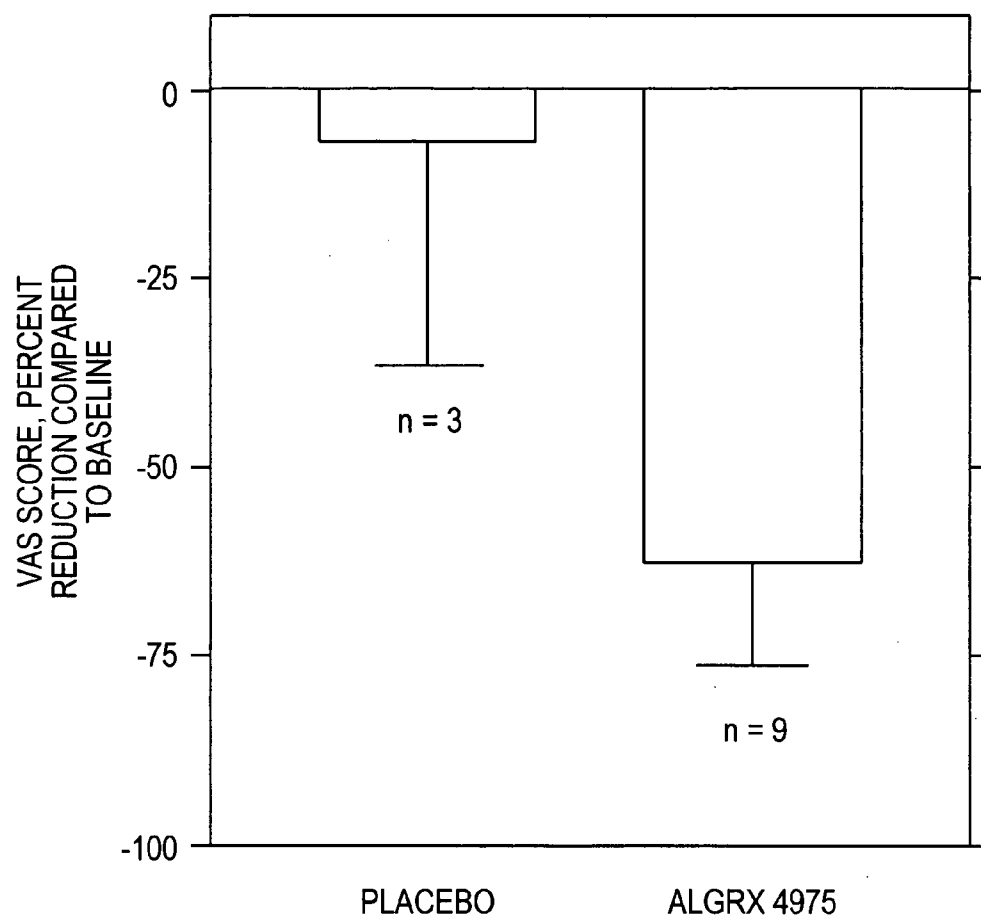
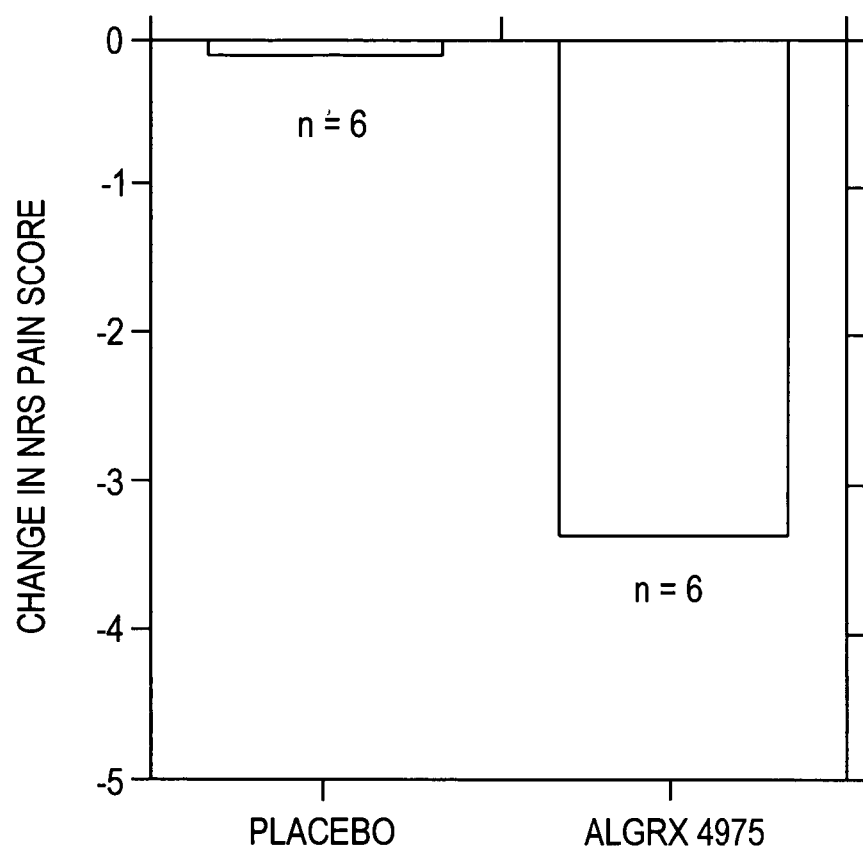


FIG. 2



CHANGE IN NRS PAIN SCORE AT THREE WEEKS
 FOLLOWING ADMINISTRATION, P= 0.05
 FINAL NRS SCORE, PLACEBO = 7.30, ALGRX 4975 = 3.97, P = 0.03

FIG. 3

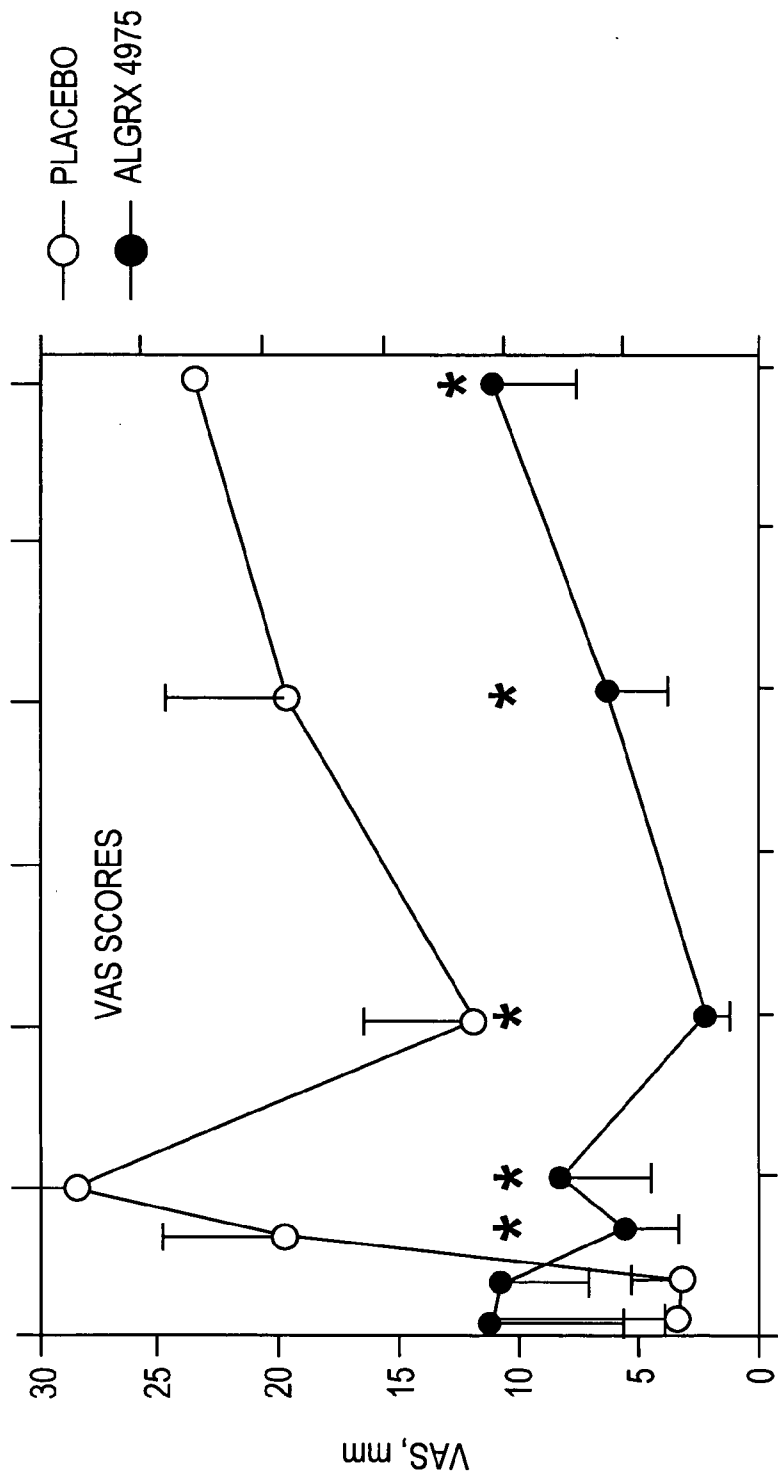


FIG. 4

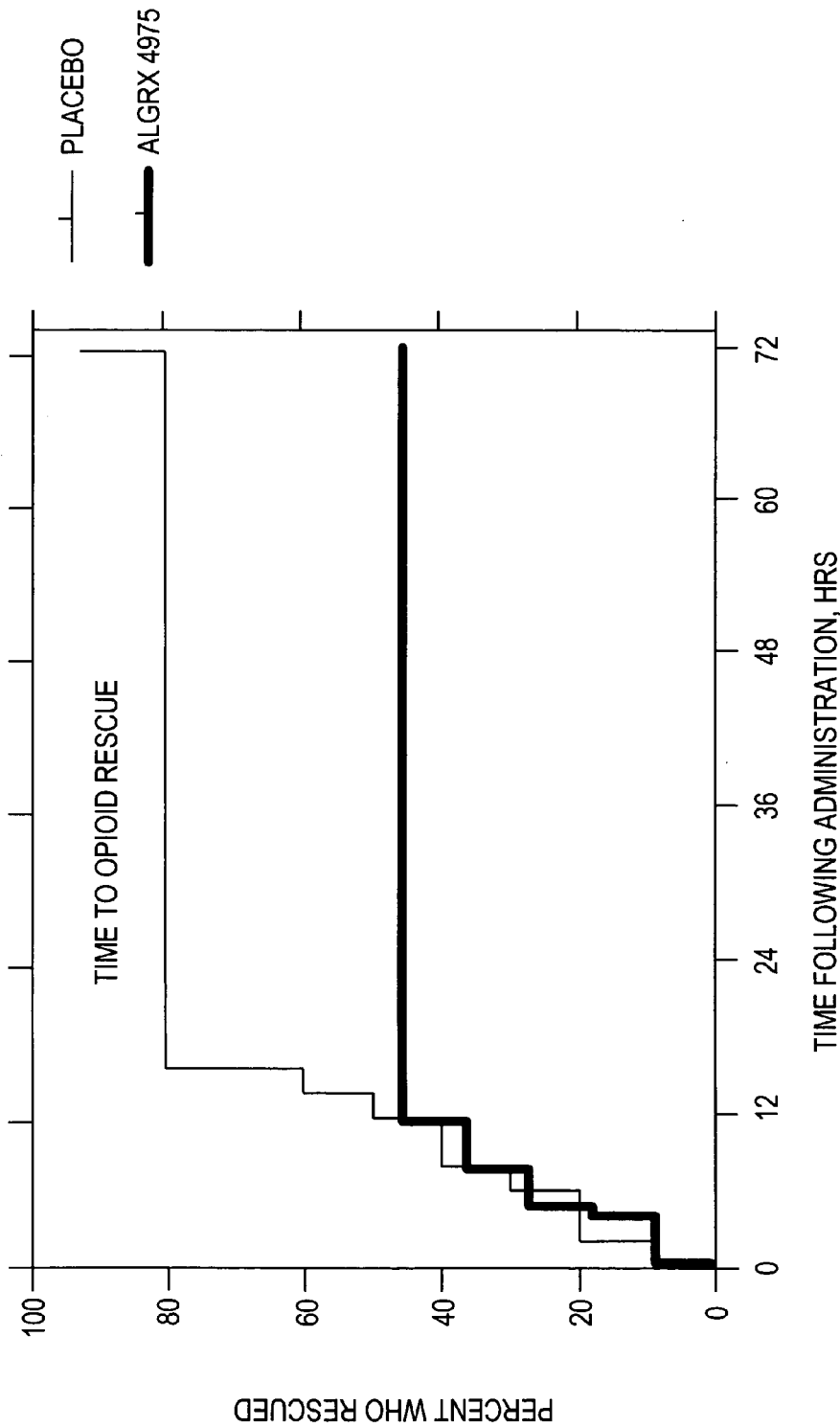


FIG. 5

*p < 0.05 COMPARED TO PLACEBO
- ALL PATIENTS WITH LIDOCAINE BLOCK DURING SURGERY

ADMINISTRATION OF CAPSAICINOIDS

[0001] This application claims the benefit of U.S. Provisional Patent Application No. 60/434,453, filed Dec. 18, 2002, U.S. Provisional Patent Application No. 60/434,530, filed Dec. 18, 2002, U.S. Provisional Patent Application No. 60/434,500, filed Dec. 18, 2002, U.S. Provisional Patent Application No. 60/434,828, filed Dec. 18, 2002, U.S. Provisional Patent Application No. 60/434,452, filed Dec. 18, 2002, U.S. Provisional Patent Application No. 60/434,501, filed Dec. 18, 2002, and U.S. Provisional Patent Application No. 60/461,164, filed Apr. 8, 2003, the disclosures of which is hereby incorporated by reference in their entirety.

FIELD OF THE INVENTION

[0002] This application is directed to compositions and methods for relieving pain at a specific site, for example, associated with inflammation of joints, tendons, nerves, muscle, and other soft tissues, nerve injury and neuropathies, and pain from tumors in soft tissues or bone.

BACKGROUND OF THE INVENTION

[0003] Capsaicin, a pungent substance derived from the plants of the solanaceae family (hot chili peppers) has long been used as an experimental tool because of its selective action on the small diameter afferent nerve fibers C-fibers and A-delta fibers that are believed to signal pain. From studies in animals, capsaicin appears to trigger C-fiber membrane depolarization by opening cation channels permeable to calcium and sodium. Recently one of the receptors for capsaicin effects has been cloned. Capsaicin can be readily obtained by ethanol extraction of the fruit of *capsicum frutescens* or *capsicum annum*. Capsaicin is known by the chemical name N-(4-hydroxy-3-methoxybenzyl)-8-methylnon-trans-6-enamide. Capsaicin is practically insoluble in water, but freely soluble in alcohol, ether, benzene and chloroform. Therapeutically capsaicin has been used as a topical analgesic. Capsaicin is available commercially as Capsaicin USP from Steve Weiss & Co., 315 East 68th Street, New York, N.Y. 10021 and can also be prepared synthetically by published methods. See Michalska et al., "Synthesis and Local Anesthetic Properties of N-substituted 3,4-Dimethoxyphenethylamine Derivatives", *Diss Pharm. Pharmacol.*, Vol. 24, (1972), pp. 17-25, (Chem. Abs. 77: 19271 a), discloses N-pentyl and N-hexyl 3,4-dimethoxyphenylacetamides which are reduced to the respective secondary amines.

[0004] Capsaicin is listed in the pharmacopoeias of the United Kingdom, Australia, Belgium, Egypt, Germany, Hungary, Italy, Japan, Poland, Portugal, Spain, and Switzerland and has previously been listed in the United States Pharmacopoeia and the National Formulary. The FDA proposed monographs on analgesic drug products for over-the-counter (OTC) human use. These include capsaicin and capsicum preparations that are regarded as safe and effective for use as OTC external analgesics. Capsaicin is the only chemical entity of Capsicum recognized by the FDA. Capsaicin (USP) contains not less than 110% total capsaicinoids which typically corresponds to 63% pure capsaicin. USP capsaicin is trans-capsaicin (55-60%) and also contains the precursors dihydrocapsaicin and nordihydrocapsaicin.

[0005] Capsaicin mediated effects include: (i) activation of nociceptors in peripheral tissues; (ii) eventual desensiti-

zation of peripheral nociceptors to one or more stimulus modalities; (iii) cellular degeneration of sensitive A-delta and C-fiber afferents; (iv) activation of neuronal proteases; (v) blockage of axonal transport; and (vi) the decrease of the absolute number of nociceptive fibers without affecting the number of non-nociceptive fibers.

[0006] The dosage forms of capsaicin which have been most widely studied clinically are capsaicin containing creams (Zostrix, Zostrix-HP, and Axsain). These products have been examined in a broad spectrum of painful conditions including osteoarthritis. However the efficacy of topically administered capsaicin in arthritis in general has proven to be limited.

[0007] Prior publications describe topical administration of capsaicin for the treatment of various conditions. For example, U.S. Pat. No. 4,997,853 (Bernstein) describes methods and compositions utilizing capsaicin as an external analgesic. U.S. Pat. No. 5,063,060 (Bernstein) describes compositions and methods for treating painful, inflammatory or allergic disorders. U.S. Pat. No. 5,178,879 (Adekunle, et al.) describes methods for preparing a non-greasy capsaicin gel for topical administration for the treatment of pain. U.S. Pat. No. 5,296,225 (Adekunle, et al.) describes indirect methods of treating orofacial pain with topical capsaicin. U.S. Pat. No. 5,665,378 (Davis, et al.) describes transdermal therapeutic formulations comprising capsaicin, a nonsteroidal anti-inflammatory agent and pamabrom for the treatment of pain. U.S. Pat. No. 6,248,788 (Robbins, et al.) describes administration of 7.5% capsaicin cream in combination with marcaine epidural injections in patients suffering from long-term persistent foot pain. U.S. Pat. No. 6,239,180 (Robbins) describes combining capsaicin loaded patches with local anesthesia to treat peripheral neuropathy. The use of topical capsaicin has also been described in the art to treat conditions as diverse as post mastectomy pain syndrome (Watson and Evans, *Pain* 51: 375-79 (1992)); painful diabetic neuropathy (Tandan et al., *Diabetes Care* 15: 8-13 (1992)); The Capsaicin Study Group, *Arch Intern Med* 151: 2225-9 (1991); post-herpetic neuralgia (Watson et al., *Pain* 33: 333-40 (1988)), Watson et al., *Clin. Ther.* 15: 510-26 (1993); Bernstein et al., *J. Am Acad Dermatol* 21: 265-70 (1989) and pain in Guillian-Barre syndrome (Morganlander et al., *Annals of Neurology* 29:199 (1990)). Capsaicin has also been used in the treatment of osteoarthritis (Deal et al., *Clin Ther* 13: 383-95 (1991); McCarthy and McCarthy, *J. Rheumatol* 19: 604-7 (1992); Altman et al., *Seminars in Arthritis and Rheumatism* 23: 25-33 (1994). In addition, U.S. Pat. No. 4,599,342 (LaHann) describes oral and subcutaneous or intramuscular administration of a combination of capsaicin or a capsaicin analog with an opioid analgesic. U.S. Pat. No. 4,313,958 (LaHann) describes intrathecal, epidural, intramuscular, intravenous, intraperitoneal and subcutaneous administration of capsaicin utilizing a "stair-step" dosing pattern.

[0008] Humans have long been exposed to dietary sources of capsaicin-containing spices and to topical preparations used for a variety of medical indications. This vast experience has not revealed significant or lasting adverse effects of capsaicin exposure. The recent determination of capsaicin's potential therapeutic effects on unmyelinated sensory afferent nerve fibers require diligent consideration of this compound for further pharmaceutical development.

[0009] Because of capsaicin's ability to desensitize nociceptors in peripheral tissues, its potential analgesic effects have also been assessed in various clinical trials. However, since the application of capsaicin itself frequently causes burning pain and hyperalgesia apart from the neuropathic pain being treated, patient compliance has been poor and the drop out rates during clinical trials have exceeded fifty percent. The spontaneous burning pain and hyperalgesia are believed to be due to intense activation and temporary sensitization of the peripheral nociceptors at the site of capsaicin application. This activation and sensitization occur prior to the desensitization phase. The activation phase could be a barrier to use of capsaicin because of the pain produced.

[0010] It would therefore be advantageous to provide methods and compositions including capsaicin or capsaicin analogues thereof with effective concentrations to cause an analgesic effect without the side effects normally associated with the use of capsaicin.

OBJECTS AND SUMMARY OF THE INVENTION

[0011] It is an object of the present invention to provide compositions and methods for providing pain relief in humans and animals by administering an injectable or implantable dose of capsaicin or capsaicin analogue to a site for the treatment of acute or chronic pain, nociceptive and neuropathic pain, pre- and post-operative pain, cancer pain, pain associated with neurotransmitter dysregulation syndromes and orthopedic disorders.

[0012] It is another object of the invention to provide compositions and methods for attenuating pain at a discrete site in a human or animal via the administration of a capsaicinoid via injection or implantation at the discrete site.

[0013] It is another object of the present invention to provide compositions and methods for relieving pain at an intra-articular site or at a body space by administering an injectable or implantable single dose of capsaicin or capsaicin analogue to the intra-articular site or body space.

[0014] It is an object of the present invention to provide compositions and methods for providing pain relief in humans and animals by administering via infiltration a dose of capsaicin or capsaicin analogue to a surgical site or open wound for the treatment of acute or chronic pain, nociceptive and neuropathic pain, pre- and post-operative pain, cancer pain, pain associated with neurotransmitter dysregulation syndromes and orthopedic disorders.

[0015] It is another object of the present invention to provide compositions and methods for attenuating pain at a surgical site in a human or animal via the administration of a capsaicinoid via infiltration at the surgical site.

[0016] It is another object of the present invention to provide compositions and methods for attenuating pain at an open wound in a human or animal via the administration of a capsaicinoid via infiltration at the open wound.

[0017] It is a further object of the invention to provide compositions and methods for treatment of sports-related injuries utilizing injectable or implantable capsaicinoids.

[0018] It is a further object of the invention to provide compositions and methods for treatment of pain associated with median sternotomy utilizing infiltratable capsaicinoids.

[0019] It is a further object of the invention to provide compositions and methods for treatment of pain associated with mastectomy utilizing infiltratable capsaicinoids.

[0020] It is a further object of the invention to provide compositions and methods for treatment of pain associated with orthopedic surgical procedures utilizing infiltratable capsaicinoids.

[0021] It is a further object of the invention to provide compositions and methods for treatment of orthopedic disorders or injuries utilizing injectable or implantable capsaicinoids.

[0022] It is a further object of the invention to provide compositions and methods for treating acute traumatic pain utilizing injectable, implantable or infiltratable capsaicinoids.

[0023] It is a further object of the invention to provide compositions and methods for treating neuropathic pain utilizing injectable, implantable or infiltratable capsaicinoids.

[0024] It is a further object of the invention to provide compositions and methods for treating nociceptive pain utilizing injectable, implantable or infiltratable capsaicinoids.

[0025] It is a further object of the invention to provide compositions and methods for treating neurotransmitter-dysregulation syndromes utilizing injectable, implantable or infiltratable capsaicinoids.

[0026] In accordance with the above objects and others, the invention is directed in part to a method for attenuating or relieving pain at a site in a human or animal in need thereof, comprising administering via injection, implantation or infiltration at a discrete site, a surgical site, or an open wound in a human or animal in need thereof a single dose of capsaicin in an amount effective to denervate the discrete site without eliciting an effect outside the discrete location and to attenuate pain emanating from said site, the dose ranging from about 1 μg to about 5,000 μg capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin when said dose is injected or infiltrated into a discrete site in the human or animal, and the dose ranging from about 1 μg to about 15,000 μg capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin when said dose is infiltrated into a surgical site or an open wound. In other words, the term "capsaicinoid" is meant to encompass formulations where the drug is capsaicin, a capsaicinoid other than capsaicin, or a mixture of capsaicin with one or more other capsaicinoids (the total amount of all capsaicinoid drug being based on a therapeutically equivalent dose to dose from about 1 μg to about 5,000 μg capsaicin for injection or infiltration, and the total amount of all capsaicinoid drug being based on a therapeutically equivalent dose to dose from about 1 μg to about 15,000 μg capsaicin for infiltration).

[0027] The present invention is further directed in part to a method for attenuating or relieving pain at a site in a human or animal in need thereof, comprising administering at a discrete painful site in a human or animal in need thereof a single injectable or implantable dose of a capsaicinoid in an amount effective to denervate said discrete site without eliciting an effect outside the discrete location and to attenuate

ate pain emanating from said site, said effective dose being from about 1 μg to about 5,000 μg of capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin. In certain preferred embodiments, the dose of capsaicin for injection or implantation is from about 10 to about 3000 μg , and preferably from about 300 to about 1200 μg . In preferred embodiments, the dose of capsaicinoid is administered in a pharmaceutically and physiologically acceptable vehicle for injection or implantation, which may optionally further include one or more pharmaceutical excipient. In certain preferred embodiments, a local anesthetic may be administered prior to or concurrently with said dose of capsaicinoid in an amount and location effective to attenuate an initial hyperalgesic effect of the administered dose of capsaicinoid. The local anesthetic may be administered, e.g., by direct injection into the site where said dose of capsaicinoid is administered, or as a proximal, regional, somatic, or neuraxial block. General anesthesia may be used, if necessary. The dose of capsaicinoid may be injected or implanted subcutaneously, intramuscularly, intrathecally, epidurally, intraperitoneally, caudally intradermally or intracutaneously, intercostally at a single nerve, intra-articularly, intrasynovially, intraspinally, intra-arterially or into body spaces. Intra-articular administration of the formulations of the invention may be, e.g., into a joint selected from the group consisting of knee, elbow, hip, sternoclavicular, temporomandibular, carpal, tarsal, wrist, ankle, intervertebral disk, ligamentum flavum and any other joint subject to pain.

[0028] In certain other embodiments of the present invention, there is provided a method for attenuating or relieving pain at a surgical site or open wound in a human or animal in need thereof, comprising administering via infiltration at a surgical site or open wound in a human or animal in need thereof a single dose of capsaicin in an amount effective to denervate the surgical site or open wound without eliciting an effect outside the surgical site or open wound, the dose ranging from about 1 μg to about 15,000 μg . In certain preferred embodiments, the effective dose of capsaicinoid is from about 500 to about 15,000 μg capsaicin, or from about 600 to about 10,000 μg capsaicin, or a therapeutically equivalent dose of a capsaicinoid other than capsaicin. In certain preferred embodiments, the dose of capsaicinoid is administered in a pharmaceutically acceptable vehicle for infiltration in a volume from about 0.1 to about 1000 ml. In certain preferred embodiments, the dose of capsaicinoid is administered in a pharmaceutically acceptable vehicle for infiltration in a volume from about 1 ml to about 100 ml. In other further preferred embodiments, the dose of capsaicinoid is administered in a pharmaceutically acceptable vehicle for infiltration in a volume from about 5 ml to about 30 ml. In certain preferred embodiments where the capsaicinoid is infiltrated into a surgical site or an open wound, the method further comprises administering a local or general anesthetic prior to or concurrently with said dose of capsaicinoid. The dose of local anesthetic may be, e.g., an amount and location effective to attenuate an initial hyperalgesic effect of said administered dose of capsaicinoid. The local anesthetic may be administered by infiltration to the surgical or wound site. In certain preferred embodiments, the administration of capsaicinoid at the site provides attenuation of pain in proximity to the surgical or wound site for at least about 48 hours, and preferably for at least about one week.

[0029] The present invention is further directed in part to a method for attenuating or relieving pain at a surgical site

or open wound in a human or animal in need thereof, comprising administering at a surgical site or open wound in a human or animal in need thereof a single infiltratable dose of a capsaicinoid in an amount effective to denervate said surgical site or open wound without eliciting an effect outside the surgical site or open wound, said effective dose being from about 1 μg to about 15,000 μg of capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin.

[0030] The dose of capsaicinoid administered by infiltration into the surgical site or open wound may be administered directly onto the tissue, muscle or bone. In other embodiments, the dose of capsaicinoid may be administered intra-articularly intra-sternally, intrasynovially, intra-bursally or into body spaces. Intra-articular administration of the formulations of the invention may be, e.g., into a joint selected from the group consisting of knee, elbow, hip, sternoclavicular, temporomandibular, carpal, tarsal, wrist, ankle, intervertebral disk, ligamentum flavum and any other joint subject to pain.

[0031] The invention is further directed in part to a method of treating acute traumatic pain associated with an injury, comprising injecting a capsaicinoid in a physiologically compatible vehicle through the skin of a patient in proximity to an injury, said dose of capsaicinoid being sufficient to attenuate the dull, aching pain associated with C-fibers in proximity to the injury and such that the patient continues to have sensation in proximity to the injury and without affecting sharp protective pain associated with A-delta fibers in proximity to the site, the dose of capsaicinoid being therapeutically equivalent to a dose of capsaicin in an amount from about 300 to about 1500 μg and being effective to attenuate dull, aching pain in proximity to the injury for at least about 48 hours.

[0032] The invention is further directed in part to a method of treating acute traumatic pain associated with surgery or open wound injury, comprising administering via infiltration a capsaicinoid in a physiologically compatible vehicle at the surgical site or open wound of a patient, said dose of capsaicinoid being sufficient to attenuate the dull, aching pain associated with C-fibers in proximity to the surgical site or open wound and such that the patient continues to have sensation in proximity to the surgical site open wound and without affecting sharp protective pain associated with A-delta fibers in proximity to the surgical site or open wound, the dose of capsaicinoid being therapeutically equivalent to a dose of capsaicin in an amount from about 600 to about 15,000 μg and being effective to attenuate dull, aching pain in proximity to the surgical site or open wound for at least about 48 hours.

[0033] In certain preferred embodiments, the capsaicinoid is capsaicin itself. In more preferred embodiments, the capsaicinoid comprises trans-capsaicin. In most preferred embodiments, the capsaicinoid is at least about 97% trans-capsaicin.

[0034] The single injectable, implantable or infiltratable dose of a capsaicinoid administered at a discrete site, surgical site or open wound in accordance with the present invention is preferably in an amount effective to a) produce a selective, highly-localized destruction or incapacitation of C-fibers and/or A-delta fibers in a discrete, localized area responsible for the initiation of pain for the purpose of

reducing or eliminating pain arising from a discrete locus, and b) minimize potential adverse consequences of C-fiber and/or A-delta activation and or damage outside of the locus of pain.

[0035] The present invention is also directed to an injectable or implantable pharmaceutical composition for attenuating pain at a site in a human or animal in need thereof, consisting essentially of from 1 μ g to 5000 μ g of a capsaicinoid comprising trans-capsaicin and a pharmaceutically acceptable vehicle for injection or implantation. In certain preferred embodiments, the dose of trans-capsaicin ranges from about 10 μ g to about 3000 μ g, from about 300 μ g to about 1500 μ g, or preferably from about 400 μ g to about 1200 μ g.

[0036] The present invention is also directed to an infiltratable pharmaceutical composition for attenuating pain at a surgical site or open wound in a human or animal in need thereof, consisting essentially of from 1 μ g to 15,000 μ g of a capsaicinoid comprising trans-capsaicin and a pharmaceutically acceptable vehicle for infiltration. In certain preferred embodiments, the dose of trans-capsaicin ranges from about 600 μ g to about 15,000 μ g, from about 600 μ g to about 10,000 μ g, or preferably from about 1,000 μ g to about 10,000 μ g.

[0037] In order that the invention described herein may be more fully understood, the following definitions are provided for the purposes of this disclosure:

[0038] The term "injection" shall mean administration of capsaicin to a discrete site through the skin of a human or animal.

[0039] The term "implantation" shall mean administration of capsaicin to a discrete site by embedding the dose of capsaicin into the skin, tissue, muscles, tendons, joints, or other body parts of a human or animal.

[0040] The term "infiltration" or "infiltratable" shall mean administration into a discrete surgical site or open wound in a human or animal.

[0041] As used herein, the term "capsaicinoid" means capsaicin, capsaicin USP and purified capsaicin, capsaicin analogues and derivatives thereof (collectively referred to as capsaicinoids in this specification and appended claims) that act at the same pharmacologic sites, e.g., VR1, as capsaicin, unless otherwise specified.

[0042] Acute pain shall mean any pain that presents with a rapid onset followed by a short, severe course, e.g., headache, pain associated with cancer, fractures, strains, sprains, and dislocations of bones, joints, ligaments and tendons.

[0043] Chronic pain shall mean pain that lasts for a long period of time or is marked by frequent recurrence, e.g., pain associated with terminal illnesses, arthritis, autoimmune diseases; or neuropathic pain caused by degenerative diseases such as diabetes mellitus or spinal degeneration, or resulting from neural remodeling following traumatic injury or surgery.

[0044] As used herein, the term "local anesthetic" means any drug or mixture of drugs that provides local numbness and/or analgesia.

[0045] By co-administration it is meant either the administration of a single composition containing both the capsaicin and an additional therapeutically effective agent(s), e.g., local anesthetic or phenol, or the administration of a capsaicin and the additional therapeutically effective agent(s) as separate compositions within short enough time periods that the effective result is equivalent to that obtained when both compounds are administered as a single composition.

BRIEF DESCRIPTION OF THE DRAWINGS

[0046] The following drawings are illustrative of embodiments of the invention and are not meant to limit the scope of the invention as encompassed by the claims.

[0047] FIG. 1 is a graph displaying the plasma concentration of the 10 μ g, 100 μ g and 300 μ g doses of capsaicin administered to study subjects entered into the Osteoarthritis Safety Study exemplified in Example 1.

[0048] FIG. 2 is a graph displaying the percent reduction in VAS score compared to baseline in study subjects entered into the Osteoarthritis Safety Study exemplified in Example 1.

[0049] FIG. 3 is a graph displaying the NRS Pain Score in study subjects entered into the Osteoarthritis Efficacy Study exemplified in Example 2.

[0050] FIG. 4 is a graph displaying a comparison of VAS Pain Score between subjects entered into the Bunionectomy Efficacy study exemplified in Example 3.

[0051] FIG. 5 is a graph displaying a comparison of the percent of subjects entered in to the Bunionectomy Efficacy study exemplified in Example 3 requiring rescue medication.

DETAILED DESCRIPTION OF THE INVENTION

[0052] The compositions and methods disclosed herein can be used for treating pain at a specific site with an effective amount of capsaicin or capsaicin analogue, hereinafter collectively referred to as "capsaicinoids". In one preferred embodiment, the methods involve administration of an effective amount of capsaicinoid to a site in a human or animal for relieving pain at the site.

[0053] In another embodiment, the methods involve providing anesthesia to the site where the capsaicinoid is to be administered, and then administering an effective amount of capsaicinoid to the site. The anesthesia can be provided directly to the site, or at a remote site that causes anesthesia at the site where the capsaicinoid is to be administered. For example, epidural regional anesthesia can be provided to patients to which the capsaicinoid is to be administered at a site located from the waist down. Alternatively, a local anesthetic may be administered as a regional block, a proximal block, a somatic block, or a neuraxial block. The anesthetic may be administered as a general anesthetic, as a spinal block, as an epidural block, or as a nerve block. Preferably, in the embodiments in which a local anesthetic is administered, the local anesthetic is administered prior to administration of the capsaicinoid, such that the local anesthetic has provided temporary anesthesia to the area to be treated with the capsaicinoid.

[0054] Examples of local anesthetic agents which can be used include bupivacaine, ropivacaine, dibucaine, procaine, chloroprocaine, prilocaine, mepivacaine, etidocaine, tetracaine, lidocaine, and xylocaine, and mixtures thereof and any other art-known pharmaceutically acceptable local anesthetic. The local anesthetic can be in the form of a salt, for example, the hydrochloride, bromide, acetate, citrate, carbonate or sulfate. More preferably, the local anesthetic agent is in the form of a free base. Preferred local anesthetic agents include, e.g., bupivacaine. For bupivacaine, the free base provides a slower initial release and avoids an early “dumping” of the local anesthetic at the infiltration site. Other local anesthetics may act differently. Local anesthetic agents typically administered systematically may also be used in those cases where the means of administration results only in a local effect, rather than systemic.

[0055] The dose of local anesthetic will depend on the anesthetic being administered as well as the site where the local anesthetic is administered. For example, in embodiments where the local anesthetic is administered via a regional block (e.g., an ankle block), the dose of anesthetic ranges from about 1 ml up to about 30 ml of a 0.5% solution (e.g., bupivacaine). In other embodiments a 3 mg/kg dose (maximum 200 mg) of a 2% solution (e.g., lidocaine) can be administered by intra-articular infiltration. In other embodiments the dose of local anesthetic can range between 0.5 ml to about 60 ml of a 0.25% to 5% solution.

[0056] Alternatively, phenol can be administered at the surgical site or open wound to be treated in place of (or in addition to) a local anesthetic to anesthetize the area. Phenol can preferably be administered prior to administration of the capsaicinoid, or can be co-administered with the dose of capsaicinoid. By co-administration it is meant either the administration of a single composition containing both the capsaicinoid and the phenol, or the administration of the capsaicinoid and the phenol as separate compositions within short enough time periods that the effective result is equivalent to that obtained when both compounds are administered as a single composition.

[0057] Prior to the present invention, for example, in U.S. Pat. No. 4,313,958 (LaHann), capsaicin is described as producing analgesia when administered via “systemic administration” (i.e., intrathecal, epidural, intramuscular, intravenous, intraperitoneal and subcutaneous). Animal testing was accomplished via “stair-step dosing” which purportedly was said to reduce or eliminate some of the side effects of capsaicin. It is reported therein that capsaicin, when systemically delivered in final doses of 25 mg/kg or less prior to ultra violet radiation, prevented radiation induced hyperalgesia, but did not elevate the pain threshold above normal range. Only when larger doses of capsaicin were administered systemically, i.e. final doses of capsaicin being 50 mg/kg or greater, was the pain threshold elevated. LaHann hypothesized (but did not exemplify), that for clinical use in humans, total doses from 0.05 mg/kg to 1,000 mg/kg were acceptable and total doses from 0.25 mg/kg to 500 mg/kg were preferred. The rats weighed between 125 and 175 grams and the total administered dose of capsaicin ranged from 27 mg/kg to 102 mg/kg (or a total dose injected subcutaneously of about 3.375 mg to about 17.85 mg capsaicin).

[0058] More recently, U.S. Pat. No. 5,962,532 (Campbell et al) describes an injection volume of 0.1 to 20 ml and a

concentration of capsaicin between 0.01 to 10% for parenteral administration, which calculates to a total dose of capsaicin of between 0.01 mg to 2,000 mg, based on volume and concentration.

[0059] In contrast, in the present invention, the administration of microgram quantities of capsaicin into discrete localized areas, surgical sites or open wounds responsible for the treatment and/or attenuation of pain recognizes significant advantages over system-wide exposure to milligram quantities in order to produce a therapeutic effect through alteration of sensory nerve function in a limited area.

[0060] In the present invention, a single dose from about 1 μ g to 5,000 μ g of capsaicin, or a therapeutically equivalent dose of one or more other capsaicinoids, is administered via injection or implantation to produce a selective, highly-localized destruction or incapacitation of C-fiber and/or A-delta-fiber in discrete localized areas responsible for the initiation of pain for the purpose of eliminating pain arising from that locus, while minimizing potential adverse consequences of C-fiber and/or A-delta-fiber activation and/or damage outside of the locus of pain. In certain preferred embodiments, from about 10 to about 3000 micrograms of capsaicin, or a therapeutically equivalent dose of one or more other capsaicinoids, is administered at the site. In certain preferred embodiments, the amount of capsaicin administered at the site is preferably from about 100 to about 1000 micrograms. In certain other embodiments the amount of capsaicin administered at the site is preferably from about 10 to about 1000 micrograms, more preferably from 20 to about 300 micrograms, and most preferably from about 35 to about 200 micrograms. In other words, the present invention is directed to administration of a single dose of capsaicin or other capsaicinoid(s) by injection or implantation in an amount that is greatly reduced as compared to the dosage range previously considered useful by those skilled in the art to denervate the nerve fibers in a discrete, localized area without eliciting a systemic effect (e.g., an effect beyond that discrete, localized location).

[0061] In other embodiments of the present invention, a single dose of from about 1 μ g to 15,000 μ g of capsaicin, or a therapeutically equivalent dose of one or more other capsaicinoids, is administered via infiltration to produce a selective, highly-localized destruction or incapacitation of C-fiber and/or A-delta-fiber in discrete localized areas responsible for the initiation of pain for the purpose of eliminating pain arising from that locus, while minimizing potential adverse consequences of C-fiber and/or A-delta-fiber activation and/or damage outside of the locus of pain. In certain preferred embodiments, from about 600 to about 15,000 micrograms of capsaicin, or a therapeutically equivalent dose of one or more other capsaicinoids, is administered at the surgical site or open wound. In certain preferred embodiments, the amount of capsaicin and/or preferably the range of capsaicin administered at the surgical site or open wound is from about 1,000 to about 10,000 micrograms. In other words, the present invention is directed to administration of a single dose of capsaicin or other capsaicinoid(s) by infiltration in an amount that is greatly reduced as compared to the dosage range previously considered useful by those skilled in the art to denervate the nerve fibers in a discrete, localized area without eliciting a systemic effect (e.g., an effect beyond that discrete, localized location).

[0062] Capsaicinoids (capsaicin analogues) with similar physiological properties, i.e., triggering C fiber membrane depolarization by opening of cation channels permeable to calcium and sodium, are known. For example, resiniferatoxin is described as a capsaicin analogue in U.S. Pat. No. 5,290,816 to Blumberg. U.S. Pat. No. 4,812,446 to Brand (Procter & Gamble Co.) describes other capsaicin analogues and methods for their preparation. U.S. Pat. No. 4,424,205 cites capsaicin analogues. Ton et al., Brit. J. Pharm. 10:175-182 (1955) discusses the pharmacological actions of capsaicin and its analogues. Capsaicin, capsaicin analogues and other capsaicinoids are also described in detail in WO 96/40079, the disclosure of which is hereby incorporated by reference. Capsaicinoids are also described in EP0 149 545, the disclosure of which is also hereby incorporated by reference.

[0063] Alternatively, capsaicinoids (analogues) may be administered at the site in replacement of, part of, or all of the dose of capsaicin, the capsaicin analogue being administered in a therapeutically equivalent amount of capsaicin for which it is substituted. Where a capsaicin analogue is selected to replace some or all of the capsaicin, the capsaicin analogue can be selected from those compounds with similar physiological properties to capsaicin as are known in the art. Resiniferatoxin qualitatively resembles capsaicin in its activity, but differs quantitatively in potency (i.e. 103 -104 fold more potent) and in relative spectrum of actions. For resiniferatoxin it is recommended to administer 0.1×10^{-3} to 5×10^{-2} mg/kg, preferably 0.1×10^{-3} to 5×10^{-3} -mg/kg, body weight of the subject for single application, or less upon multiple application. In certain embodiments, resiniferatoxin is administered in the range of 1×10^{-5} mg/kg to 5×10^{-2} mg/kg to the subject. Resiniferatoxin also shows a somewhat different spectrum of action, providing greater relief of pain at a given dose. Therefore, the dose of resiniferatoxin should be at least 100 fold less than a dose of capsaicin alone.

[0064] Other suitable capsaicin analogues preferably include, but are not limited to, N-vanillylnonanamides, N-vanillylsulfonamides, N-vanillylureas, N-vanillylcarbamates, N[(substituted phenyl)rethyl]alkylamides, methylene substituted N[(substituted phenyl)methyl]alkanamides, N[(substituted phenyl) methyl]-cis-monosaturated alkenamides, N[(substituted phenyl)methyl]diunsaturated amides, 3-hydroxyacetanilide, hydroxyphenylacetamides, pseudocapsaicin, dihydrocapsaicin, nordihydrocapsaicin, homocapsaicin, homodihydrocapsaicin I, anandamide, piperine, zingerone, warburganal, polygodial, aframodial, cinnamodial, cinnamosmolide, cinnamolide, civamide, nonivamide, olvanil, N-oleyl-homovanillamidia, isovelleral, scalaradial, ancistrodial, β -acardial, merulidial, scutigeral and any combinations or mixtures thereof.

[0065] In certain embodiments, the capsaicinoid utilized in the compositions and methods of the invention is capsaicin itself. In certain preferred embodiments, the capsaicin is in a purified form obtained from the chemical purification of Capsaicin USP. In certain preferred embodiments, the purified capsaicin used in the compositions and methods of the invention consists essentially of the trans isomer. The trans-isomer of capsaicin has its activity at the vanilloid receptor, and this embodiment, the methods and formulation of the present invention are especially useful for treating disorders or pain that can be alleviated through activation of the

vanilloid receptors via the VR-1 mechanism. Whereas Capsaicin USP contains only about 55-60% trans-capsaicin, with the remainder comprising the precursors dihydrocapsaicin and nordihydrocapsaicin, in such embodiments the formulation preferably consists essentially of trans-capsaicin, e.g., preferably having a purity of greater than about 97%, preferably greater than about 98%, more preferably greater than about 99% trans-capsaicin.

[0066] The trans isomer is preferably prepared in accordance with the method for synthesizing the trans isomer of capsaicin from a four step process and purified as describe in U.S. Provisional Application No. 60/461,164 filed Apr. 8, 2003, the disclosure of which is hereby incorporated by reference in its entirety. In accordance with U.S. Provisional Application No. 60/461,164 said method for synthesizing the trans isomer of capsaicin comprises a) alkylating 3-methyl butyne with halovaleric acid and/or haloalkanic acid to obtain 8-methyl-6-nonynoic acid and/or alkynoyic acid analogues thereof, b) reducing said 8-methyl-6-nonynoic acid to obtain trans-8-methyl-nonenoic acid; c) activating the 8-methyl-nonenoic acid to obtain an acid chloride; and d) acylating 4-hydroxy-3-methoxybenzylamine hydrochloride with the acid chloride to obtain trans-capsaicin.

[0067] In certain embodiments, step a) of the method for preparation of the capsaicin for use in the present invention comprises the steps of: i) mixing anhydrous tetrahydrofuran (THF) with hexamethylphosphoramide (HMPA) and cooling the mixture to about -78°C . to about -75°C .; ii) adding to the mixture of step i) 3-methyl butyne followed by a dropwise addition of a base at a temperature from about -78°C . to about -65°C . to obtain a second mixture; iii) warming the second mixture up to about -30°C . and stirring for about 30 minutes; and iv) adding dropwise a solution of a halovaleric acid in anhydrous tetrahydrofuran at a temperature of about -30°C . for about 10 to about 15 minutes, then gradually warming to room temperature and stirring overnight to obtain a reaction mixture.

[0068] In certain other embodiments, there is provided a method for obtaining a crude step a) intermediate product further comprising the steps of: i) adding 3M hydrochloric acid (HCl) to a reaction mixture and extracting the reaction mixture with ethyl acetate; and ii) washing the extracted reaction mixture with brine to yield a crude product.

[0069] In certain embodiments, step b) of the method for preparation of the capsaicin for use in the present invention comprises the steps of: i) dissolving said 8-methyl-6-nonynoic acid in a mixture of anhydrous tetrahydrofuran and tertiary-butyl alcohol (t-BuOH) to obtain a solution and cooling the solution to about -55°C . to about -40°C .; ii) condensing ammonia (NH_3) to the solution to a temperature of about -50°C . to about -40°C .; iii) adding sodium drips piece-wise and stirring from about 30 minutes to about 2 hours at a temperature from about -45°C . to about -30°C ., and iv) adding ammonium chloride (NH_4Cl), warming to room temperature and allowing the NH_3 to evaporate overnight to obtain a reaction mixture. Step iii) of the step b) reaction may further comprise adding piece-wise lithium and stirring from about 30 minutes to about 2 hours at a temperature from about -65°C to about -45°C .

[0070] In certain other embodiments crude step b) intermediate product further comprises the steps of: i) adding water to a reaction mixture; ii) acidifying the reaction

mixture with 6N HCl to a pH of about 2 to about 3; iii) extracting the reaction mixture with ethyl acetate, washing with brine and drying over anhydrous sodium sulfate (Na₂SO₄); and iv) filtering and removing solvents under vacuum to obtain a crude step b) intermediate product.

[0071] In certain embodiments, step c) of the method for preparation of the capsaicin for use in the present invention comprises the steps of: i) adding dropwise a thionyl halide to the 8-methyl-nonenic acid at room temperature for about 15 minutes to about 30 minutes to form a solution; ii) heating the solution at about 50° C. to about 75° C. for a period of about 1 hour; and iii) removing excess thionyl halide under vacuum at about 40° C. to about 45° C. to obtain a step c) intermediate product.

[0072] In certain embodiments, step d) of the method for preparation of the capsaicin for use in the present invention comprises the steps of: i) mixing 4-hydroxy-3-methoxy benzylamine hydrochloride and dimethylformamide (DMF); ii) adding portion-wise at room temperature to the mixture of step i) 5N sodium hydroxide (NaOH) and stirring for about 30 minutes; iii) adding acid halide in anhydrous ether dropwise at a temperature of about 0° C. to about 10° C. for about 20 minutes to about 1 hour; and, thereafter, iv) gradually warming the mixture to room temperature and stirring overnight. In certain embodiments step d) further comprises the steps of: i) adding water to the mixture and extracting the mixture with ethyl acetate to obtain an ethyl acetate extract; ii) washing said extract with 1N HCl and, thereafter, washing with sodium bicarbonate (NaHCO₃); iii) washing the solution with brine and drying over anhydrous sodium sulfate (Na₂SO₄); and iv) filtering and removing solvents under vacuum to obtain a crude product.

[0073] In certain preferred embodiments, the method of preparing the trans-capsaicin or capsaicin intermediate after one or more of the steps (e.g., a), b), c) and/or d)) further comprises purifying the crude product by column chromatography, flash chromatography, or the like, using silica gel and eluting with a mixture of ethyl acetate/hexane to obtain a crude trans-capsaicin product.

[0074] Preferably after the capsaicin is formed via the 4 step process as described above, the trans-capsaicin product is subjected to purification process comprising the steps of: i) dissolving the crude trans-capsaicin product in a mixture of ether/hexane and heating the mixture to about 40° C. to about 45° C.; ii) cooling the mixture to room temperature while stirring for about 2 hours; and iii) filtering the mixture to provide a purified trans-capsaicin product.

[0075] Alternatively, or additionally to the purification process(es) as described above, the capsaicin is subjected to a further purification process also referred to as a "semi-prep purification" or "semi-preparative purification" of capsaicin. In the semi-prep purification, the capsaicin or previously purified capsaicin is purified via the use of a semi-preparative HPLC (high performance liquid chromatography), which preferably provides for a trans-capsaicin product having a purity of greater than about 97%, preferably greater than about 98%, more preferably greater than about 99% capsaicin.

[0076] In certain preferred embodiments, the active ingredient in the preparation comprises substantially pure trans-capsaicin (e.g. having no more than about 10% precursors or

other capsaicin compounds such as cis-capsaicin). In more preferred embodiments, the preparation includes at least about 95% pure trans-capsaicin. In most preferred embodiments, the preparation includes at least about 99% pure trans-capsaicin. While the cis-isomer of capsaicin has activity via a number of mechanisms, VR-1 is not considered to comprise a major effect of this agent.

[0077] In view of the collective activity of the trans-isomer of capsaicin at the VR-1 receptor, it is contemplated that it is possible in certain embodiments of the present invention that the amount of trans-capsaicin included in the methods and formulations of the present invention will be reduced in comparison to a preparation which includes a less pure form of capsaicin (e.g., capsaicin USP).

[0078] In other embodiments of the present invention, the formulations and methods of the invention contemplate the use of a capsaicin agent consisting essentially of cis-capsaicin.

[0079] Capsaicin, in either crude extract form, Capsaicin USP, or as purified capsaicin, has been comprehensively studied in a variety of tests in vitro, and in several animal species in vivo. Administration of a single dose of capsaicinoid according to the methods of the present invention minimizes and/or prevents systemic delivery of the capsaicin for the purposes of: a) producing a selective, highly-localized destruction or incapacitation of C-fibers and/or A-delta fibers in a discrete, localized area responsible for the initiation of pain (e.g., intra-articular joints, intrabursally) for the purpose of reducing or eliminating pain arising from a discrete locus (i.e., producing antinociception), and b) minimizing potential adverse consequences of C-fiber and/or A-delta activation and or damage outside of the locus of pain (i.e., damage to homeostatic mechanisms, such as cardiac reflex [e.g., Bezold-Jarisch reflex] or micturition reflex [e.g., urge to void] or to nerve fibers in the central nervous system). The analgesic effect preferably provides pain relief for at least about 48 to about 120 hours, preferably from about 10 to about 21 days, more preferably from about 4 to about 5 weeks, even more preferably for at least about 6 to about 8 weeks, and most preferably for at least about 16 weeks or more.

[0080] Delivery systems can also be used to administer capsaicin and local anesthetics that produce modality-specific blockade, as reported by Schneider, et al., *Anesthesiology*, 74:270-281 (1991), or possess physical-chemical attributes that make them more useful for sustained release than for single injection blockade, as reported by Masters, et al., *Soc. Neurosci. Abstr.*, 18:200 (1992), the teachings of which are incorporated herein. An example of a delivery system includes microspheres wherein the anesthetic is incorporated into a polymer matrix in a percent loading of 0.1% to 90% by weight, preferably 5% to 75% by weight. It is possible to tailor a system to deliver a specified loading and subsequent maintenance dose by manipulating the percent drug incorporated in the polymer and the shape of the matrix, in addition to the form of local anesthetic (free base versus salt) and the method of production. The amount of drug released per day increases proportionately with the percentage of drug incorporated into the matrix (for example, from 5 to 10 to 20%). Other forms of delivery systems include microcapsules, slabs, beads, and pellets, which in some cases can also be formulated into a paste or suspension.

[0081] The delivery systems are most preferably formed of a synthetic biodegradable polymer, although other materials may also be used to formulate the delivery systems, including proteins, polysaccharides, and non-biodegradable synthetic polymers. It is most preferable that the polymer degrade in vivo over a period of less than a year, with at least 50% of the polymer degrading within six months or less. Even more preferably, the polymer will degrade significantly within a month, with at least 50% of the polymer degrading into non-toxic residues which are removed by the body, and 100% of the capsaicin and anesthetic being released within a two week period. Polymers should also preferably degrade by hydrolysis by surface erosion, rather than by bulk erosion, so that release is not only sustained but also linear. Polymers which meet this criteria include some of the polyanhydrides, poly(hydroxy acids) such as copolymers of lactic acid and glycolic acid wherein the weight ratio of lactic acid to glycolic acid is no more than 4:1 (i.e., 80% or less lactic acid to 20% or more glycolic acid by weight), and polyorthoesters containing a catalyst or degradation enhancing compound, for example, containing at least 1% by weight anhydride catalyst such as maleic anhydride. Other polymers include protein polymers such as gelatin and fibrin and polysaccharides such as hyaluronic acid. Polylactic acid is not useful since it takes at least one year to degrade in vivo. The polymers should be biocompatible. Biocompatibility is enhanced by recrystallization of either the monomers forming the polymer and/or the polymer using standard techniques.

[0082] Other local carrier or release systems can also be used, for example, the lecithin microdroplets or liposomes of Haynes, et al., *Anesthesiology* 63, 490-499 (1985), or the polymer-phospholipid microparticles of U.S. Pat. No. 5,188,837 to Domb.

[0083] Methods for manufacture of suitable delivery systems for administration of capsaicin alone or together with the local anesthetic are known to those skilled in the art. The formulations may also be designed to deliver both the anesthetic and the capsaicin, either simultaneously or sequentially.

[0084] The local anesthetic can preferably be administered by direct injection, implantation or infiltration to the site where the capsaicin or capsaicin analogue is to be administered, for example, by administering the local anesthetic directly in the diseased or pain producing structure or the injured nerve or the nerve that provides innervation to the painful area, or to effect a regional block of the area including the site where the capsaicin is to be administered.

[0085] In another embodiment, the local anesthetic can preferably be administered by injection or implantation of the anesthetic into the epidural space adjacent to the spine for pain originating below a patient's waist, or directly into a joint for pain originating above the patient's waist. The prior administration of a proximal neural block sufficiently desensitizes C fibers to the expected pungent side effects of the subsequent capsaicin administration.

[0086] In the embodiment wherein the anesthetic is administered as microspheres, the microspheres may be injected, implanted or infiltrated through a trocar, or the pellets or slabs may be surgically placed adjacent to nerves, prior to surgery or following repair or washing of a wound. The microspheres can be administered alone when they

include both the capsaicin and local anesthetic or in combination with a solution including capsaicin in an amount effective to prolong nerve blockade by the anesthetic released from the microspheres. The suspensions, pastes, beads, and microparticles will typically include a pharmaceutically acceptable liquid carrier for administration to a patient, for example, sterile saline, sterile water, phosphate buffered saline, or other common carriers.

[0087] The expected side effects of the dose of capsaicin are believed to be from the intense nociceptor discharge occurring during the excitatory phase before nociceptor desensitization. However, the prior administration of an anesthetic, such as a nerve block, proximally or directly to the site of administration, eliminates or substantially reduces such side effects. If some "breakthrough pain" occurs despite the anesthetic, this pain may be treated by administering an analgesic such as a nonsteroidal anti-inflammatory agent or narcotic analgesic (i.e., the various alkaloids of opium, such as morphine, morphine salts, and morphine analogues such as normorphine). The administration of the capsaicin can be repeated if necessary.

[0088] The administration of the anesthetic along with the subsequent administration of capsaicin or capsaicin-like compounds alleviates pain at the site for a prolonged period of time. Patients can be monitored for pain relief and increased movement, in the situation where treatment is in a joint. The treatment can be repeated as necessary to control the symptoms.

[0089] The compositions and methods of the present invention can be used for treating various conditions associated with pain by providing pain relief at a specific site, a surgical site or open wound. Examples of conditions to be treated include, but are not limited to, nociceptive pain (pain transmitted across intact neuronal pathways), neuropathic pain (pain caused by damage to neural structures), pain from nerve injury (neuromas and neuromas in continuity), pain from neuralgia (pain originating from disease and/or inflammation of nerves), pain from myalgias (pain originating from disease and/or inflammation of muscle), pain associated with painful trigger points, pain from tumors in soft tissues, pain associated with neurotransmitter-dysregulation syndromes (disruptions in quantity/quality of neurotransmitter molecules associated with signal transmission in normal nerves) and pain associated with orthopedic disorders such as conditions of the foot, knee, hip, spine, shoulders, elbow, hand, head and neck that require surgery.

[0090] The receptors involved in pain detection are aptly enough referred to as nociceptor-receptors for noxious stimuli. These nociceptors are free nerve endings that terminate just below the skin as to detect cutaneous pain. Nociceptors are also located in tendons and joints, for detection of somatic pain and in body organs to detect visceral pain. Pain receptors are very numerous in the skin, hence pain detection here is well defined and the source of pain can be easily localized. In tendons, joints, and body organs the pain receptors are fewer. The source of pain therefore is not readily localized. Apparently, the number of nociceptors also influences the duration of the pain felt. Cutaneous pain typically is of short duration, but may be reactivated upon new impacts, while somatic and visceral pain is of longer duration. It is important to note that almost all body tissue is equipped with nociceptors. As explained

above, this is an important fact, as pain has primary warning functions. If we did not feel pain and if pain did not impinge on our well-being, we would not seek help when our body aches. Nociceptive pain preferably includes, but is not limited to post-operative pain, cluster headaches, dental pain, surgical pain, pain resulting from severe burns, post-partum pain, angina, genitor-urinary tract pain, pain associated with sports injuries (tendonitis, bursitis, etc . . .) and pain associated with joint degeneration and cystitis.

[0091] Neuropathic pain generally involves abnormalities in the nerve itself, such as degeneration of the axon or sheath. For example, in certain neuropathies the cells of the myelin sheath and/or Schwann cells may be dysfunctional, degenerative and may die, while the axon remains unaffected. Alternatively, in certain neuropathies just the axon is disturbed, and in certain neuropathies the axons and cells of the myelin sheath and/or Schwann cells are involved. Neuropathies may also be distinguished by the process by which they occur and their location (e.g. arising in the spinal cord and extending outward or vice versa). Direct injury to the nerves as well as many systemic diseases can produce this condition including AIDS/HIV, Herpes Zoster, syphilis, diabetes, and various autoimmune diseases. Neuropathic pain is often described as burning, or shooting type of pain, or tingling or itching pain and may be unrelenting in its intensity and even more debilitating than the initial injury or the disease process that induced it.

[0092] Neuropathies treatable by the methods of the present invention include: syndromes of acute ascending motor paralysis with variable disturbance of sensory function; syndromes of subacute sensorimotor paralysis; syndromes of acquired forms of chronic sensorimotor polyneuropathy; syndromes of determined forms of genetic chronic polyneuropathy; syndromes of recurrent or relapsing polyneuropathy; and syndromes of mononeuropathy or multiple neuropathies (Adams and Victor, *Principles of Neurology*, 4th ed., McGraw-Hill Information Services Company, p. 1036, 1989). Syndromes of acute ascending motor paralysis are selected from the group consisting of acute idiopathic polyneuritis, Landry-Guillain-Barre Syndrome, acute immune-mediated polyneuritis, infectious mononucleosis polyneuritis, hepatitis polyneuritis; diphtheric polyneuropathy; porphyric polyneuropathy; toxic polyneuropathy (e.g., thallium); acute axonal polyneuropathy; acute panautonomic neuropathy; vaccinogenic, serogenic, paraneoplastic, polyarteritic and lupus polyneuropathy.

[0093] Syndromes of subacute sensorimotor paralysis are selected from the group consisting of deficiency states (e.g., beriberi, pellagra, vitamin B12); heavy metal/industrial solvent poisonings (e.g., arsenic, lead); drug overdose (e.g., isoniazid, disulfuram, vincristine, taxol, chloramphenicol); uremic polyneuropathy; diabetes; sarcoidosis; ischemic neuropathy and peripheral vascular disease; AIDS; and radiation (radiotherapy). Syndromes of chronic sensorimotor are selected from the group consisting of carcinoma, myeloma and other malignancies; paraproteinemias; uremia; beriberi (usually subacute), diabetes, hypo/hyperthyroidism; connective tissue disease; amyloidosis; leprosy and sepsis. Genetic chronic polyneuropathies are selected from the group consisting of dominant mutilating sensory neuropathy (adult); recessive mutilating sensory neuropathy (childhood); congenital insensitivity to pain; spinocerebellar degenerations, Riley Day Syndrome; Universal Anesthesia Syndrome;

polyneuropathies w/ metabolic disorder; and mixed sensorimotor-autonomic type polyneuropathies. Recurrent/relapsing polyneuropathy are selected from the group consisting of idiopathic polyneuritis; porphyria; chronic inflammatory polyradiculoneuropathy; mononeuritis multiplex; beriberi/drug overdose; refsum disease and tangier disease. Mono/multiple neuropathies are selected from the group consisting of pressure palsies; traumatic neuropathies (e.g., irradiation or electrical injury); serum, vaccinogenic (e.g., rabies, smallpox); herpes zoster; neoplastic infiltration; leprosy; diphtheric wound infections; migrant sensory neuropathy; shingles and post herpetic neuralgia.

[0094] Neurotransmitter-dysregulation pain syndromes, rather than involving abnormal or damaged nerves, result from normal nerves having disruptions in the quantity and/or quality of the various neurotransmitter molecules associated with signal transmission from one neuron to another. More specifically, sensory transmitters are released from the afferent nerve ending of one nerve cell and received by receptors at the afferent end of another nerve cell. They are chemical messengers which transmit the signal. There are numerous transmitters, including glutamate, serotonin, dopamine, norepinephrine, somatostatin, substance P, calcitonin gene-related peptide, cholecystokinin, opiates and saponins. Alterations in the quantity of transmitters and neuropeptide release, changes in the afferent receptor, changes of reuptake of the transmitter and/or neuropeptides can all yield qualitative change of the neural signaling process. As a result, the aberrant signal transmission is interpreted by the body as pain. A representative neurotransmitter dysregulation syndrome that may be treated by the present invention includes fibromyalgia, which is a common condition characterized by a history of chronic generalized pain and physical exam evidence of at least 11 of 18 defined "tender point" sites in muscles and connective tissue (Wolfe et al., *Arthritis Rheum* 33:160-72, 1990). Commonly associated conditions include irritable bowel syndrome, headache, irritable bladder syndrome (interstitial cystitis), sleep disturbance, and fatigue (Goldenberg, *Current Opinion in Rheumatology* 8:113-123, 1996; Moldofsky et al., *Psychosom Med* 37:341-51, 1975; Wolfe et al., 1990; Wolfe et al., *J Rheum* 23:3, 1996; Yunus et al., *Semin Arthritis Rheum* 11: 151-71, 1981).

[0095] A predominant theory regarding the etiology of fibromyalgia holds that an imbalance and/or dysregulation of neurotransmitter function may occur within the central nervous system (CNS), either in the brain or spinal cord and in the relation of the CNS to muscle and connective tissue via regulatory nerve pathways (Goldenberg, 1996; Russell, *Rheum Dis Clin NA* 15:149-167, 1989; Russell et al., *J Rheumatol* 19:104-9, 1992; Vaeroy et al., *Pain* 32:21-6, 1988; Wolfe et al., 1996). Neurotransmitters are chemical messengers, amino acids, biogenic amines and neuropeptides, emitted from nerve cells that interact with receptors on other nerve cells, as well as other cell types, including muscle and immune cells. Neurotransmitter imbalance, which leads to increased pain experience, may include a qualitative and/or quantitative decrease in the function of such neurotransmitters as glutamate, serotonin, dopamine, norepinephrine, somatostatin, substance P, calcitonin gene-related peptide, cholecystokinin, opiates and saponins. Fibromyalgia is characterized by a relative deficit of serotonin effect and relative excess of substance P effect. This imbalance results in amplified modulation of pain-signaling

in the central nervous system, resulting in neurogenic pain (Matucci-Cerinic, *Rheumatic Disease Clinics of North America* 19:975-991, 1993; Bonica, *The Management of pain*, Lea and Febiger, 2d ed., Philadelphia, pp. 95-121, 1990). Similar mechanisms may be at work to cause associated conditions; for example, dysregulation of neurotransmitter signaling in the bowel musculature, leading to irritable bowel syndrome symptoms such as cramping, diarrhea, and/or constipation.

[0096] Neurotransmitter-dysregulation pain syndromes include, but are not limited to the following: generalized syndromes, localized syndromes; craniofacial pain;; vascular disease; rectal, perineum and external genitalia pain; and local syndromes of the leg/foot.

[0097] Generalized syndromes are selected from the group consisting of stump pain, causalgia, reflex sympathetic dystrophy, fibromyalgia or diffuse myofascial pain and burns. Localized syndromes are selected from the group consisting of trigeminal neuralgia; acute herpes zoster; panautonomic neuralgia; geniculate neuralgia (Rom'say Hunt Syndrome); glossopharyngeal neuralgia; vagus nerve neuralgia and occipital neuralgia. Craniofacial pain includes temporomandibular pain. Suboccipital and cervical musculoskeletal disorders are selected from the group consisting of myofascial syndrome, which includes cervical sprain cervical hyperextension (whiplash); sternocleidomastoid muscle; trapezius muscle; and stylohyoid process syndrome (Eagle's syndrome). Vascular disease is selected from the group consisting of Raynaud's disease; Raynaud's phenomenon; frostbite; erythema pernio (chilblains); acrocyanosis and livedo reticularis. Rectal, perineum and external genitalia pain are selected from the group consisting of iliohypogastric neuralgia; ilioinguinal nerve; genitofemoral nerve and testicular pain. Local syndromes of the leg/foot are selected from the group consisting of lateral cutaneous neuropathy (neuralgia paresthetica); obturator neuralgia; femoral neuralgia; sciatica neuralgia; interdigital neuralgia of the foot (Morton's metatarsalgia or neuroma); injection neuropathy and painful legs and moving toes.

[0098] Pain Intensity assessment scales are typically used by those of ordinary skill in the art to evaluate analgesic choices and therapeutic effects.

[0099] A Visual Analogue Scale (VAS) is a measurement instrument that measures a characteristic that is believed to range across a continuum of values and cannot easily be directly measured. For example, the amount of pain that a patient feels ranges across a continuum from none to an extreme amount of pain may be indirectly measured via the use of a VAS. Operationally a VAS is usually a horizontal line, 100 mm in length, anchored by word descriptors at each end, for example "no pain" at one end and "very severe pain" at the other end. The patient, marks on the line the point that they feel represents their perception of their current state. The VAS score is determined by measuring in millimeters from the left hand end of the line to the point that the patient marks. The 100-mm visual analog scale (VAS), a unidimensional scale that is versatile and easy to use, has been adopted in many settings.

[0100] The capsaicinoid formulations and methods described herein may be used to treat many conditions where the capsaicinoid can be administered via injection, implantation or infiltration into a specific site, a surgical site

or open wound of the patient, including but not limited to the treatment of acute or chronic pain, nociceptive and neuropathic pain, pre- and post-operative pain, cancer pain, pain associated with neurotransmitter dysregulation syndromes and orthopedic disorders, sports-related injuries, acute traumatic pain, nociceptive pain, and neurotransmitter-dysregulation syndromes.

[0101] Treatment of Chronic Post-Herniorrhaphy Pain

[0102] In a preferred embodiment, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of chronic post-herniorrhaphy pain. Chronic post-herniorrhaphy pain occurs in between 5-30% of patients, with social consequences limiting some type of activity in about 10% of patients and 1-4% of patients are referred to chronic pain clinics. Nerve damage is probably the most plausible pathogenic factor, but specific principles for therapy have not been evidence-based and range from usual analgesics to re-operation with mesh removal and various types of nerve sections without any demonstrated efficacy in sufficient follow-up studies with or without randomized data. In patients suffering from pain associated with chronic post-herniorrhaphy, the dose of capsaicinoid can be administered to the site where the surgery was performed or to the immediate area surrounding the incision.

[0103] Treatment of Pain Associated with Morton's Neuroma

[0104] In another preferred embodiment, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of pain associated with Morton's Neuroma. Morton's Neuroma is considered to be most likely a mechanically induced degenerative neuropathy which has a strong predilection for the third common digital nerve in middle-aged women. It is considered a well-defined model of neuropathic pain. The usual medical treatment of Morton's neuroma includes local injection of steroids, often with lidocaine. When nonsurgical means fail to relieve patient's symptoms, surgical removal of this offending neuroma through a dorsal approach can produce dramatic relief of symptoms in approximately 80% of patients. However, 20% of patients experience neuroma recurrence (referred to as stump or amputation neuroma) that often causes more severe pain than the original neuroma and is generally treatment resistant. Administration of capsaicinoid in accordance with the invention is useful for the treatment of the neuropathic pain associated with Morton's Neuroma and may reduce the re-occurrence of pain associated with stump or amputation neuroma.

[0105] Treatment of Pain Associated with Mastectomy

[0106] In a preferred embodiment, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of pain associated with mastectomy. Mastectomy results in significant pain and requires substantial doses of opioids postoperatively. Analgesic techniques that provide good pain control while minimizing opioid side effects are thus highly desirable. The administration of capsaicinoid in a patient requiring a mastectomy may reduce the amount of opioid consumption and postoperative pain scores associated with the procedure. In patients requiring a mastectomy, the dose of capsaicinoid can be administered to the site where the surgery was performed or to the muscle, tissue and bones surrounding the surgical site.

[0107] Treatment of Pain Associated With Median Sternotomy

[0108] In another preferred embodiment, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of pain associated with median sternotomy. Median sternotomy is performed in patients undergoing cardiac, pulmonary, or mediastinal surgery for various indications. The procedure is performed through a vertical midline incision over the sternum. After dividing the overlying midline fascia and muscle the sternum is divided in its midline, from the sternal notch to the xiphoid process, using either a sternal saw or a Lebsche knife. Bleeding edges in the periosteum are controlled with point electrocautery. Hemostasis of the marrow may be achieved using bone wax or a Gel-foam/Thrombin mixture pressed into the marrow. A sternal retractor is then placed to spread the sternal edges apart and to maintain the surgical exposure. The dose of capsaicinoid can be administered directly to the sternal edges, the muscle and/or tissue surrounding the surgical site or or directly to the bone (e.g., sternum). At completion of the procedure the sternal edges are reapproximated with stainless steel wire. The remaining wound is closed in fascial layers. Median sternotomy results in sternal instability and pain requiring not only substantial doses of opioids postoperatively, but also substantial amounts of nursing and physical therapy time in order to ambulate the patients. Analgesic techniques that provide good pain control while minimizing opioid side effects are thus highly desirable. The administration of a capsaicinoid in a patient requiring a median sternotomy may reduce the amount of opioid consumption and postoperative pain scores associated with the procedure.

[0109] Orthopedic Disorders

[0110] The capsaicinoid formulations and methods disclosed herein may be utilized to treat/attenuate pain associated with orthopedic disorders. Orthopedic disorders treatable via the use of the formulations and methods of the invention include but are not limited to disorders of the knee, shoulders, back, hip, spine, elbows, foot, hand and other disorders, which involve pain at a specific site or body space. Orthopedic disorders affecting these locations include, but are not limited to bursitis, tendonitis, osteoarthritis, and rheumatoid arthritis.

[0111] A. Bursitis

[0112] Bursitis is the inflammation of a bursa. Bursae are saclike cavities or potential cavities that contain synovial fluid located at tissue sites where friction occurs (e.g., where tendons or muscles pass over bony prominences). Bursae facilitate normal movement, minimize friction between moving parts, and may communicate with joints. In the normal state, the bursa provides a slippery surface that has almost no friction. A problem arises when a bursa becomes inflamed. The bursa loses its gliding capabilities, and becomes more and more irritated when it is moved. When the condition called bursitis occurs, the slippery bursa sac becomes swollen and inflamed. The added bulk of the swollen bursa causes more friction within already confined spaces. Also, the smooth gliding bursa becomes gritty and rough. Movement of an inflamed bursa are painful and irritating. Bursitis usually occurs in the shoulder (subacromial or subdeltoid bursitis). Other sites include the olecranon (miners' elbow), prepatellar (housemaid's knee) or suprapatellar, retrocalcaneal (Achilles), iliopectineal (iliop-

soas) of the hip, ischial (tailor's or weaver's bottom) of the pelvis, greater trochanteric of the femur, and first metatarsal head (bunion). Bursitis may be caused by trauma, chronic overuse, inflammatory arthritis (eg, gout, rheumatoid arthritis), or acute or chronic infection (eg, pyogenic organisms, particularly *Staphylococcus aureus*; tuberculous organisms, which now rarely cause bursitis). Orthopedic disorders of the foot include, but are not limited to, heel spurs, corns, bunions, Morton's neuroma, hammertoes, ankle sprain, fractures of the ankle or metatarsals or sesamoid bone or toes, plantar fasciitis and injuries to the achilles tendon. Orthopedic disorders of the hand include, but are not limited to, arthritis, carpal tunnel syndrome, ganglion cysts, tendon problems such as lateral epicondylitis, medial epicondylitis, rotator cuff tendonitis, DeQuervian's tenosynovitis, and trigger finger/trigger thumb. Other orthopedic disorders include, but are not limited to, Paget's disease, scoliosis, soft-tissue injuries such as contusions, sprains and strains, long bone fractures and various other sports injuries some of which include patellar tendonitis and lumbar strain.

[0113] Treatment of non-infected acute bursitis has mainly consisted of temporary rest or immobilization and high-dose NSAIDs, sometimes narcotic analgesics, may be helpful. Voluntary movement should be increased as pain subsides. Pendulum exercises are particularly helpful for the shoulder joint. Aspiration and intrabursal injection of depot corticosteroids 0.5 to 1 ml (triamcinolone diacetate 25 or 40 mg/ml) mixed with at least 3 to 5 ml of local anesthetic after infiltration with 1% local anesthetic (e.g., lidocaine) is the treatment of choice when rest alone is inadequate. The depot corticosteroid dose and volume of mixture are gauged to the size of the bursa. Reaspiration and injection may be required with resistant inflammation. Systemic corticosteroids (prednisone 15 to 30 mg/day or equivalent for 3 days) are occasionally indicated in resistant acute cases after infection and gout have been excluded. Chronic bursitis is treated as acute bursitis, except that splinting and rest are less likely to be helpful. Surgery is rarely needed to treat bursitis and is usually done only in the chronic cases that have not improved with traditional therapy. The most common surgical treatment, if needed, is an Incision and Drainage (called an I and D) and is used only in cases of infected bursa. The surgeon first numbs the skin with an anesthetic and then opens the bursa with a scalpel. Finally, the surgeon drains the fluid present in the inflamed bursa. Sometimes it is necessary to excise the entire bursa surgically. This is indicated only if the bursal swelling causes problems.

[0114] The capsaicinoid may be administered via injection in a location and fashion similar to that currently utilized with respect to localized injections of corticosteroids. For example, in certain embodiments, the dose of capsaicin is administered by intra-articular injection into the bursa.

[0115] In another embodiment, the capsaicinoid may be administered via infiltration into the bursa and/or the tissue and muscle surrounding the bursa.

[0116] B. Tendonitis

[0117] The capsaicinoid formulations and methods disclosed herein may be utilized to treat/attenuate pain associated with tendonitis (inflammation of the tendons) and tendonitis surgery. When tendons become inflamed, the action of pulling the muscle becomes irritating and painful. The cause is often unknown. Most instances tendonitis

occurs in middle-aged or older persons as the vascularity of tendons attenuates; repetitive microtrauma may increase injury. Repeated or extreme trauma (short of rupture), strain, or excessive (unaccustomed) exercise is most frequently implicated. The most common cause of tendonitis is overuse. Commonly, individuals begin an exercise program, or increase their level of exercise, and begin to experience symptoms of tendonitis. The tendon is unaccustomed to the new level of demand, and this overuse will cause an inflammation and tendonitis. Tendonitis produces pain, tenderness and stiffness near a joint which is aggravated by movement.

[0118] General practitioners commonly use non-steroidal anti-inflammatory drugs (NSAIDs) to treat tennis elbow, but there are no trials to date that have compared them with other painkillers and one study found no clinically important benefit over placebo. Symptomatic relief is provided by rest or immobilization (splint or cast) of the tendon, application of heat for chronic inflammation or cold for acute inflammation (whichever benefits the patient should be used), local analgesic drugs, and NSAIDs for 7 to 10 days. A critical review of the role of various anti-inflammatory medications in tendon disorders found limited evidence of short-term pain relief and no evidence of their effectiveness in providing even medium term clinical resolution. Use of corticosteroid injections provides mixed results in relief of pain and at times insufficient evidence to support their use. Injection of the tendon sheath with a depot corticosteroid (eg, dexamethasone acetate, methylprednisolone acetate, hydrocortisone acetate) 0.5 to 1 mL mixed with an equal or double volume of 1% local anesthetic (eg, lidocaine) has been utilized as a treatment, depending on severity and site. The injection is made blindly or proximal to the site of maximum tenderness if the specific inflammation site cannot be identified. Particular care should be taken not to inject the tendon *per se* (which offers greater resistance) because it may be weakened and rupture in active persons. Reexamination of a less inflamed site 3 or 4 days later often discloses the specific lesion, and a second injection can be made with greater precision. Rest of the injected part is advisable to diminish risk of tendon rupture. Although complications associated with intrarticular and soft tissue steroid injection are relatively uncommon, when a complication does occur, it can result in severe and disabling consequences for the subject. A small proportion of subjects fail to respond to only one injection of corticosteroid and some subjects who initially improve at four weeks had worst symptoms by six months. Therefore with this lack of consensus, no good evidence to support the use of local corticosteroid injections and the unknown long-term side-effects of using steroids, an alternative treatment must be sought. Surgery is rarely necessary, except for release of fibro-osseous tunnels (as in de Quervain's disease) or for tenosynovectomy of chronic inflammation (as in rheumatoid arthritis).

[0119] In one embodiment of the present invention, pain associated with tendonitis of the knee, shoulders, hip, pelvis, spine, elbows, leg and foot is treated with a capsaicinoid injection undertaken in similar fashion as a localized corticosteroid injection. For example, in embodiments where the capsaicinoid formulation is used for the treatment/attenuation of pain associated with tendonitis or bursitis of the shoulder, the dose of capsaicinoid can be administered by injection into the subacromial bursa with the needle inserted into the space between the acromium and the humerus on the lateral aspect of the shoulder.

[0120] In another embodiment of the present invention, when surgery for the treatment of tendonitis is required, pain associated with tendonitis and tendonitis surgery of the knee, shoulders, hip, pelvis, spine, elbows, leg and foot is treated with administration via infiltration of a capsaicinoid directly into the affected tendon. In other embodiments, and in addition to administration to the affected tendon, the capsaicin can be administered by infiltration to the muscle and tissue surrounding the affected tendon.

[0121] C. Osteoarthritis

[0122] The capsaicinoid formulations and methods disclosed herein may be used to treat/attenuate pain associated with osteoarthritis (degenerative joint disease) and osteoarthritis surgery. Osteoarthritis is characterized by the breakdown of the joint's cartilage. Cartilage is the part of the joint that cushions the ends of bones. Cartilage breakdown causes bones to rub against each other, causing pain and loss of movement. Most commonly affecting middle-aged and older people, osteoarthritis can range from very mild to very severe. It affects hands and weight-bearing joints such as knees, hips, feet and the back. There are many factors that can cause osteoarthritis, including but not limited to age, genetics, obesity, sports-related activities, work-related activities, or accidents. Treatment of osteoarthritis focuses on decreasing pain and improving joint movement, and may include: Exercises to keep joints flexible and improve muscle strength; Many different medications are used to control pain, including corticosteroids and NSAIDs, glucocorticoids injected into joints that are inflamed and not responsive to NSAIDs. For mild pain without inflammation, acetaminophen may be used; heat/cold therapy for temporary pain relief; joint protection to prevent strain or stress on painful joints; surgery (sometimes) to relieve chronic pain in damaged joints; and weight control to prevent extra stress on weight-bearing joints.

[0123] Surgical treatment to replace or repair damaged joints is indicated in severe, debilitating disease. Surgical options include: arthroplasty (total or partial replacement of the deteriorated joint with an artificial joint; arthroscopic surgery to trim torn and damaged cartilage and wash out the joint; osteotomy (change in the alignment of a bone to relieve stress on the bone or joint); and arthrodesis (surgical fusion of bones, usually in the spine).

[0124] Pain associated with osteoarthritis and osteoarthritis surgery may be treated/attenuated with the capsaicinoid formulations administered via infiltration into the affected joint, e.g., by intra-articular injection at the affected site or by intra-articular infiltration and/or to the tissue and muscle surrounding the affected joint, including but not limited to osteoarthritis disorders of the knee

[0125] D. Rheumatoid Arthritis

[0126] The capsaicinoid formulations and methods disclosed herein may be used to treat/attenuate pain associated with rheumatoid arthritis and surgery to treat or attenuate rheumatoid arthritis. Rheumatoid arthritis is a chronic, systemic, inflammatory disease that chiefly affects the synovial membranes of multiple joints in the body. Because the disease is systemic, there are many extra-articular features of the disease as well. Rheumatoid Arthritis can affect many joints in the body, including the knee, ankle, elbow, and wrist. Joints that are actively involved with the disease are

usually tender, swollen, and likely demonstrate reduced motion. The disease is considered an autoimmune disease that is acquired and in which genetic factors appear to play a role.

[0127] In patients with progressive rheumatoid arthritis, joint pathology may occur despite appropriate conservative measures. In such patients, loss of joint function usually causes a loss of functional ability. Therefore, surgery is usually performed on joints that have caused the patient a significant loss of function. Surgery is not without risks however, and therefore the decision to operate must be carefully made. Synovectomy is done to remove diseased portions of the joint synovium. Ideally, this type of surgery is performed before there is destruction of cartilage. Total joint arthroplasty is performed when there is significant destruction of the bones forming the joint resulting in loss of function, or there is significant pain in the joint limiting function. "Total" means that the ends of both bones that comprise the joint have diseased portions that are surgically removed and replaced with man-made components (i.e., a prosthesis). The hip and knee are common sites for total joint arthroplasty in the patient with rheumatoid arthritis and therefore are the sites of many complications of the surgery. Complications include: infections, dislocation, loosening of the prosthetic components from the bone, breakage of the prosthetic components, and fractures of bones caused by the prosthetic devices, usually the result of a loss of bone density. In some cases where the total joint replacement fails, the prosthetic components are removed from the bone. In the case of the hip joint, this procedure (Girdlestone Excision) leaves the femur without the anatomical neck or head resulting in a soft tissue "joint" between the femur and pelvis. In some patients, the shoulder becomes very painful and/or mechanically non-functional. Total shoulder arthroplasty may be indicated in these patients. There is evidence that a majority of patients that have had total shoulder arthroplasty secondary to significant pain have obtained substantial pain relief.

[0128] There are several different classes of drugs utilized to treat patients with the various types of rheumatic disease. These classes include analgesics to control pain, corticosteroids, uric acid-lowering drugs, immunosuppressive drugs, nonsteroidal anti-inflammatory drugs, and disease-modifying antirheumatic drugs.

[0129] Pain associated with rheumatoid arthritis and rheumatoid arthritis surgery may be treated/attenuated with the capsaicinoid formulations administered via infiltration into the affected joint. In other embodiments, and in addition to administration to the affected joint, the capsaicinoid can be administered by infiltration to the muscle and tissue surrounding the affected joint.

[0130] E. Back Pain

[0131] The capsaicinoid formulations and methods disclosed herein may be used to treat/attenuate pain associated with back pain. Back pain is the second most common reason for doctor visits in the U.S. The causes of lower back pain are numerous. Some of the more common causes of lower back pain are: sudden injury to the back such as may occur in an auto accident, fall, sports, or other manner; gynecological conditions such as endometriosis, menstrual cramps, fibroid tumors, and pregnancy are sometimes the cause of lower back pain in women; and stress to the

muscles, nerves, or ligaments in the lower back. Slipped discs, pinched nerves, sciatica, aging, and infections are other common causes of lower back pain. The treatment of lumbar strain consists of resting the back (to avoid re-injury), medications to relieve pain and muscle spasm, local heat applications, massage, and eventual (after the acute episode resolves) reconditioning exercises to strengthen the low back and abdominal muscles. Zygapophysial joints, better known as facet or "Z" joints, are located on the back (posterior) of the spine on each side of the vertebrae where it overlaps the neighboring vertebrae. The facet joints provide stability and give the spine the ability to bend and twist. They are made up of the two surfaces of the adjacent vertebrae, which are separated by a thin layer of cartilage. The joint is surrounded by a sac-like capsule and is filled with synovial fluid (a lubricating liquid that reduces the friction between the two bone surfaces when the spine moves and also nourishes the cartilage.) A problem (such as inflammation, irritation, swelling or arthritis) in the facet joint may cause low back pain. Diagnostic tests can show an abnormality in a facet joint, which may suggest that the facet joint is the source of the pain. However, sometimes normal study results can be present while the facet joint is still the source of pain, and abnormal results do not always implicate the facet joint.

[0132] To determine if a facet joint is truly the source of back pain, an injection of local anesthetic (e.g., as a block) may be utilized. If an injection of a small amount of anesthetic or numbing medication into the facet joint reduces or removes the pain, it indicates that the facet joint may be the source of the pain. This is diagnostic use of the facet joint injection. Once a facet joint is pinpointed as a source of pain, therapeutic injections of anesthetic agents and anti-inflammatory medications may give pain relief for longer periods of time. The capsaicinoid formulations may be administered in such situations to attenuate such pain.

[0133] Facet joint injections are performed while the patient is awake, under a local anesthetic, and able to communicate. Sometimes, the health care provider may also administer drugs to make the patient more comfortable during the procedure. The injection is usually performed while the patient is lying on his or her stomach on an X-ray table. EKG, blood pressure cuffs and blood-oxygen monitoring devices may be hooked up prior to the injection process. Once the proper site has been determined, the physician will inject the anesthetic (often lidocaine or bupivacaine) and the anti-inflammatory (usually a corticosteroid.). This process may then be repeated depending on the number of affected facet joints.

[0134] F. Heel Spur

[0135] The capsaicinoid formulations and methods disclosed herein may be used to treat/attenuate pain associated with a heel spur, which is a projection or growth of bone where certain muscles and soft tissue structures of the foot attach to the bottom of the heel, or heel spur surgery. Most commonly, the plantar fascia, a broad, ligament-like structure extending from the heel bone to the base of the toes becomes inflamed, and symptoms of heel pain begin. As this inflammation continues over a period of time, with or without treatment, a heel spur is likely to form. If heel pain is treated early, conservative therapy is often successful and surgery is usually avoided. Early signs of heel pain are

usually due to plantar fasciitis, the inflammation of the plantar fascia. It is probably the most common cause of heel pain seen by the podiatrist. It is seen in all groups of people; runners, athletes, week-end warriors, people who have jobs requiring a fair amount of standing, walking, or lifting, and those who have recently gained weight. Initially, patients receive taping of the foot and when indicated, cortisone injections or a short course an anti-inflammatory medication, taken orally. Exercises, night splints, and physical therapy are used as adjunct methods to try to reduce the inflammation. If successful, a custom made in shoe orthotic is made to control the abnormal stress and strain on the plantar fascia resulting in remission of the majority of the symptoms. In some instances, conservative therapy fails, and surgery is indicated. Many times an endoscopic procedure, called a plantar fasciotomy, is done in which a release of some of the fibers of the plantar fascia is performed through two, small incisions on each side of the heel. Recovery is often 2 weeks or less, with the patient walking with only a surgical shoe 24 hours after surgery. When the plantar fascia undergoes micro-hemiations (tears), a heel spur may develop. Again, if treated early, even patients with spurs find satisfactory remission of symptoms with conservative therapy such as padding, strapping, injections and in-shoe orthotics. Unfortunately there are those whose symptoms are severe enough to prevent them from performing their job or recreational activities, and surgery is then indicated. Surgery involves releasing a part of the plantar fascia from its insertion in the heel bone, as well as removing the spur. Many times during the procedure, pinched nerves (neuromas), adding to the pain, are found and removed. Often, an inflamed sac of fluid call a accessory or adventitious bursa is found under the heel spur, and it is removed as well. Post operative recovery is usually a slipper cast and minimal weight bearing for a period of 2-3 weeks. On some occasions, a removable short-leg walking boot is used or a below knee cast applied. After they are removed normal weight-bearing is allowed and the patient is treated with in-office physical therapy.

[0136] When a capsaicinoid is used for plantar fascia, the dose of capsaicinoid is preferably administered by injection into the affected area. When surgery is required, the dose of capsaicinoid is preferably administered by infiltration into the heel bone after the surgical incision is made and/or to the tissue and muscle surrounding the heel bone.

[0137] Treatment of Pain Associated With Laparoscopic Cholecystectomy

[0138] In another preferred embodiment, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of pain associated with laparoscopic cholecystectomy. Laparoscopic cholecystectomies have virtually replaced open surgical cholecystectomy. However, patients undergoing laparoscopic cholecystectomies still have pain. Pain control following surgery typically includes use of opioids, especially within the first several days after surgery. The administration of a capsaicinoid in a patient who has undergone a laparoscopic cholecystectomy may reduce the amount of opioid consumption and postoperative pain scores associated with the procedure. In patients requiring a laparoscopic cholecystectomy, the dose of capsaicinoid can be administered either by injection, infiltration or both injection and infiltration. When the dose of capsaicinoid is administered by injection, the capsaicinoid may

be-injected directly the site of incision or to the immediate area surrounding the surgical site. In other embodiments, the dose of capsaicinoid can be administered to the site where the surgery is being performed or to the muscle, tissue and bones surrounding the surgical site prior to closure of the wound. In certain other embodiments, the capsaicinoid formulations and methods disclosed herein can be used for the treatment/attenuation of pain associated with cholecystectomy requiring a more invasive surgery than a laparoscopy.

[0139] Infiltration Dose

[0140] In preferred embodiments of the present invention, the dose of capsaicinoid contained in a unit dose for infiltration is from about 1 μg to about 15,000 μg of capsaicin, preferably from about 600 μg to about 15,000 μg capsaicin, more preferably from about 600 μg to about 10,000 μg capsaicin, or a therapeutically equivalent amount of one or more capsaicinoids. In certain preferred embodiments, the dose of capsaicin is from about 1000 μg to about 10,000 μg , or a therapeutically equivalent amount of one or more capsaicinoids. Preferably, the capsaicinoid is administered in a pharmaceutically and physiologically acceptable vehicle for injection or implantation.

[0141] In certain other embodiments, suitable doses of capsaicin/capsaicinoid for infiltration for the treatment of nociceptive pain, neuropathic pain, pain from nerve injury, pain from myalgias, pain associated with painful trigger points, pain from tumors in soft tissues, pain associated with neurotransmitter-dysregulation syndromes and pain associated with orthopedic disorders range from about 600 μg to about 15,000 μg of capsaicin (trans 8-methyl-N-vanillyl-6-noneamide), preferably from about 600 to about 10,000 micrograms, more preferably from about 1000 to 10,000 micrograms, with 5,000 μg most preferred.

[0142] In certain preferred embodiments, an injection of local anesthetic can be administered in proximity to the site prior to administration of the capsaicinoid, e.g., as described above and in the appended examples. In other embodiments, phenol can be used instead of or in addition to the local anesthetic.

[0143] Injectable Dose

[0144] In preferred embodiments of the present invention, the dose of capsaicinoid contained in a unit dose injection/implantation is from about 1 μg to about 5000 μg of capsaicin, preferably from about 10 μg to about 3000 μg capsaicin, more preferably from about 300 μg to about 1500 μg capsaicin, or a therapeutically equivalent amount of one or more capsaicinoids. In certain preferred embodiments, the dose of capsaicin is from about 400 μg to about 1200 μg , or a therapeutically equivalent amount of one or more capsaicinoids. Preferably, the capsaicinoid is administered in a pharmaceutically and physiologically acceptable vehicle for injection or implantation.

[0145] In certain other embodiments, suitable doses of capsaicin/capsaicinoid for injection or implantation for the treatment of nociceptive pain, neuropathic pain, pain from nerve injury, pain from myalgias, pain associated with painful trigger points, pain from tumors in soft tissues, pain associated with neurotransmitter-dysregulation syndromes and pain associated with orthopedic disorders range from about 1 μg to about 3000 μg of capsaicin (trans 8-methyl-

N-vanillyl-6-noneamide), preferably from about 20 to about 300 micrograms, more preferably from about 35 to 200 micrograms, with 100 μ g most preferred.

[0146] The administration of the anesthetic along with the subsequent administration of the capsaicinoid formulations and methods of the invention alleviate or attenuate pain at the site for a prolonged period of time. With respect to joint pain, in certain preferred embodiments a single unit dose capsaicinoid injection or implantation attenuates pain at the site for at least about one month, more preferably at least about 3 months, and typically in certain embodiments from about 3 to about 6 months. With respect to pain associated with arthritic conditions such as osteoarthritis, in certain preferred embodiments a single unit dose capsaicinoid injection or implantation attenuates pain at the site for at least about 3 months to at least about 4 months. With respect to post-surgical pain, in certain preferred embodiments a single unit dose capsaicinoid injection or implantation attenuates pain at the site for at least about one week, and in certain embodiments for at least about 1 month. Patients can be monitored for pain relief and increased movement, in the situation where treatment is in a joint. The treatment can be repeated as necessary to control the symptoms.

[0147] In certain preferred embodiments, an injection of local anesthetic can be administered in proximity to the site prior to administration of the capsaicinoid, e.g., as described above and in the appended examples. In other embodiments, phenol can be used instead of or in addition to the local anesthetic.

[0148] Injectable/Implantable and Infiltratable Formulations

[0149] In embodiments where the capsaicinoid is administered by injection, implantation or infiltration, the capsaicinoid is administered to a discrete site by penetrating the outer layer of the skin or a surgical site or wound opening by instillation or injection to the site or wound opening (e.g., tissue, muscle, and bone) with an instrument known to those skilled in the art for administering agents via infiltration, e.g., a needle and syringe.

[0150] The dose of capsaicinoid is preferably prepared for injection, implantation or infiltration by being incorporated into a pharmaceutically and physiologically acceptable vehicle for administration into a surgical site or wound opening of the patient (e.g., human or animal). For example, the capsaicinoid may be dissolved in oils, propyleneglycol or other solvents commonly used to prepare injectable, implantable or infiltratable solutions. Suitable pharmaceutically acceptable vehicles preferably include aqueous vehicles, nonaqueous vehicles, antimicrobial agents, isotonic agents, buffers, antioxidants, suspending and dispersing agents, emulsifying agents, sequestering or chelating agents and any combinations or mixtures thereof. Examples of aqueous vehicles preferably include Sodium Chloride Injection, Bacteriostatic Sodium Chloride Injection, Ringers Injection, Isotonic Dextrose Injection, Sterile Water Injection, Bacteriostatic Sterile Water Injection, Dextrose Lactated Ringers Injection and any combinations or mixtures thereof. Nonaqueous parenteral vehicles preferably include fixed oils of vegetable origin, cottonseed oil, corn oil, sesame oil, peanut oil and any combinations or mixtures thereof. Antimicrobial agents in bacteriostatic or fungistatic concentrations preferably include phenols, cresols, mercu-

rials, benzyl alcohol, chlorobutanol, ethyl and propyl p-hydroxybenzoic acid esters, thimerosal, benzalkonium chloride benzethonium chloride and mixtures thereof. Isotonic agents preferably include sodium chloride, dextrose and any combinations or mixtures thereof. Buffers preferably include acetate, phosphate, citrate and any combinations or mixtures thereof. Antioxidants preferably include ascorbic acid, sodium bisulfate and any combinations or mixtures thereof. Suspending and dispersing agents preferably include sodium carboxymethylcellulose, hydroxypropyl methylcellulose, polyvinylpyrrolidone and any combinations or mixtures thereof. Emulsifying agents preferably include Polysorbate 80 (Tween 80). Sequestering or chelating agents of metal ions preferably include ethylenediaminetetraacetic acid. Additional pharmaceutically acceptable vehicles also preferably include ethyl alcohol, polyethylene glycol, glycerin and propylene glycol for water miscible vehicles and sodium hydroxide, hydrochloric acid, citric acid or lactic acid for pH adjustment and any combinations or mixtures thereof.

[0151] Depending on the pharmaceutically acceptable vehicle chosen, the dose of capsaicinoid can be administered as an aqueous solution or suspension for injection, implantation or infiltration. Injections or infiltrations may be separated into five distinct types, generally classified as (i) medicaments or solutions or emulsions suitable for infiltration; (ii) dry solids or liquid concentrates containing no buffers, diluents, or other added substances, and which upon the addition of suitable vehicles, yield solutions conforming in all aspects to the requirements for infiltration; (iii) preparations as described in (ii) except that they contain one or more buffers, diluents or other added substances; (iv) solids which are suspended in a suitable fluid medium and which are not to be injected intravenously or into the spinal canal; and (v) dry solids, which upon the addition of suitable vehicles, yield preparations conforming in all respects to the requirements of Sterile Suspensions (see: H. C. Ansel, *Introduction to Pharmaceutical Dosage Forms*, 4th Edit., 1985, pg. 238).

[0152] In certain other embodiments, a surfactant can preferably be combined with one or more of the pharmaceutically acceptable vehicles previously described herein so that the surfactant or buffering agent prevents the initial stinging or burning discomfort associated with capsaicinoid administration, as a wetting agent, emulsifier, solubilizer and/or antimicrobial.

[0153] Suitable surfactants include, but are not limited to, sodium stearyl fumarate, diethanolamine cetyl sulfate, polyethylene glycol, isostearate, polyethoxylated castor oil, benzalkonium chloride, nonoxyl 10, octoxynol 9, polyoxyethylene sorbitan fatty acids (polysorbate 20, 40, 60 and 80), sodium lauryl sulfate, sorbitan esters (sorbitan monolaurate, sorbitan monooleate, sorbitan monopalmitate, sorbitan monostearate, sorbitan sesquioleate, sorbitan trioleate, sorbitan tristearate, sorbitan laurate, sorbitan oleate, sorbitan palmitate, sorbitan stearate, sorbitan dioleate, sorbitan sesqui-isostearate, sorbitan sesquistearate, sorbitan tri-isostearate), lecithin pharmaceutical acceptable salts thereof and combinations thereof. When one or more surfactants are utilized in the formulations of the invention, they may be combined, e.g., with a pharmaceutically acceptable vehicle and may be present in the final formulation, e.g., in an amount ranging from about 0.1% to about 20%, more preferably from about 0.5% to about 10%.

[0154] Buffering agents may also be used to provide drug stability; to control the therapeutic activity of the drug substance (Ansel, Howard C., "Introduction to Pharmaceutical Dosage Forms," 4th Ed., 1985); and/or to prevent the initial stinging or burning discomfort associated with capsaicin administration. Suitable buffers include, but are not limited to sodium bicarbonate, sodium citrate, citric acid, sodium phosphate, pharmaceutically acceptable salts thereof and combinations thereof. When one or more buffers are utilized in the formulations of the invention, they may be combined, e.g., with a pharmaceutically acceptable vehicle and may be present in the final formulation, e.g., in an amount ranging from about 0.1% to about 20%, more preferably from about 0.5% to about 10%.

[0155] In certain preferred embodiments, the pharmaceutical vehicle utilized to deliver the capsaicinoid comprises polyethylene glycol, histidine, and sucrose, in water for injection. In one preferred embodiment, the pharmaceutical vehicle comprises about 20% PEG 300, about 10 mM histidine and about 5% sucrose in water for injection.

[0156] In other preferred embodiments, delivery systems can be used to administer a unit dose of capsaicinoid. The dose of capsaicinoid can preferably be administered as injectable, implantable or infiltratable microparticles (microcapsules and microspheres). The microparticles are preferably in a size and distribution range suitable for infiltration. The diameter and shape of the microparticles can be manipulated to modify the release characteristics. For example, larger diameter microparticles will typically provide slower rates of release and reduced tissue penetration and smaller diameters of microparticles will produce the opposite effects, relative to microparticles of different mean diameter, but of the same composition. In addition, other particle shapes, such as cylindrical shapes, can also modify release rates by virtue of the increased ratio of surface area to mass inherent to such alternative geometrical shapes, relative to a spherical shape. The diameter of microparticles preferably range in size from about 5 microns to about 200 microns in diameter.

[0157] In a more preferred embodiment, the microparticles range in diameter from about 20 to about 120 microns. Methods for manufacture of microparticles are well known in the art and include solvent evaporation, phase separation and fluidized bed coating.

[0158] When the preferred methods of the present invention provide for administration of a single dose of capsaicinoid alone, the single dose of capsaicinoid is preferably administered at a discrete site, a surgical site or open wound in an amount effective to denervate the surgical site or open wound without eliciting an effect outside the site or wound. The single dose is preferably administered onto a nerve directly at the site where pain relief is needed, directly into the pain producing structure, or onto a nerve that provides innervation to the painful area via infiltration. Infiltration preferably includes, but is not limited to, administration onto the tissue, muscle or bone surrounding the surgical site or open wound. In other embodiments, the dose of capsaicinoid may be administered intra-articularly, intrasternally, intrasynovially, intra-bursally or into body spaces. Injectable or implantable administration preferably includes, but is not limited to subcutaneous (under the skin), intramuscular (muscle), intrathecal, epidural, intraperitoneal, cau-

dal, intradermal or intracutaneous (into the skin), intercostals at a single nerve, intra-articular (joints) or body spaces, intrasynovial (joint fluid), intraspinal (spinal column), intra-arterial (arteries) administrations and administration into other connective tissue compartments. As used herein "intraspinal" means into or within the epidural space, the intrathecal space, the white or gray matter of the spinal cord affiliated structures such as the dorsal root and dorsal root ganglia. Infiltratable administration of the formulations of the invention may be, e.g., into a joint selected from the group consisting of knee, elbow, hip, sternoclavicular, temporomandibular, carpal, tarsal, wrist, ankle, intervertebral disk, ligamentum flavum and any other joint subject to pain. Examples of body spaces include pleura, peritoneum, cranium, mediastinum, pericardium, and bursae or bursal. Examples of bursae include acromial, bicipitoradial, cubitoradial, deltoid, infrapatellar, ischiadic, and other bursa known to those skilled in the art to be subject to pain.

[0159] When the single dose of capsaicinoid is administered via injection, the injection volume of capsaicin will depend on the localized site of administration. Suitable injection volumes to be delivered preferably range from about 0.1 to about 20 ml, more preferably from about 0.5 to about 10 ml and most preferably from about 1.0 to about 5 ml, depending on the site to be treated. Alternatively, when the single dose of capsaicinoid is administered via infiltration, the volume of capsaicinoid administered will depend on the surgical site or size of the opened wound. Suitable infiltration volumes to be delivered preferably range from about 0.1 to about 1000 ml, more preferably from about 1 ml to about 100 ml and most preferably from about 5 ml to about 30 ml, depending on the site or wound opening to be treated.

[0160] The administration of the anesthetic along with the subsequent administration of capsaicinoid alleviates pain at the discrete site, the surgical site or wound opening for a prolonged period of time. Patients can be monitored for pain relief and increased movement, in the situation where treatment is in a joint. The treatment can be repeated as necessary to control the symptoms.

[0161] In certain embodiments of the invention, an adjunctive agent can be co-administered with the capsaicinoid. Suitable adjunctive agents for use in the present invention include, but are not limited to non-steroidal inflammatory agents ("NSAIDs"), non-anesthetic sodium channel blockers, vasoconstrictors, vasodilators and tricyclic anti-depressants.

[0162] In certain embodiments of the present invention, the capsaicinoid and the adjunctive agent are administered together in a single composition. In other embodiments, the capsaicinoid and the adjunctive agent are administered as separate compositions before, after or at the same time as the capsaicinoid, by the same or different routes of administration. For example, the adjunctive agent can be administered orally, via implant, parenterally, sublingually, rectally, topically, or via inhalation. When administered in separate compositions, preferably the adjunctive agent formulation and the capsaicinoid formulation provide overlapping duration of effect.

[0163] In certain embodiments, one or more adjunctive agents can be co-administered with the capsaicinoid. The multiple adjunctive agents can be selected within the same

group (e.g., two NSAIDs) or from different groups (e.g., an NSAID and a vasoconstrictor) and can be administered by multiple routes of administration. Further a local anesthetic can be administered with the capsaicinoid, in addition to the adjunctive agent.

[0164] NSAIDs useful as adjunctive agents in the present invention include aspirin, ibuprofen, diclofenac, naproxen, benoxaprofen, flurbiprofen, fenoprofen, flubufen, ketoprofen, indoprofen, piroprofen, carprofen, oxaprozin, pramoprofen, muprofen, trioxaprofen, suprofen, aminoprofen, tiaprofenic acid, fluprofen, bucloxic acid, indomethacin, sulindac, tolmetin, zomepirac, tiopinac, zidometacin, acemetacin, fentiazac, clidanac, oxpinac, mefenamic acid, meclofenamic acid, flufenamic acid, niflumic acid, tolfenamic acid, diflunisal, flufenisal, piroxicam, sudoxicam or isoxicam, pharmaceutically acceptable salts thereof, and mixtures thereof. Other suitable agents classified as NSAIDs include the following, non-limiting, chemical classes of analgesic, antipyretic, nonsteroidal antiinflammatory drugs: salicylic acid derivatives, including aspirin, sodium salicylate, choline magnesium trisalicylate, salsalate, diflunisal, salicylsalicylic acid, sulfasalazine, and olsalazin; para-aminophenol derivatives including acetaminophen; indole and indene acetic acids, including indomethacin, sulindac, and etodolac; heteroaryl acetic acids, including tolmetin, diclofenac, and ketorolac; anthranilic acids (fenamates), including mefenamic acid, and meclofenamic acid; enolic acids, including oxicams (piroxicam, tenoxicam), and pyrazolidinediones (phenylbutazone, oxyphenbutazone); and alkanones, including nabumetone. For a more detailed description of the NSAIDs that may be included within the medicaments employed in the present invention, see Paul A. Insel Analgesic-Antipyretic and Anti-inflammatory Agents and Drugs Employed in the treatment of Gout in Goodman & Gilman's The Pharmacological Basis of Therapeutics, 617-57 (Perry B. Molinoff and Raymond W. Ruddon, Eds., Ninth Edition, 1996), and Glen R. Hanson Analgesic, Antipyretic and Anti-Inflammatory Drugs in Remington: The Science and Practice of Pharmacy Vol II, 1196-1221 (A. R. Gennaro, Ed. 19th Ed. 1995) which are hereby incorporated by reference in their entireties.

[0165] NSAIDs exhibit inhibition of cyclooxygenases I and II, the enzymes responsible for the biosynthesis of the prostaglandins and certain related autacoids. NSAIDs are known to be antipyretic, analgesic, and antiinflammatory. Specific classes of non-steroidals useful in the present invention are also disclosed in detail in the following U.S. Patents, all incorporated by reference herein: U.S. Pat. No. 4,275,059, Flora, et al, issued Jun. 23, 1983, discloses salicylic acid, its pharmaceutically-acceptable salts, and its pharmaceutical-acceptable esters and derivatives; U.S. Pat. No. 4,264,582, Flora, et al, issued Apr. 28, 1981, discloses p-(isobutylphenyl) acetic acid compounds including the parent acid (ibufenac) and its salts and esters, and derivatives thereof; U.S. Pat. No. 4,282,214, Flora, et al, issued Aug. 4, 1981, discloses various phenylacetic acid derivatives, their pharmaceutically-acceptable salts, and their pharmaceutically-acceptable ester; U.S. Pat. No. 4,216,212, Flora, et al, issued Aug. 5, 1980, discloses prazolidine compounds, their pharmaceutically-acceptable salts, and their pharmaceutically-acceptable esters; U.S. Pat. No. 4,269,828, Flora, et al, issued May 26, 1981, discloses indole compounds, their pharmaceutically-acceptable salts, and their pharmaceutically-acceptable esters.

[0166] Aspirin is the prototypical nonsteroidal anti-inflammatory agent. It possesses analgesic-antipyretic and anti-inflammatory properties and is the standard for the comparison and evaluation of other nonsteroidal anti-inflammatory agents. Aspirin is a member of the class of nonsteroidal anti-inflammatory agents known as "the salicylates." Other salicylates include, but are not limited to salicylic acid, methyl salicylate, diflunisal, salsalate, olsalazine and sulfasalazine. Administration of salicylates is generally recognized in the art for the treatment of low intensity pain arising from integumental structures rather than from viscera.

[0167] Another class of nonsteroidal anti-inflammatory agents is the para-aminophenol derivatives; of which, acetaminophen (Tylenol™) and phenacetin are members. Acetaminophen and phenacetin possess analgesic-antipyretic activity, however, they both possess weak anti-inflammatory activity. Therefore, these agents are a suitable substitute for the salicylates in the treatment of low intensity pain, but are generally not recommended for the treatment of anti-inflammatory conditions.

[0168] In addition there are several other classes of nonsteroidal anti-inflammatory agents. These include, but are not limited to the propionic acid derivatives, the fenamates, the oxicams, the indole derivatives, the pyrazolon derivatives and any combinations or mixtures thereof.

[0169] The propionic acid derivatives include, but are not limited to ibuprofen, naproxen, flurbiprofen, fenoprofen, ketoprofen, oxaprozin, carprofen, fenbufen, piroprofen, indobufen, indoprofen and tiaprofenic acid.

[0170] The fenamates include, but are not limited to meclofenamate sodium, mefenamic acid, flufenamic acid, tolfenamic acid, etofenamic acid, diclofenac, ketorolac and tolmetin.

[0171] The oxicams include, but are not limited to piroxicam, meloxicam, nabumetone, lornoxicam, cinnoxicam, sudoxicam, tenoxicam, and piroxicam prodrugs, e.g., ampiroxicam, droxicam, and pivoxicam.

[0172] The indole derivatives include, but are not limited to indomethacin, sulindac, and etodolac.

[0173] The pyrazolon derivatives include, but are not limited to phenylbutazone, oxyphenbutazone, antipyrine, amonopyrine, azapropazone, remifenzone and dipyrone.

[0174] Other nonsteroidal anti-inflammatory agents known as COX-II inhibitors include flosulide, nimesulide, rofecoxib, celecoxib, valdecoxib and parecoxib.

[0175] Non-steroidal, anti-inflammatory agents (NSAIDs) exert most of their anti-inflammatory, analgesic and antipyretic activity and inhibit hormone-induced uterine contractions and certain types of cancer growth through inhibition of prostaglandin G/H synthase, also known as cyclooxygenase.

[0176] Fatty acid cyclooxygenase (COX) was described as the source of prostaglandins, thromboxanes, and a variety of other arachidonic acid-, and higher desaturated fatty acid-derived biologically active hydroxylated metabolites beginning in the late 1960's. Bengt Samuelsson, Sune Bergstrom and their colleagues discovered the biological activity and elucidated the structures of the products of cyclooxy-

genase in the late 1960's and early 1970's and John Vane discovered that aspirin and other NSAIDs exert their major biological activities by inhibiting cyclooxygenase. COX is directly responsible for the formation of PGG and PGH and these serve as the intermediates in the synthesis of PGD, PGE, PGF, PGI, and TXA. By the late 1970's and early 1980's, it was appreciated that many hormones and other biologically active agents could regulate the cellular activity of COX. At first, it was assumed that COX induction was the simple result of oxidative inactivation of COX, which happens after only a few substrate turnovers. This is common among enzymes that incorporate molecular oxygen into their substrates—the oxygen rapidly degrades the enzyme. Such enzymes are sometimes referred to as suicide enzymes. In response to the rapid (within seconds) inactivation of cyclooxygenase, its message is transcribed, and the enzyme is rapidly induced to replace that lost due to catalysis. It was noticed by several groups that cyclooxygenase was induced to a much greater degree than necessary to replace the lost enzyme. Using an oligonucleotide directed to the cloned COX-1 enzyme, a second band was identified on Northern blots under low stringency. This gene was cloned and identified as a second COX enzyme, named COX-2, and was found to be largely absent from many cells under basal conditions but rapidly induced by several cytokines and neurotransmitters. The expression of this enzyme was found to be largely responsible for the previously-observed excess COX activity in activated cells. The genes for COX-1 and COX-2 are distinct, with the gene for COX-1 being 22 kb and the message size 2.8 kb whereas the gene for COX-2 is 8.3 kb and the message size 4.1 kb. Whereas the COX-1 promoter does not contain recognized transcription factor binding sites, the COX-2 promoter contains sites for NF- κ B, AP-2, NF-IL-6 and glucocorticoids (H. R. Herschman, *Canc. Metas. Rev.* 13: 256, 1994). There are some differences in the active sites of the enzymes. Aspirin inhibits the cyclooxygenase activity of COX-1 but leaves intact its peroxidase activity, whereas aspirin converts COX-2 from a cyclooxygenase to a 15-lipoxygenase (E. A. Meade et al, *J. Biol. Chem.* 268: 6610, 1993).

[0177] It has been proposed that the COX-1 enzyme is responsible, in many cells for endogenous basal release of prostaglandins and is important in the physiological functions of prostaglandins which include the maintenance of gastrointestinal integrity and renal blood flow. Inhibition of COX-1 causes a number of side effects including inhibition of platelet aggregation associated with disorders of coagulation, and gastrointestinal toxicity with the possibility of ulcerations and of hemorrhage. It is believed that the gastrointestinal toxicity is due to a decrease in the biosynthesis of prostaglandins which are cytoprotective of the gastric mucosa. Thus a high incidence of side effects has historically been associated with chronic use of classic cyclooxygenase inhibitors, all of which are about equipotent for COX-1 or COX-2, or which are COX-1-selective. While renal toxicity occurs, it usually becomes evident in patients who already exhibit renal insufficiency (D. Kleinknecht, *Sem. Nephrol.* 15: 228, 1995). By far, the most prevalent and morbid toxicity is gastrointestinal. Even with relatively nontoxic drugs such as piroxicam, up to 4% of patients experience gross bleeding and ulceration (M. J. S. Langman et al, *Lancet* 343: 1075, 1994). In the United States, it is estimated that some 2000 patients with rheumatoid arthritis and 20,000 patients with osteoarthritis die each year due to

gastrointestinal side effects related to the use of COX inhibitors. In the UK, about 30% of the annual 4000 peptic ulcer-related deaths are attributable to COX inhibitors (Scrip 2162, p.17). COX inhibitors cause gastrointestinal and renal toxicity due to the inhibition of synthesis of homeostatic prostaglandins responsible for epithelial mucus production and renal blood flow, respectively.

[0178] The second form of cyclooxygenase, COX-2, is rapidly and readily inducible by a number of agents including mitogens, endotoxins, hormones, cytokines and growth factors.

[0179] It has been proposed that COX-2 is mainly responsible for the pathological effects of prostaglandins, which arise when rapid induction of COX-2 occurs in response to such agents as inflammatory agents, hormones, growth factors, and cytokines. A selective inhibitor of COX-2 therefore would have anti-inflammatory, antipyretic and analgesic properties similar to those of a conventional non-steroidal anti-inflammatory drug (NSAID). Additionally, a COX-2 inhibitor would inhibit hormone-induced uterine contractions and have potential anti-cancer effects. A COX-2 inhibitor would have advantages over NSAIDs such as a diminished ability to induce some of the mechanism-based side effects. Moreover, it is believed that COX-2 inhibitors have a reduced potential for gastrointestinal toxicity, a reduced potential for renal side effects, a reduced effect on bleeding times and a lessened ability to induce asthma attacks in aspirin-sensitive asthmatic subjects.

[0180] Thus, compounds with high specificity for COX-2 over COX-1, may be useful as alternatives to conventional NSAIDs. This is particularly the case when NSAID use is contra-indicated, such as in patients with peptic ulcers, gastritis, regional enteritis, ulcerative colitis, diverticulitis or with a recurrent history of gastrointestinal lesions; GI bleeding, coagulation disorders including anemia, hypoprothrombinemia, haemophilia or other bleeding problems; kidney disease, and patients about to undergo surgery or taking anticoagulants.

[0181] Once it became clear that COX-1 but not COX-2 is responsible for gastrointestinal epithelial prostaglandin production and a major contributor to renal prostaglandin synthesis, the search for selective COX-2 inhibitors became extremely active. This led very quickly to the recognition that several COX inhibitors, including rofecoxib (Vioxx), celecoxib (Celebrex), DUP-697, flosulide, meloxicam, 6-MNA, L-745337, nabumetone, nimesulide, NS-398, SC-5766, T-614, L-768277, GR-253035, JTE-522, RS-57067-000, SC-58125, SC-078, PD-138387, NS-398, flosulide, D-1367, SC-5766, PD-164387, etoricoxib, valdecoxib and parecoxib or pharmaceutically acceptable salts, enantiomers or tautomers thereof.

[0182] In certain embodiments, the amount of COX 2 selective inhibitor that is used in accordance with the present invention preferably ranges from about 0.001 to about 100 milligrams per day per kilogram of body weight of the subject (mg/day kg), more preferably from about 0.05 to about 50 mg/day kg, even more preferably from about 1 to about 20 mg/day kg.

[0183] Administration of capsaicinoid alone or with a local anesthetic sometimes results in the patient experiencing a dull aching pain at and around the site of local

anesthetic administration. To prevent or reduce the occurrence of this dull aching pain, the non-steroidal antiinflammatory adjunctive agent is preferably administered prior to capsaicinoid and local anesthetic administration. Preferably, the non-steroidal antiinflammatory adjunctive agent is administered orally, which also helps to avoid the discomfort of the patient receiving another injection. Alternatively, in certain embodiments, a selective Cox-2 inhibitor can be administered peripherally by injection or infiltration.

[0184] Suitable doses of the non-steroidal antiinflammatory adjunctive agents vary due to the wide variations in potency among the various NSAIDs and there respective selectivity for COX-1 or COX-2 inhibition. The dose is also dependant on the severity of the pain which must be prevented or alleviated, the physical condition of the patient, the relative severity and importance of adverse side effects, and other factors within the judgment of the physician. Examples of suitable doses and routes of administration for non-steroidal anti-inflammatory adjunctive agents are listed in Tables IV-X below:

TABLE IV

<u>SALICYLATES and PARA-AMINOPHENOL DERIVATIVES</u>	
NSAID	Dose
Aspirin	325–650 mg orally every 4–6 hours
Diflunisal	500–1000 mg/day orally in 2 divided doses
Salsalate	3 gm/day orally in 2–3 divided doses
Olsalazine	1 gm/day orally in 2 divided doses
Sulfasalazine	1 gm every 6–8 hours
Salicylic Acid	10% or 60%; gel 6%, 12%, 17% or 26%; oint. 3%, 25% or 60% applied topically.
Acetaminophen	325–650 mg orally every 4–6 hours; 1000 mg orally every 6–8 hours

[0185]

TABLE V

<u>PROPRIONIC ACID DERIVATIVES</u>	
NSAID	Dose
Ibuprofen	400–800 mg orally every 6–8 hours
Naproxen	500–1000 mg/day orally in 2 divided doses
Flurbiprofen	200–300 mg/day orally in 2, 3 or 4 divided doses
Fenoprofen	300–600 mg orally every 6–8 hours or 200 mg orally every 4–6 hours
Ketoprofen	25–75 mg orally every 6–8 hours
Oxaprozin	600–1200 mg/day orally

[0186]

TABLE VI

<u>FENAMATES</u>	
NSAID	Dose
Meclofenamate	50 mg orally every 4–6 hours
Mefenamic acid	250 mg orally every 4 hours
Diclofnac	50 mg orally every 8 hours; 150–200 mg/day orally in 2–4 divided doses or 100–125 mg/day orally in 4–5 divided doses
Tolmentin	400 mg orally every 8 hours or 600 mg–1.8 gm/day orally

TABLE VI-continued

<u>FENAMATES</u>	
NSAID	Dose
Ketorolac	10 mg orally every 4–6 hours for 5 days 30–60 mg intramuscular X1, then 15–30 intramuscularly every 6 hours for max. 5 days

[0187]

TABLE VII

<u>OXICAMS</u>	
NSAID	Dose
Piroxicam	10–20 mg/day orally
Meloxicam	7.5–15 mg/day orally
Nabumetone	1000 mg/day orally, additional 500–1000 mg orally if necessary

[0188]

TABLE VIII

<u>INDOLE DERIVATIVES</u>	
NSAID	Dose
Indomethacin	25–50 mg orally or rectally every 8–12 hours
Sulindac	150–200 mg orally every 12 hours
Etodolac	200–400 mg orally every 6–8 hours

[0189]

TABLE IX

<u>PYRAZOLON DERIVATIVES</u>	
NSAID	Dose
Phenylbutazone	100–200 mg orally every 6–8 hours

[0190]

TABLE X

<u>COX-II INHIBITORS</u>	
NSAID	Dose
Nimesulide	100 mg orally every 12°
Rofecoxib	12.5–25 mg/day orally
Celecoxib	100–200 mg orally every 12–24 hours

[0191] In certain embodiments, dosage levels of NSAIDs on the order of about 0.05 mg/kg to about 75 mg/kg body weight per day are effective for enhancing the desired effects of localized capsaicinoid administration and decreasing the undesired effects, or for minimizing diffusion of capsaicinoid from the site of administration so as to amplify either of the preceding. Dosage levels of NSAIDs on the order of about 5 mg/kg to about 40 mg/kg body weight per day and dosage levels of NSAIDs on the order of about 0.1 mg/kg to about 4 mg/kg body weight per day can also be administered.

[0192] In embodiments where the present invention contemplates the use of a non-anesthetic sodium channel blocker adjunctive agent, suitable non-anesthetic sodium channel blocker adjunctive agents may include, but are not limited to aminopyridines, benzothiazoles, phenylbenzothiazoles, 5-amino-triazines, pyrazinoylguanidines, derivatives thereof and mixtures thereof, which include antiarrhythmic agents, anticonvulsant agents, diuretic agents, combinations thereof and mixtures thereof.

[0193] Suitable antiarrhythmic agents include, but are not limited to disopyramide, encainide, flecainide, lorcaïnide, mexilitine, moricizine, phenytoin, procainide, propafenone, quinidine, tocainide, pharmaceutically acceptable salts thereof and mixtures thereof.

[0194] Suitable anticonvulsant agents include, but are limited to carbamazepine, lamotrigine, phenytoin, pharmaceutically acceptable salts thereof and mixtures thereof.

[0195] Suitable diuretic agents include, but are not limited to amiloride, triamterene, pharmaceutically acceptable salts thereof and mixtures thereof.

[0196] In certain other embodiments of the present invention, the non-anesthetic sodium channel blocker adjunctive agent can be selected from the group consisting of phenytoin, carbamazepine, lamotrigine, zonisamide, riluzole, lifarizine, ralitoline, flunarizin, mexilitine, aprinidine, benzamil, phenamil, trimebutine, GEA-968, azure A, pancuronium; N-methylstrychnine, CNS1237, BW1003C87, BW619C89, U54494A, PD85639, C1953, pharmaceutically acceptable salts thereof and mixtures thereof.

[0197] The sodium channel blockers may be administered to mammals, e.g. humans, orally at a dose of 0.1 to 10 mg/kg, or an equivalent amount of the pharmaceutically acceptable salt thereof, per day of the body weight of the mammal being treated. For carbamazepine, from about 50 to about 1500 mg/day, preferably about 800 mg/day, more preferably about 100 to about 600 mg/day, and most preferably about 100 to about 400 mg/day; can be orally administered. For lamotrigine, from about 50 to about 1200 mg/day, preferably 100 to about 600 mg/day, more preferably about 100 to about 450 mg/day, and most preferably about 100 to about 300 mg/day can be orally administered.

[0198] Many of the above contemplated non-anesthetic sodium channel blocker adjunctive agents are described more fully in the literature, such as in Goodman and Gilman, The Pharmacological Basis of Therapeutics (9th Edition), McGraw-Hill, 1993, and Drug Facts and Comparisons, Wolters Kluwer Co. (1999).

[0199] In another embodiment of the present invention, it is preferable to administer the non-anesthetic sodium channel blocker adjunctive agent peripherally by injection.

[0200] In preferred embodiments, carbamazepine is the adjunctive agent and is administered by injection or by infiltration.

[0201] Suitable doses of the non-anesthetic sodium channel blocker adjunctive agents may vary due to the wide variations in potency among the particular agents and their respective mechanism for decreasing propagation and/or generation of action potentials. The dose administered may also be dependant on the severity of the pain which must be prevented or alleviated, the physical condition of the patient,

the relative severity and importance of adverse side effects, and other factors within the judgment of the physician. Examples of suitable doses and routes of administration for the various non-anesthetic sodium channel blocker adjunctive agents are listed in Tables XI-XIII below:

TABLE XI

Antiarrhythmic Sodium channel Blocking Agents	
Antiarrhythmic	Dose
Disopyramide	100–1600 mg/day orally
Encainide	25–300 mg/day orally
Flecainide	50–400 mg/day orally
Mexilitine	200–1200 mg/day orally
Moricizine	600–900 mg/day orally every 8 hours
Phenytoin	50–600 mg/day orally; intravenous injection 5 mg/kg/day
Propafenone	150–900 mg/day orally
Procainamide	50 mg/kg/day intramuscularly or orally
Quinidine	200–1800 mg/day orally; 200 mg–600 mg intramuscular
Tocainide	400–1800 mg/day orally

[0202]

TABLE XII

Anticonvulsant Sodium channel Blocking Agents	
Anticonvulsant	Dose
Carbamazepine	5 mg/kg/day orally
Lamotrigine	1–15 mg/kg/day orally
Phenytoin	50–600 mg/day orally; 5 mg/kg/day intravenous injection

[0203]

TABLE XIII

Diuretic Sodium Channel Blocking Agents	
Diuretic	Dose
Amiloride	5–30 gm/day orally or intravenously
Triamterene	50–300 mg/day orally

[0204] In embodiments where the present invention contemplates the use of a vasoconstrictor adjunctive agent, vasoconstrictors suitable for use in the present invention include, but are not limited to catecholamines, alpha-1 and alpha-2 adrenergic agonists, analogs thereof, active metabolites thereof, and mixtures thereof. Catecholamines include, but are not limited to epinephrine, norepinephrine, and dopamine. Alpha-1 adrenergic agonists include, but are not limited to methoxamine, phenylephrine, mephentermine, metaraminol, mitodrine, methysergide, ergotamine, ergotroxine, dihydroergotamine, sumatriptan, and mixtures thereof. Alpha-2 adrenergic agonists include, but are not limited to clonidine, guanfacine, guanabenz, methylodopa, ephedrine, amphetamine, methamphetamine, methylphenidate, ethylnorepinephrine, ritalin, pemoline and other sympathomimetic agents including active metabolites, and mixtures thereof.

[0205] Each of the above contemplated vasoconstricting agents is described more fully in the literature, such as in

Goodman and Gilman, *The Pharmacological Basis of Therapeutics* (9th Edition), McGraw-Hill, 1993, Pgs. 199-225. For example, the catecholamine epinephrine is a potent stimulant of both α - and β -adrenergic receptors. It is considered as one of the most potent vasopressor drugs known. Epinephrine's chief vascular action is exerted on the smaller arterioles and precapillary sphincters, although veins and large arteries also respond to epinephrine administration. Administration of epinephrine via injection produces a marked decrease in cutaneous blood flow, constricting precapillary vessels and small venules. Cutaneous vasoconstriction produces a significant decrease in blood flow in the hands and feet. The marked decrease in cutaneous blood flow after intravenous administration of epinephrine contributes to epinephrine's slow absorption from subcutaneous tissues. However, absorption of epinephrine is more rapid after intramuscular administration.

[0206] Compounds, formulations, and dosages of the vasoconstrictors described in this method are known in the art. In certain embodiments, for example, vasoconstrictive compositions may be used at art-recognized effective doses, such as, about 0.001 milligram per milliliter to about 0.01 milligram per milliliter of epinephrine.

[0207] In certain embodiments, when epinephrine is administered with an anesthetic, preferably the epinephrine is added in an amount of 0.5 to 1 ml (1:1000) per 100 ml of anesthetic solution for a vasoconstrictive effect. Preferably epinephrine 1:100,000 or 1:200,000 dilution is used.

[0208] Norepinephrine, like epinephrine, is a potent agonist at α -receptors, but it is somewhat less potent than epinephrine. Dopamine, the immediate metabolic precursor of norepinephrine and epinephrine, produces vasoconstriction at high concentrations, whereas, total peripheral resistance due to vasoconstriction is practically unchanged at low to intermediate doses due to dopamine's ability to reduce regional arterial resistance in the mesentery and kidneys while causing only minor increases in other vascular beds.

[0209] The existence of more than one adrenergic receptor was first proposed in 1948 by Ahlquist. His hypothesis was based on a study of the abilities of epinephrine, norepinephrine and other related agonists to regulate various physiological processes. As a result of his studies, the alpha (α) and beta (β) designations were established.

[0210] Alpha adrenergic receptors are present in many organs throughout the human body. However, vasoconstriction is not produced in all organs. In fact, adrenergic vasoconstriction is produced in veins and the following arterioles: coronary, skin and mucousa, skeletal muscle, cerebral, pulmonary, abdominal viscera, salivary glands, and renal arterioles. Only alpha-1 receptors are found in skeletal muscle, cerebral, pulmonary, and abdominal viscera and both alpha-1 and alpha-2 receptors are found in coronary, skin and mucousa, salivary glands, and renal arterioles.

[0211] When the vasoconstrictor adjunctive agents used in the present invention are co-administered with the capsaicinoids and/or local anesthetic of the present invention, the vasoconstrictor adjunctive agent produces a decrease in cutaneous blood flow to the area surrounding the injection site, thus prolonging the activity of the capsaicinoid and/or local anesthetic at the injection site.

[0212] Suitable doses of vasoconstrictor adjunctive agents may vary due to the wide variations in potency among the

particular catecholamines and adrenergic agonist and their respective selectivity for alpha-1 or alpha-2 adrenergic receptors. The dose administered may also be dependant on the severity of the pain which must be prevented or alleviated, the physical condition of the patient, the relative severity and importance of adverse side effects, and other factors within the judgment of the physician. Examples of suitable doses and routes of administration for the various vasoconstrictor adjunctive agents are listed in Tables XIV-XV below:

TABLE XIV

ENDOGENOUS CATECHOLAMINES	
Catecholamine	Dose
Epinephrine	0.3-5 mg by intravenous or subcutaneously

[0213]

TABLE XV

α -1 ADRENERGIC AGONISTS	
α -1 Agonist	Dose
Methoxamine	3-5 mg intravenously or 10-20 mg intramuscularly (during spinal anesthesia); DOA-1-1.5 hrs.
Phenylephrine	2-5 mg/dose intramuscularly every 1-2 hours as needed; intravenous bolus 0.1-0.5 mg/dose every 1-15 min as needed; 100-180 mcg/min intravenous drip
Mephentermine	30-45 mg intravenously, 30 mg doses repeated as required; 30-45 mg intramuscularly 1-20 min prior to anesthesia.
Metaraminol	2-10 mg intramuscularly or intravenously
Dihydroergotamine	1-3 mg intramuscularly; 1-2 mg intravenous push
sumatriptan	1-6 mg subcutaneously

[0214] In embodiments where the present invention contemplates the use of a tricyclic antidepressant adjunctive agent, the term tricyclic antidepressant adjunctive agent ("TCA" adjunctive agent), as used herein, represents a tricyclic antidepressant agent which can be identified as such by the skilled artisan. Tricyclic antidepressants are known for their use in the treatment of depression. For example, Goodman and Gilman's *"The Pharmacological Basis of Therapeutics,"* 9th edition, Macmillan Publishing Co., 1996, pp 413-423, provides well known examples of tricyclic antidepressant agents. Specific tricyclic antidepressant agents useful in the present invention are also disclosed in detail in *The Merck Index*, 12th Edition, Merck & Co., Inc.

[0215] Tricyclic antidepressant agents useful in the present invention include, but are not limited to, adinazolam, amitriptyline, amitriptyline oxide, amoxapine, butriptyline, clomipramine, demexiptiline, desipramine, dibenzepin, dimetacrine, dothiepin, doxepin, fluazepine, imipramine, imipramine-oxide, iprindole, lofepramine, maprotiline, melitracen, metapramine, nortriptyline, noxiptilin, opipramol, pizotyline, propizepine, protriptyline, quinupramine, tianeptine, trimipramine, pharmaceutically acceptable salts thereof and mixtures thereof.

[0216] Systemically administered antidepressants offer an alternate therapy in neuropathic and chronic pain states. Interactions with biogenic amines, endogenous opioids,

excitatory amino acid receptors, substance P and calcium and sodium channels have been considered in efforts to pinpoint the mechanism of systemically administered antidepressants (reviewed by Eschalier A, Mestre C, Dubray C, Ardid D (1994) *CNS Drugs* 2: 261). What is clear is that antidepressants can act at both supraspinal (Spiegel, K., Kalb, R; and Pasternak, G. W., *Ann. Neurol.* 13 (1983) 462-465, Eschalier A, Mestre C, Dubray C, Ardid D (1994) *CNS Drugs* 2: 261) and spinal (Hwang, A. S. and Wilcox, G. L., *Pain* 28 (1987) 343-355; Iwashita, T. and Shimizu, T., *Brain Research* 581 (1992) 59-66; J. Eisenach and G. F. Gebhart, *Anesthesiology* 83 (1995) 1046-1054) sites of action.

[0217] This analgesic action is independent of antidepressant effects as it occurs in non-depressed subjects and occurs independently of mood changes in depressed subjects (Magni G (1991) *Drugs* 42: 730; Onghena P, Van Houdenhove B (1992) *Pain* 49: 205; Max M B (1994) In: *Progress in Pain Research and Management* (Ed. Fields H L, Liebskind J C) IASP Press, Seattle, 229, McQuay H J, Tramer M, Nye B A, Carroll D, Wiffen P J, Moore R A (1996) *Pain* 68: 217). Agents which block the uptake of both noradrenaline (NA) and 5-hydroxytryptamine (5-HT) such as amitriptyline, or which block NA but not 5-HT, such as desipramine, are more effective than those with selectivity for 5-HT, such as fluoxetine (Max M B (1994) In: *Progress in Pain Research and Management* (Ed. Fields H L, Liebskind J C) IASP Press, Seattle, 229). Pain relief is reported to be apparent within one week of therapy (McQuay H J, Carroll D, Glynn C J (1992) *Anaesthesia* 47: 646). This time course corresponds to the time required to attain stable plasma levels ($t_{1/2}$) 17-36 hours in humans, Ziegler V E, Biggs J T, Aardekani A B, Rosen S H (1978) *J Clin Pharmacol* 18: 462). By contrast, the antidepressant activity of these compounds takes 4-6 weeks to become apparent (Potter W Z, Rudorfer M, Manji H (1991) *New Eng J Med* 325: 633). These differences in profile of active drugs, time course, and independent expression of effects suggest that mechanisms underlying pain relief and alleviation of depression differ.

[0218] In animal tests, both the systemic and spinal administration of antidepressants show intrinsic efficacy in a number of nociceptive pain tests, and augment analgesia produced by opioids (reviewed by Eschalier A, Mestre C, Dubray C, Ardid D (1994) *CNS Drugs* 2: 261). However, this profile can be variable, and inhibitory effects on the action of morphine have been observed in some cases (reviewed by Eschalier et al., supra). Methodological issues (e.g., test paradigm, intensity of stimulus, dose, regimen of acute versus chronic administration) are reported to account for many of these differences (Kellstein D E, Malseed R T, Goldstein F J (1984) *Pain* 60: 275; Kellstein D E, Malseed R T, Ossipov M H, Goldstein F J (1988) *Neuropharmacology* 27: 1; Fialip J, Marty H, Makambila M C, CiViato M A, Eschalier A (1989) *J Pharmacol Exp Ther* 248: 747). Systemically administered antidepressants also exhibit intrinsic actions in a number of neuropathic pain tests including nerve transection (Seltzer Z, Tal M, Sherav Y (1989) *Pain* 37: 245), mononeuropathy (Ardid D, Gilbaud G (1992) *Pain* 49: 279) and diabetic neuropathy models (C. Courteix et al. (1994) *Pain* 57:153-160). One study examined chronic versus acute dosing regimens (Ardid D, Gilbaud G (1992) *Pain* 49: 279), and observed that the activity seen following chronic para-

digms appeared to be accounted for by accumulating doses rather than being qualitatively different.

[0219] The mechanism of action of the tricyclic antidepressant agents used in the present invention is presumed to be due to the anticholinergic action of the tricyclic antidepressant, whereby they block the neurotransmitter acetylcholine to prevent transmission of impulses in the A-delta and C pain fibers, thereby resulting in pain relief.

[0220] Locally administered tricyclic, second generation, or third generation antidepressant(s) produce a local antinociceptive action, especially against inflammatory and neuropathic pain. When administered locally in animal models of inflammatory (formalin test) and neuropathic pain (spinal nerve ligation), amitriptyline, a non selective noradrenaline (NA) and 5-hydroxytryptamine (5-HT) reuptake inhibitor, and desipramine, a selective NA reuptake inhibitor, produced local antinociceptive actions.

[0221] Suitable doses of the tricyclic antidepressant adjunctive agents vary due to the wide variations in potency among the various TCAs. The dose is also dependant on the severity of the pain which must be prevented or alleviated, the physical condition of the patient, the relative severity and importance of adverse side effects, and other factors within the judgment of the physician. Examples of suitable doses and routes of administration of tricyclic antidepressant adjunctive agents are listed in Table XVI below:

TABLE XVI

TRICYCLIC ANTIDEPRESSANTS	
TCA	Dose
Amitriptyline	25-300 mg/day orally or injection
Clomipramine	25-250 mg/day orally
Doxepin	25-300 mg/day orally
Imipramine	25-300 mg/day orally or injection
Trimipramine	25-300 mg/day orally
Amoxapine	50-600 mg/day orally
Desipramine	25-300 mg/day orally
Maprotiline	25-225 mg/day orally
Nortriptyline	25-250 mg/day orally
Protriptyline	10-60 mg/day orally

[0222] In embodiments where the present invention contemplates the use of a vasodilator, e.g., a nitrate vasodilator. Nitrate vasodilators include, but are not limited to nitrites, organic nitrates, nitroso compounds and any other nitrogen oxide-containing substances.

[0223] As capsaicinoids are highly protein bound, vasodilators are useful as adjunctive agents as they facilitate the capsaicinoid being diffused throughout the desired site before it has a chance to bind to the tissue.

[0224] Organic nitrates and nitrites act on almost all smooth muscle structures, e.g., bronchial, biliary, gastrointestinal tract, uterine and ureteral smooth muscles. Pain and other symptoms associated with increased pressure can be transiently relieved. For example, administration of a nitrate in a patient with T-tube drainage can reduce biliary pressure and can induce rapid emptying of biliary contents into the duodenum.

[0225] Nitrates, organic nitrates, nitroso compounds, and a variety of other nitrogen oxide-containing compounds work

by activating guanylate cyclase and increasing the synthesis of guanosine 3', 5'-monophosphate (cyclic GMP) in smooth muscle and other tissues. These agents all lead to the formation of nitric oxide (NO). Nitric oxide is a reactive free radical that interacts with and activates guanylate cyclase. The interaction of nitric oxide and guanylate cyclase stimulates cyclic-GMP dependent protein kinase, which results in the phosphorylation of various proteins in smooth muscle, which further results in de-phosphorylation of the light chain of myosin, a protein thought to play an important role in the contractile process in its phosphorylated form. Analogs of cyclic-GMP can also relax vascular and bronchial smooth muscle (See: Goodman and Gilman's "The Pharmacological Basis of Therapeutics," 9th edition, Macmillan Publishing Co., 1996, pp 798-799 and 806-816).

[0226] Specific nitrate vasodilator adjunctive agents useful in the present invention are also disclosed in detail in The Merck Index, 12th Edition, Merck & Co., Inc nitrate vasodilator agents useful in the present invention include, but are not limited to clonitrate, erythrityl tetranitrate, isobutyl nitrate, isoidide dinitrite or mononitrite, isomannide dinitrite or mononitrite, isosorbide dinitrate or mononitrate, mononitrate, mannitol hexanitrate, nitroglycerin, pentaerythritol tetranitrate, pentaerythritol trinitrate or dinitrite or mononitrite, pentritinol, propatyl nitrate, sodium nitroprusside, trolnitrate phosphate, 1,3-propane dinitrite, 1,7-heptane dinitrite, cyclohexylmethyl nitrite, 2-phenylethyl nitrite, 3-chloro-2,2 dimethylpropyl nitrite, tert-amyl nitrite, 2-methyl-2-hexyl nitrite, hexyl nitrite, 2-methyl-1,3-propane dinitrite, 2,2,dimethyl-1,3-propane dinitrite, 2-methyl-2-propyl-1,3-propane dinitrite, 3-hexyl nitrite, octyl nitrite, 4-methyl-2-pentyl nitrite, 4-methyl-1-pentyl nitrite, 2-heptyl nitrite, 3-octyl nitrite, 2-methyl-2-pentyl nitrite, 5-methyl-2-hexyl nitrite, 6-methyl-2-heptyl nitritepharmaceutically acceptable salts thereof and mixtures thereof.

[0227] Suitable doses of the nitrate vasodilator adjunctive agents vary due to the wide variations in potency among the various nitrate vasodilators. The dose is also dependant on the severity of the pain which must be prevented or alleviated, the physical condition of the patient, the relative severity and importance of adverse side effects, and other factors within the judgment of the physician. In certain embodiments of the present invention suitable doses of nitrate vasodilator adjunctive agents may range from about 0.0001 to 120 mg/kg of body weight per day, more preferably from about 0.01 to about 75 mg/kg and most preferably from about 0.5 to about 30 mg/kg.

[0228] In certain embodiments of the present invention, oral doses of the vasodilator adjunctive agents range from about 2.5 to about 300 mg/day of nitrite, preferably from about 5 to about 160 mg/day.

[0229] In certain embodiments, a vasodilator and a vasoconstrictor can be used as adjunctive therapy for capsaicinoid administration. For example, the capsaicinoid can be administered with a vasodilator at the intended site. To compliment the capsaicinoid therapy, a local anesthetic can be administered at a distal site to provide a regional block at the site of capsaicinoid administration. The vasoconstrictor can be administered with the local anesthetic to prolong the duration of effect of the local anesthetic.

[0230] In certain other embodiments there is provided a composition comprising a capsaicinoid and one or more adjunctive agents disclosed herein.

[0231] Breakthrough Pain

[0232] The term "breakthrough pain" means pain which the patient experiences despite the fact that the patient is being or was administered generally effective amounts of, e.g., capsaicin. In conjunction with the use of the capsaicinoid formulations and methods described herein, it is contemplated that it is nonetheless possible that the patient will experience breakthrough pain. For the treatment of breakthrough pain, the individual may be further administered an effective amount of an analgesic in accordance with the treatment of pain in such situations performed by those skilled in the art. The analgesic may be any known to the person skilled in the art such as those selected from the group comprising gold compounds such as sodium aurothiomalate; non-steroidal anti-inflammatory drugs (NSAIDs) such as naproxen, diclofenac, flurbiprofen, ibuprofen ketoprofen, ketorolac, pharmaceutically acceptable salts thereof and the like; opioid analgesics such as codeine, dextropropoxyphene, dihydrocodeine, morphine, diamorphine, hydromorphone, hydrocodone, methadone, pethidine, oxycodone, levorphanol, fentanyl and alfentanil, para- aminophenol derivatives such as paracetamol, pharmaceutically acceptable salts thereof and the like; and salicylates such as aspirin.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENTS

EXAMPLE I

OSTEOARTHRITIS OF THE KNEE SAFETY STUDY

[0233] The following clinical study was carried out in order to evaluate the safety, tolerability, systemic pharmacokinetics, and efficacy of purified capsaicin administered by intra-articular infiltration together with a local anesthetic administered by intra-articular infiltration in subjects with osteoarthritis of the knee.

[0234] The primary objective of the study was to evaluate the safety and tolerability of intra-articular capsaicin, when co-administered with intra-articular local anesthetic, compared to placebo, in subjects with end-stage osteoarthritis of the knee, already scheduled to receive knee replacements.

[0235] Purified capsaicin was supplied in vials containing 5 mL of purified capsaicin at a concentrations of 500 $\mu\text{g/mL}$. Study drug was stored at a temperature between 15° C. and 25° C. Within four hours prior to injection, vehicle was used to dilute the drug to final concentrations of purified capsaicin, as follows:

TABLE 1

Dose Level	Concentration	Total Volume of Dose
10 μg	2 $\mu\text{g/mL}$	5 mL
100 μg	20 $\mu\text{g/mL}$	5 mL
300 μg	60 $\mu\text{g/mL}$	5 mL

[0236] Each vial was used for one infiltration administration only and appropriately labeled. The supplier of the purified capsaicin was FormaTech, Inc., 200 Bullfinch Drive, Andover, Mass. 01810. The vials were supplied in bulk to the study center with each vial labeled according to the contents of the vial. The Pharmacist/Study Nurse, who

prepared the injection, maintained the investigational product in a lockable cabinet at the required temperature, 15-25°C. The study blind was maintained by the Pharmacist/Study Nurse.

[0237] Placebo vehicle for purified capsaicin was supplied in vials containing 5 mL. Local anesthetic (Lignocaine 2%) was used for each intra-articular infiltration.

[0238] The study was a single center, randomized, double blind, placebo controlled, dose ranging Phase 1 study of three dose levels (10 µg, 100 µg, or 300 µg) of intra-articularly administered purified capsaicin, when co-administered with intra-articular local anesthetic, in subjects with osteoarthritis of the knee who were scheduled to undergo total knee replacement. The doses of purified capsaicin used in this trial were well below (>100 fold) doses known to be toxic to animals. The study was designed to include 16 evaluation subjects. Sixteen subjects were enrolled in the study; 12 were treated with ultra-purified capsaicin (4 each with 10, 100, and 300 µg doses) and 4 were treated with placebo vehicle. Sixteen subjects completed the study.

[0239] Patients were treated randomly and in double-blind fashion in four treatment groups, with each group having a progressively longer interval between the intra-articular administration of study medication and subsequent total knee replacement (2, 4, 7, and 14 days). Four subjects, 1 in each of the 4 dose groups (placebo, 10 µg, 100 µg, and 300 µg of capsaicin), were enrolled in each treatment group. Gross and microscopic pathology analysis was completed for each treatment group before the next treatment group was treated.

[0240] Each subject had 3 study visits: a Screening Day (Day -7 to -1), the Treatment Day (Day 0), and a Post-Treatment Day (scheduled for Day +2, +4, +7, or +14). On the Treatment Day the subject was randomized, pre-treatment evaluation was performed. The patients were brought into the procedure room, and a VAS pain score was taken (0 mm—no pain, 100 mm—extreme pain). Once the patient had marked his or her pain on the card, he/she was prepped for knee cannulation. Once the cannula was placed, the patient received by intra-articular infiltration, 3 mg/kg (maximum dose of 200 mg) of 2% lignocaine into the knee scheduled to be replaced. This administration of local anesthetic was followed in 10 minutes by an intra-articular infiltration of placebo (vehicle) or 10 µg, 100 µg, or 300 µg of purified capsaicin diluted with vehicle to a total volume of 5 mL.

[0241] VAS pain scores as well as verbal reports were taken immediately following administration, as well as prior to knee replacement surgery. No subjects discontinued from the study due to adverse events.

[0242] Immediately following instillation of capsaicin, some patients, (0 of 4 receiving placebo, 0 of 4 receiving 10 µg capsaicin, 1 of 4 receiving 100 µg capsaicin, and 4 of 4 receiving 300 µg capsaicin) reported transient burning pain representative of capsaicin injection (onset within a few seconds to minutes and lasting less than one hour). Pain was mild but for some patients, the investigator chose to place ice packs on the treated knee until the pain resolved. In particular, the subject in the 100 µg dose group and 2 of the subjects in the 300 µg dose group had burning post-administration (hyper) algescic pain alone; two subjects in the 300

µg dose group had burning pain in conjunction with other types of post-administration (hyper) algescic pain (1 subject had burning and stinging pain and the second subject had burning and toothache-like pain). All of the episodes of post-administration (hyper) algescia began immediately (within 5 minutes) after administration. All of these painful episodes were brief: the duration of this pain was 9 minutes for the subject in the 100 µg dose group, and 17, 25, 25, and 42 minutes for the subjects in the 300 µg dose group. The 4 subjects in the 300 µg dose group and 1 subject in the 100 µg dose group required intervention for their post-injection (hyper) algescia. For all but 1 of these 5 subjects, the only intervention was ice packs. One subject in the 300 µg dose group was treated with paracetamol; no subjects were treated with intravenous morphine or granisetron for post-administration (hyper) algescia. Most of the concomitant medications used in the study were medications taken prior to the study that continued to be taken during the study. The only concomitant non-drug treatments during the study were the ice packs used in the 5 subjects with post-administration (hyper) algescia.

[0243] On the Post-Treatment Day, study evaluation was performed followed by the scheduled knee replacement, with intra-operative bone and soft tissue biopsies performed for subsequent examination. For overall efficacy analysis, we chose to exclude the patients who had surgery two days following administration since analgesia from remaining lignocaine or residual pain from the actual procedure (large volume infiltration) and lysing c-fiber endings could not be excluded (In normal volunteers, a mild “aching” pain is sometimes observed for up to two days following capsaicin administration). This therefore left the 3 placebo and 9 active patients from the 4 day, 7 day, and 14 day cohorts. Examination of the VAS scores prior to drug/placebo administration and the day of surgery (prior to surgery) showed that pain scores were not reduced in the placebo group (VAS decreased by only 7±30%), but was reduced in the capsaicin group (VAS reduced by 62±14%). The changes in VAS score are reported graphically as shown in FIG. 1. The plasma concentration over time of the three dosage ranges of capsaicin are shown in FIG. 2.

[0244] Ten-mL blood samples for subsequent assay of plasma ultra-purified capsaicin concentrations were collected prior to study medication administration, at 30 minutes, 1, 2, and 4 hours after study medication injection, and immediately prior to the first administration of pre-operative medications on the Post Treatment Day. The pharmacokinetic parameters of C_{max}, T_{max}, AUC(0–t_{last}) and t_{1/2} were evaluated.

[0245] In the 10 µg dose group, purified capsaicin plasma concentrations were measurable at only 0, 1, or 2 time points; therefore, no pharmacokinetic parameters could be estimated for any subject in this dose group. For the 3 subjects in each of the 100 µg, and 300 µg dose groups for which pharmacokinetic parameters could be estimated, the magnitude of the C_{max} and AUC (0–t_{last}) values was similar in the 2 dose groups. T_{max} values were 0.5 hr in all subjects for which they could be estimated. Terminal exponential half-lives were similarly brief in all subjects in both the 100 µg and 300 µg dose groups.

[0246] The AUC (0–t_{last}) values for the subjects in the 100 µg dose group (366.10, 75.19, and 511.21 pg*hr/mL) were

similar in magnitude to the values for the 300 μg dose group (449.01, 2.20.42, and 498.83 $\text{pg}\cdot\text{hr}/\text{mL}$). Similarly, the C_{max} values in the 100 μg dose group (292.06, 79.94, and 538.32 pg/mL) were similar in magnitude to the values in the 300 μg dose group (207.62, 251.42, and 499.88 pg/mL). T_{max} was 0.5 hours in all 6 subjects. The terminal exponential half lives were brief in all subjects, with values of 0.1498, 1.1488, and 0.1014 hr in the 100 μg dose group and values of 0.3268, 0.2298, and 0.1663 in the 300 μg dose group.

[0247] The pharmacokinetic conclusions are necessarily limited, because the number of timepoints at which plasma concentrations of purified capsaicin was measurable was so limited in these study subjects. However, there was some evidence for a pharmacokinetic dose response over the 10 μg to 300 μg dose range in that the purified capsaicin plasma concentrations in the 10 μg dose group were clearly lower than in either the 100 μg or the 300 μg dose groups. However, there was little evidence for a pharmacokinetic dose response over the 100-300 μg dose range.

[0248] Purified capsaicin was well tolerated at all dose levels. There was low leakage of study drug from the joint space and gross and microscopic pathology was normal. There were no treatment related signs of erythema, edema, or hemorrhage at the site of injection, and no treatment related effects on soft tissue, cartilage, or bone upon histopathological examination. No treatment related systemic side effects were seen, and there were no treatment related effects on laboratory safety parameters or vital signs. There was no discernable effect on proprioception at the injected knee in any dose group at any time point.

[0249] There was a clear dose response for the incidence of post injection hyperalgesia. This symptom occurred in 4 subjects in the 300 μg dose group, 1 subject in the 100 μg dose group, and no subjects in the 10 μg dose group or placebo. In all but one case, the hyperalgesia was described as a burning sensation, which developed within five minutes of injection and lasted on average less than thirty minutes. In all cases where intervention was required, the hyperalgesia was easily and effectively controlled by the application of ice packs to the knee.

[0250] Subjects were asked to rank their level of pain on a visual analogue scale (VAS), anchored by "no pain" on the left and "extreme pain" on the right, prior to receiving the intra-articular dose of purified capsaicin and local anesthetic and then again just prior to administration of preoperative medications on the day of knee replacement surgery. No clear treatment related indication of efficacy was seen at any of the dose levels (10 μg , 100 μg , and 300 μg) of purified capsaicin.

[0251] Since intra-articular infiltration of local anesthetic followed by intra-articular infiltration of capsaicin was generally well-tolerated, and the median decreases from baseline to the pre-operative time point in the VAS for pain at the target knee in all 3 capsaicin dose groups were all substantially greater than the median change from baseline in the placebo group, the risk to benefit ratio of this treatment strategy appears favorable. Further studies of this treatment in larger numbers of subjects with osteoarthritis appear warranted.

EXAMPLE II

OSTEOARTHRITIS OF THE KNEE EFFICACY STUDY

[0252] The following clinical study evaluates the efficacy of purified capsaicin administered by intra-articular infiltration together with a local anesthetic injected by intra-articular infiltration in subjects with osteoarthritis of the knee.

[0253] The primary objective of the study is to evaluate the efficacy of intra-articular capsaicin, when co-administered with intra-articular local anesthetic, compared to placebo, in subjects with end-stage osteoarthritis of the knee, already scheduled to receive knee replacements (21 and 42 days after injection of study medication).

[0254] Purified capsaicin is supplied in vials containing 5 mL of purified capsaicin at a concentrations of 500 $\mu\text{g}/\text{mL}$. Study drug was stored at a temperature between 15° C. and 25° C. Within four hours prior to injection, vehicle is used to dilute the drug to final concentrations of purified capsaicin, as follows:

TABLE 2

Dose Level	Concentration	Total Volume of Dose
1000 μg	200 $\mu\text{g}/\text{mL}$	5 mL

[0255] Each vial is used for one infiltration administration only and appropriately labeled. The supplier of the purified capsaicin is FormaTech, Inc., 200 Bullfinch Drive, Andover, Mass. 01810. The vials are supplied in bulk to the study center with each vial labeled according to the contents of the vial. The Pharmacist/Study Nurse, who prepares the injection, maintains the investigational product in a lockable cabinet at the required temperature, 15-25° C. The study blind is maintained by the Pharmacist/Study Nurse.

[0256] Placebo vehicle for purified capsaicin is supplied in vials containing 5 mL. Local anesthetic (Lignocaine 2%) is used for each subacromial bursa infiltration.

[0257] The study is a single center, randomized, double blind, placebo controlled, dose ranging Phase 2 study of capsaicin (1000 μg) administered by intra-articular infiltration, when co-administered with intra-articular local anesthetic, in subjects with osteoarthritis of the knee who are scheduled to undergo total knee replacement from three to six weeks post study drug administration, wherein the primary endpoint is pain reduction at three weeks following study drug administration.

[0258] The study is designed to include 12 evaluation subjects (Patients suffering a defined pain: >40 mm on VAS). Six (6) subjects will be treated with capsaicin 1000 μg and 6 subjects will be treated with placebo vehicle. Patients are treated randomly and in double-blind fashion. Gross and microscopic pathology analysis are completed for each treatment group. Each subject has 3 study visits: a Screening Day (Day -7 to -1), the Treatment Day (Day 0), and a Post-Treatment Day (scheduled for Day +2, +4, +7, or +14). On the Treatment Day the subject is randomized, pre-treatment evaluation is performed. The patient is brought into the procedure room, and a VAS pain score is taken (0

mm—no pain, 100 mm—extreme pain). Once the patient marks his or her pain on the card, he/she is prepped for knee cannulation. Once the cannula is placed, the patient receives, by intra-articular infiltration, 3 mg/kg (maximum dose of 200 mg) of 2% lignocaine into the knee scheduled to be replaced. This infiltration of local anesthetic is followed in 10 minutes by an intra-articular infiltration of placebo (vehicle) or 1000 μ g of purified capsaicin diluted with vehicle to a total volume of 5 mL.

[0259] VAS pain scores as well as verbal reports are taken immediately following administration, as well as prior to knee replacement surgery. On the Post-Treatment Day, a study evaluation is performed followed by the scheduled knee replacement, with intra-operative bone and soft tissue biopsies performed for subsequent examination. For overall efficacy analysis, patients having surgery two days following infiltration are excluded since analgesia from remaining lignocaine or residual pain from the actual procedure (large volume injection) and lysing c-fiber endings is not capable of being excluded.

[0260] Changes in NRS (Numerical Rating Scale) pain scores were measured at three weeks following administration. Final NRS score for placebo=7.30 ($p=0.05$), whereas final NRS score for capsaicin=3.97 ($P=0.03$) (See FIG. 3).

EXAMPLE III

BUNIONECTOMY EFFICACY STUDY

[0261] The following study was carried out in order to evaluate the safety, tolerability, systemic pharmacokinetics, and efficacy of intra-operative (infiltration) capsaicin when co-administered with a local anesthetic in patients scheduled to undergo transpositional osteotomy (bunionectomy).

[0262] The primary objective of the study was to evaluate the safety and tolerability of capsaicin, when co-administered by intra-articular infiltration with a local anesthetic, compared to placebo, in subjects with hallux valgus deformity, already scheduled to undergo transpositional osteotomy (bunionectomy). The secondary objective of the study was to evaluate the safety, tolerability and systemic pharmacokinetics of purified capsaicin following intra-operative administration. The primary efficacy endpoint was the proportion of subjects in each treatment group requiring opioid analgesia in the first 24 hours post-operatively. The proportions were compared amongst treatment groups using the Cochran-Haenszel test. Secondary efficacy endpoints included: i) proportion of subjects in each treatment group requiring opioid analgesia in the first 36 hour period post-operatively (Similarly, the proportions were compared amongst treatment groups using the Cochran-Haenszel test); ii) proportion of subjects in each treatment group requiring opioid analgesia in the 10 day period post-operatively (Similarly, the proportions were compared amongst treatment groups using the Cochran-Haenszel test); iii) time to first usage of opioid analgesia in each treatment group (a survival analysis approach will be used: the product-limit (Kaplan-Meier) method will be applied to time to first usage of opioid analgesia. The median time to first usage of opioid analgesia will be estimated in both treatment groups. Pairwise comparisons will be performed to test for equality of the survival curves between the 2 treatment groups using both the log-rank and the Wilcoxon test); iv) total usage of analgesia

in each treatment group (the total usage of analgesia will be compared by an analysis of variance with treatment and center as independent variables. A pairwise comparison will be performed between the treatment groups); and v) VAS assessment of pain at the site of operation in each treatment group (The VAS score at each time point will be compared by an analysis of variance with treatment and center as independent variables. A pairwise comparison will be performed between the treatment groups). Safety endpoints included: i) laboratory safety parameters; ii) adverse events; and iii) purified capsaicin blood levels. The efficacy analysis was performed on the data obtained ten days postoperatively. The safety analysis was performed based on the safety data for the entire study, including the 6 week and 12 week follow-up periods. The blind was broken at the time the efficacy analysis was performed. However, the individual treatment assignment was available to the statistical analysis group only. All other personnel involved in the study, including the Investigator, study monitor and proprietary staff, remained blinded until the entire study was completed.

[0263] Purified capsaicin was supplied in vials containing 5 mL of purified capsaicin at a concentrations of 500 μ /mL. Study drug was stored at a temperature between 15° C. and 25° C., Within four hours prior to injection, vehicle was used to dilute the drug to final concentrations of purified capsaicin, as follows:

TABLE 3

Dose Level	Concentration	Total Volume of Dose
1000 μ g	250 μ g/mL	4 mL

[0264] Each vial was used for one infiltration administration only and appropriately labeled. The supplier of the purified capsaicin was FormaTech, Inc., 200 Bullfinch Drive, Andover, Mass. 01810. The vials were supplied in bulk to the study center with each vial labeled according to the contents of the vial. The Pharmacist/Study Nurse, who prepared the injection, maintained the investigational product in a lockable cabinet at the required temperature, 15-25° C. The study blind was maintained by the Pharmacist/Study Nurse.

[0265] Placebo vehicle for purified capsaicin was supplied in vials containing 5 mL. Local anesthetic (Lignocaine 2%) was used for each infiltration.

[0266] The study was a single center, randomized, double blind, placebo controlled, Phase II study of the safety and efficacy of intra-operative capsaicin, when co-administered with local anaesthetic, in subjects undergoing transpositional first metatarsal osteotomy and fixation for the correction of hallux valgus deformity. The dose of capsaicin used in the trial was 1000 μ g.

[0267] The study was designed to include 40 evaluation subjects. Twenty (20) randomized to the capsaicin treatment group and twenty (20) to the placebo control group. Each subject had six (6) study visits: a Screening Day (Day -28 to -1), an Operation Day (Day 0), and four (4) Follow-up visits (scheduled for Days 3, 10 and weeks 6 and 12).

[0268] On Operation Day (Day 0) the following was performed: a) Pre-operation: Prior to the initiation of an

ankle block, inclusion/exclusion criteria assessment was performed. Eligible subjects were randomized, pre-treatment evaluation was performed, which included laboratory safety assessments, measurement of vital signs, VAS assessment of pain at the target Hallux valgus, blood sample measurement for purified capsaicin concentration, and review of concomitant medications; b) Operation: An ankle block [lidocaine 0.5% (up to a total of 20 ml)] was initiated by the investigator to provide surgical anesthesia, and then a transpositional osteotomy of the first metatarsal +/- an Akin osteotomy of the proximal phalanx in accordance with normal practices and procedures was performed. Immediately prior to wound closure, the Investigator slowly dripped the study medication (4 mL) from a syringe into the wound, ensuring even tissue exposure. The wound was then be closed according to normal practices and procedures.

[0269] Post-Operation:

[0270] In the 24 hours following administration of study medication, vital signs (supine pulse rate and blood pressure) were recorded at 1, 2, 4 and 24 hours post administration. VAS assessment of pain at the operation site was performed at 1, 4, 8, 12 and 24 hours post administration. In those instances where VAS measurements coincide with blood sampling procedures, the VAS assessment was performed first. Blood samples for measurement of capsaicin concentration were obtained at 1, 2, and 4 hours post administration. The quantity of each blood sample was 10 mL. Laboratory safety assessments, e.g., haematology, biochemistry, urinalysis were performed at 24 hours post administration. Adverse events were spontaneously reported by the subject and recorded. Rescue analgesia medication was provided to the subject if required (initially diclofenac 50 mg, repeated at 8 hourly intervals if necessary). When diclofenac was judged by the Investigator to provide inadequate pain relief then the subject was provided with alfentanil 1 mg, repeated at 6 hourly intervals, if necessary. After discharge from the hospital, alfentanil was substituted with co-codamol 30/500 (codeine phosphate 30 mg+paracetamol 500 mg), repeated at 4 hourly intervals when necessary. Any usage of rescue medication or concomitant medication was recorded in the subject's CRF. At 24 hours post administration of study medication, the subject was discharged from the clinic.

[0271] Follow Up:

[0272] Follow-up (days 1-10): Upon discharge from the clinic, the subject was provided with a diary card for Days 1-10, and asked to record: VAS assessment of pain at the operation site, performed each morning; time and amount of any rescue medication taken by the subject (at any time); usage of concomitant medications (at any time); adverse events experienced by the subject (at any time). Each subject was also be asked to return to the clinic on Day 3 and on Day 10 post-operation. At these clinic visits the Investigator examined the subject's diary card and resolved any unclear or inconsistent entries. Data from the diary card was transcribed to the subject's CRF. The site of the operation was inspected by the Investigator to confirm that normal wound healing took place.

[0273] Follow Up (Week 6): The subject was asked to return to the clinic at 6 weeks post operation. The site of the operation was inspected by the Investigator to confirm that normal wound healing is took place. The subject was

questioned about any adverse events he/she experienced since the last clinic visit, and any usage of concomitant medication.

[0274] Follow Up (Week 12): The subject was asked to return to the clinic at 12 weeks post operation. The site of the operation was inspected by the Investigator to confirm that normal wound healing is took place. The subject was questioned about any adverse events he/she may experienced since the last clinic visit, and any usage of concomitant medication. The Investigator discharge the subject from the study.

[0275] The results of the bunionectomy study proved that capsaicin administered at a dose of 1000 μ g into the wound prior to wound closure reduced both pain score as well as the use of rescue as shown in FIGS. 3 and 4. Reduction in rescue was almost always associated with maintenance of VAS score, i.e., the new drug simply substitutes for the old drug (See; Table 4 below):

TABLE 4

Time	Placebo	purified capsaicin
1 hr	3.3 +/- 2.3	11.1 +/- 7.3
4 hr	3.1 +/- 2.2	10.7 +/- 3.6
8 hr	19.7 +/- 4.9	5.5 +/- 2.3
12 hr	28.1 +/- 9.0	8.2 +/- 3.8
24 hr	11.7 +/- 4.6	1.9 +/- 1.0
48 hr	19.3 +/- 8.9	5.9 +/- 2.5
72 hr	22.9 +/- 9.9	10.6 +/- 3.5

mean +/- SEM n = 10 placebo,
n = 11 purified capsaicin
P < 0.05 at each time point

[0276] Administration of 1000 μ g of capsaicin prior to wound closure decreased opioid rescue. Only 45% of the study subjects randomized to receive capsaicin required rescue (one subject required rescue at 1 hr, a second subject required rescues at 4 hr, a third subject required rescue at 5 hr, a fourth subject required rescue at 8 hr, and a fifth subject required rescue at 12 hr; 6 subjects did not rescue in 72 hours (n=11)), whereas 80% of the study subjects randomized to receive placebo required rescue (one subject required rescue at 1 hr, a second subject required rescue at 2 hr, a third subject required rescue at 6 hr, a fourth subject required rescue at 8 hr, a fifth subject required rescue at 12 hr, a sixth subject required rescue at 14 hr, a seventh and eighth subject required rescue at 16 hr, and 2 subjects did not require rescue in 72 hours (n=10) P<0.05).

EXAMPLE IV

MEDIAN STERNOTOMY STUDY

[0277] The primary objective of the study is to determine the amount of opioid consumption and postoperative pain scores following median sternotomy for patients receiving purified capsaicin by infiltration and/or injection. Eligible subjects are patients undergoing cardiac, pulmonary, or mediastinal surgery for any indication between the ages of 20-70 years. The operation is performed under general anesthesia and are closely observed in a post-anesthesia care unit as per the practice of the institution. The study drug will be administered to the sternal edges, muscles (e.g., muscle edges), bone (e.g., bone edges), and tissues. All patients receive standard of care opioid on demand for treatment of

pain when transferred to the ward. The dose of capsaicin is administered to the sternal edges, the muscle, the tissues and/or bone.

[0278] Pain is assessed utilizing VAS 100 mm scale—baseline, every 60 minutes beginning when the patient first is placed in a bedside chair (or ambulated) for 24 hours and then every 4 hours while awake until discharge from the hospital. Patient diaries will be used following discharge for a two-week period.

[0279] The primary study endpoint is the time to first request of postoperative opioid. The amount of opioid rescue used is recorded every 24 hours for the first 2 weeks, patients will complete an opioid-related symptom distress (SDS) questionnaire.

EXAMPLE V

LAPAROSCOPIC CHOLECYSTECTOMY STUDY

[0280] The primary objective of this study is to evaluate the amount of opioid consumption and postoperative pain scores following laparoscopic cholecystectomy in patients administered purified capsaicin by infiltration and/or injection. Study subjects will receive a dose of purified capsaicin in proximity to the surgical site.

[0281] This study includes 40 patients (20 randomized to receive capsaicin study drug and 20 randomized to receive placebo study drug) between the ages of 20-60 years old with symptomatic gallstones. The operation is performed under general anesthesia and the subject is closely observed in a post-anesthesia care unit for up to 24 hours and remains in the hospital (typically for 1 to 5 days). All patients receive standard of care opioid on demand for treatment of pain before discharge, and opioid (to be determined) post discharge. Pain is assessed utilizing VAS 100 mm scale—baseline, every 30 minutes till the 2nd postoperative hour then every 4 hours the following 12 hours, and at 24 hours and at days 2, 3, 4, 5, 6 and 7. Patient diaries are used following discharge. Study subject will receive a dose of purified capsaicin 1000-3000 μg divided over the 4 part wounds—infiltrated along the cut muscle edges.

[0282] The primary study endpoint is the time to first request of postoperative analgesia. The amount of opioid rescue is every 24 hours for first 3 days, patients complete an opioid-related symptom distress (SDS) questionnaire.

EXAMPLE VI

KNEE REPLACEMENT STUDY

[0283] The primary objective of the study evaluates the amount of opioid consumption and postoperative pain scores following knee replacement surgery for patients receiving administration of purified capsaicin by infiltration.

[0284] This study includes 80 patients (20 patients are randomized to receive placebo, 20 randomized to receive capsaicin 300 μg , 20 randomized to receive capsaicin 1000 μg , and 20 randomized to receive capsaicin 2000 μg). Eligible subjects are patients who undergoing knee replacement surgery between the ages of 20-70 years old.

[0285] The knee replacement operation is performed under general anesthesia and is closely observed in a post-

anesthesia care unit as per the practice of the institution. All patients receive standard of care opioid on demand for treatment of pain once transferred to the ward. The volume of capsaicin administered into the wound opening during closure ranges from about 5 ml to about 10 ml.

[0286] Pain is assessed utilizing VAS 100 mm scale—baseline, every 60 minutes beginning when the patient first is placed on mechanical flexion/extension for 24 hours and then every 4 hours while awake until discharge from the hospital. Patient diaries are used following discharge for a two-week period.

EXAMPLE VII

MASTECTOMY STUDY

[0287] Mastectomy results in significant pain and requires substantial doses of opioids postoperatively. Analgesic techniques that provide good pain control while minimizing opioid side effects are thus highly desirable. The primary objective of the study is to determine the amount of opioid consumption and postoperative pain scores following mastectomy for patients receiving capsaicin.

[0288] The study includes 80 patients (20 patients are randomized to receive placebo, 20 randomized to receive capsaicin 300 μg , 20 randomized to receive capsaicin 1000 μg , and 20 randomized to receive capsaicin 2000 μg). Eligible patients include patients undergoing mastectomy between the ages of 20-70 years old. The operation is performed under general anesthesia and is closely observed in a post-anesthesia care unit as per the practice of the institution. All patients receive standard of care opioid on demand for treatment of pain once transferred to the ward.

[0289] The dose of study drug is administered by infiltration in a volume from about 5 ml to about 10 ml within the wound cavity during closure.

[0290] Pain is assessed utilizing VAS 100 mm scale—baseline, every 60 minutes beginning when the patient first is placed on mechanical flexion/extension for 24 hours and then every 4 hours while awake until discharge from the hospital. Patient diaries are used following discharge for a two-week period.

[0291] The primary endpoint is time to first request of postoperative opioid. Opioid rescue occurs every 24 hours for the first 2 weeks, patients complete an opioid-related symptom distress (SDS) questionnaire.

EXAMPLE VIII

[0292] (i) Examples I to VII are repeated and ibuprofen is administered orally in an amount of 10/mg/kg before, during or after the administration of the capsaicinoid in order to decrease the pain and inflammation at the site of capsaicinoid administration.

[0293] (ii) Examples I to VII are repeated and carbamazepine is administered orally in an amount of 800 mg/day, before, during or after the administration of the capsaicinoid in order to decrease propagation and/or generate action potentials.

[0294] (iii) Examples I to VII are repeated and amitriptyline is administered orally in an amount of 100

mg/day either before, during or after the administration of the capsaicinoid in order to diffuse the capsaicinoid throughout the area.

[0295] (iv) Examples I to VII are repeated and epinephrine is administered parenterally at the site of action either before, during or after the administration of the capsaicinoid restrict the capsaicinoid at the area.

[0296] (v) Examples I to VII are repeated and isosorbide dinitrite is administered by injection at the site of administration of the capsaicinoid either before, during or after the administration of the capsaicinoid in order to diffuse the capsaicinoid throughout the area.

[0297] The invention has been described in an illustrative manner, and it is to be understood that the particular embodiments of the capsaicinoid formulations and methods of treatment described herein are intended to be descriptive rather than limiting. Many modifications and variations of the methodologies and formulations disclosed herein are possible in light of the above teachings, and such obvious modifications are deemed to be encompassed within the scope of the appended claims.

What is claimed is:

1. A method for relieving pain at a site in a human or animal in need thereof, comprising:

administering at a discrete painful site in a human or animal in need thereof a single injectable or implantable dose of a capsaicinoid in an amount effective to denervate said discrete site without eliciting an effect outside the discrete location and to attenuate pain emanating from said site, said effective dose being from about 1 μ g to about 5000 μ g of capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin; and coadministering an amount of a non-anesthetic sodium channel blocker.

2. The method of claim 1, wherein the non-anesthetic sodium channel blocker is in the same formulation as the capsaicinoid.

3. The method of claim 1, wherein the non-anesthetic sodium channel blocker is in a different formulation than the capsaicinoid.

4. The method of claim 1, wherein the non-anesthetic sodium channel blocker is administered by a different route than the capsaicinoid.

5. The method of claim 1, wherein the non-anesthetic sodium channel blocker is administered by the same route as the capsaicinoid.

6. The method of claim 1, wherein the non-anesthetic sodium channel blocker is administered orally, via implant, parenterally, sublingually, rectally, topically, or via inhalation.

7. The method of claim 3, wherein the administration of the capsaicinoid and the coadministration of the non-anesthetic sodium channel blocker have overlapping durations of effect.

8. The method of claim 1, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of antiarrhythmic agents, anticonvulsant agents, diuretic agents, combinations thereof and mixtures thereof.

9. The method of claim 1, wherein the non-anesthetic sodium channel blocker is selected from the group consist-

ing of phenytoin, carbamazepine, lamotrigine, zonisamide, riluzole, lifarizine, ralitoline, flunarizine, mexiletine, aprinidine, benzamil, phenamil, trimebutine, GEA-968, azure A, pancuronium, N-methylstrychnine, CNS 1237, BW1003C87, BW619C89, U54494A, PD85639, C1953, pharmaceutically acceptable salts thereof and mixtures thereof.

10. The method of claim 8, wherein the non-anesthetic sodium channel blocker is administered orally.

11. The method of claim 8, wherein the non-anesthetic sodium channel blocker is administered parenterally.

12. The method of claim 1, wherein the non-anesthetic sodium channel blocker is in an effective amount to decrease propagation and/or generate action potentials.

13. The method of claim 1, further comprising administering a local anesthetic to the human or animal.

14. The method of claim 1, wherein said dose of capsaicin is from about 10 to about 3000 μ g.

15. The method of claim 1, wherein said dose of capsaicin is from about 300 to about 1200 μ g.

16. The method of claim 1, wherein said dose of capsaicinoid is administered in a pharmaceutically acceptable vehicle for injection or implantation.

17. The method of claim 16, wherein said pharmaceutically acceptable vehicle is an aqueous vehicle is selected from the group consisting of Sodium Chloride Injection, Ringers Injection, Isotonic Dextrose Injection, Sterile Water Injection, Dextrose, Lactated Ringers Injection and any combinations or mixtures thereof.

18. An injectable or implantable pharmaceutical composition for attenuating pain at a site in a human or animal in need thereof, comprising from 1 μ g to 5000 μ g of a capsaicinoid, and an effective amount of a non-anesthetic sodium channel blocker to decrease propagation and/or generate action potentials.

19. The composition of claim 18, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of antiarrhythmic agents, anticonvulsant agents, diuretic agents, combinations thereof and mixtures thereof.

20. The composition of claim 18, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of phenytoin, carbamazepine, lamotrigine, zonisamide, riluzole, lifarizine, ralitoline, flunarizine, mexiletine, aprinidine, benzamil, phenamil, trimebutine, GEA-968, azure A, pancuronium, N-methylstrychnine, CNS 1237, BW1003C87, BW619C89, U54494A, PD85639, C1953, pharmaceutically acceptable salts thereof and mixtures thereof.

21. A method for attenuating pain at a surgical site or an open wound in a human or animal, comprising:

infiltrating a dose of a capsaicinoid in an amount effective to denervate a site selected from a surgical site or an open wound without eliciting an effect outside the site, said effective dose being from about 1 μ g to about 15,000 μ g of capsaicin or a therapeutically equivalent dose of a capsaicinoid other than capsaicin; and coadministering an amount of a non-anesthetic sodium channel blocker.

22. The method of claim 21, wherein the non-anesthetic sodium channel blocker is in the same formulation as the capsaicinoid.

23. The method of claim 21, wherein the non-anesthetic sodium channel blocker is in a different formulation than the capsaicinoid.

24. The method of claim 21, wherein the non-anesthetic sodium channel blocker is administered by a different route than the capsaicinoid.

25. The method of claim 21, wherein the non-anesthetic sodium channel blocker is administered by the same route as the capsaicinoid.

26. The method of claim 21, wherein the non-anesthetic sodium channel blocker is administered orally, via implant, parenterally, sublingually, rectally, topically, or via inhalation.

27. The method of claim 23, wherein the administration of the capsaicinoid and the coadministration of the non-anesthetic sodium channel blocker have overlapping durations of effect.

28. The method of claim 21, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of antiarrhythmic agents, anticonvulsant agents, diuretic agents, combinations thereof and mixtures thereof.

29. The method of claim 21, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of phenytoin, carbamazepine, lamotrigine, zonisamide, riluzole, lifarizine, ralitoline, flunarizine, mexiletine, aprinidine, benzamil, phenamil, trimebutine, GEA-968, azure A, pancuronium, N-methylstrychnine, CNS 1237, BW1003C87, BW619C89, U54494A, PD85639, C1953, pharmaceutically acceptable salts thereof and mixtures thereof.

30. The method of claim 28, wherein the non-anesthetic sodium channel blocker is administered orally.

31. The method of claim 28, wherein the non-anesthetic sodium channel blocker is administered parenterally.

32. The method of claim 21, wherein the non-anesthetic sodium channel blocker is in an effective amount to decrease propagation and/or generate action potentials.

33. The method of claim 21, further comprising administering a local anesthetic to the human or animal.

34. The method of claim 21, wherein said dose of capsaicin is from about 600 to about 15000 μ g.

35. The method of claim 21, wherein said dose of capsaicin is from about 600 to about 10000 μ g.

36. The method of claim 21, wherein said dose of capsaicinoid is administered in a pharmaceutically acceptable vehicle for injection or implantation.

37. The method of claim 36, wherein said pharmaceutically acceptable vehicle is an aqueous vehicle is selected from the group consisting of Sodium Chloride Injection, Ringers Injection, Isotonic Dextrose Injection, Sterile Water Injection, Dextrose, Lactated Ringers Injection and any combinations or mixtures thereof.

38. A pharmaceutical composition for attenuating pain at a surgical site in a human or animal in need thereof, comprising a capsaicinoid selected from the group consisting of from 1 μ g to 15,000 μ g of capsaicin, a therapeutically equivalent amount of one or more other capsaicinoids, and therapeutically equivalent combinations thereof; an effective amount of a non-anesthetic sodium channel blocker to decrease propagation and/or generate action potentials; and from about 1 ml to about 100 ml of a pharmaceutically acceptable vehicle for infiltration.

39. The composition of claim 38, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of antiarrhythmic agents, anticonvulsant agents, diuretic agents, combinations thereof and mixtures thereof.

40. The composition of claim 38, wherein the non-anesthetic sodium channel blocker is selected from the group consisting of phenytoin, carbamazepine, lamotrigine, zonisamide, riluzole, lifarizine, ralitoline, flunarizine, mexiletine, aprinidine, benzamil, phenamil, trimebutine, GEA-968, azure A, pancuronium, N-methylstrychnine, CNS 1237, BW1003C87, BW619C89, U54494A, PD85639, C1953, pharmaceutically acceptable salts thereof and mixtures thereof.

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