The focus on limiting opioids will raise questions about the role of muscle relaxants (cyclobenzaprine, etc) for acute low back pain. About 1 in 3 patients with low back pain are on a muscle relaxant. But there’s limited evidence they improve symptoms. Most don’t directly relax muscles...any benefit is likely due to a sedative effect. Plus muscle relaxants are linked to respiratory depression and death when used with other CNS depressants...opioids, benzos, alcohol, etc.

Limit the use of muscle relaxants...especially in the elderly, patients at high fall risk, or those with sleep apnea, COPD, etc.

Consider a muscle relaxant only for patients with ACUTE back pain when scheduled doses of an NSAID or acetaminophen aren’t enough.

Stick with PRN use...for no more than about a week.

If a muscle relaxant is needed, use cyclobenzaprine. It’s been studied the most and is inexpensive. But it’s structurally similar to a tricyclic antidepressant...so it may have anticholinergic effects. Methocarbamol (Robaxin, etc) or metaxalone (Skelaxin, etc) may be less sedating. But these have even less evidence of benefit...and metaxalone can cost significantly more than cyclobenzaprine.

Avoid using benzodiazepines or carisoprodol (Soma, etc) as muscle relaxants...due to their potential for dependence and abuse.

Save baclofen and tizanidine (Zanaflex, etc) for patients with SPASTICITY due to multiple sclerosis, spinal cord injury, etc.

Be aware that tizanidine is similar to clonidine...so it can cause hypotension. Taper when discontinuing to minimize rebound hypertension.

See our chart, Muscle Relaxants, to compare dosing, costs, etc.

Sincerely,

Jeff M. Jask

Prescriber’s Letter Editorial Staff