Neuropathic Pain – Primary Care Pharmacological Management for Adults

Assessment: Screening tool questionnaires (Appendix 1: DN4 , Appendix 2: S-LANSS or PainDETECT)

Before prescribing discuss with patient and/or carer:

- Mange patient expectations of treatments at an early stage. Being pain free is often unrealistic. Aim for pain reduction and/or functional improvement, with a view to improving quality of life.
- Medication does not work for everyone; and will be reviewed regularly. Will be stopped if not providing useful benefit.
- Won't necessarily be for long-term use. These medicines can cause problems for people taking them, or coming off them, especially if taken for a long time.
- Medication will be carefully 'stepped down' at intervals in order to ascertain on-going effectiveness.
- Use non-pharmacological ways of reducing/managing pain https://www.nhs.uk/live-well/exercise/free-fitness-ideas/

If plan is to prescribe: See manufacturer's information

- Discuss benefits and risks of drug therapy with patient and/or carer. Consider any physical or psychological problems, and concurrent medications. Inform patient of possible side-effects e.g. drowsiness, dizziness, confusion Care if driving DVLA advice or operate machinery. Consider using: Appendix 3, Patient record pain medication.
- Ensure patient understands where treatment is unlicensed and get informed consent.
- Discuss titration process and provide written information when required.

Gabapentinoid (pregabalin and gabapentin): (MHRA update and PHE and NHSE Advice)

- Before prescribing pregabalin or gabapentin, think 'Am I doing harm?' - RCGP Top Ten Tips: DFMs. Pregabalin and gabapentin are associated with risk of dependence and abuse (Schedule 3). They can be misused for their euphoric effects. Take care if history of substance misuse (particularly when co-prescribed with opioids).
- CNS additive effect when prescribed with other centrally acting drugs, particularly opioids. May cause opioid tolerance reversal. Consider opioid dose reduction & monitor patient for signs of CNS and/or respiratory depression.
- The pharmacokinetics of pregabalin make the drug relatively more dangerous than gabapentin in high doses.

Clinical reviews: Complete initial trial of any new treatment and review at 8 weeks or earlier.

- Assess benefit (checking for improvement in, pain, function, mood, sleep and overall quality of life), tolerability, adverse effects and continued need for treatment.
- For treatments that are effective; continue and review as clinically needed (gradually taper dose at regular intervals to assess on-going benefit).

All neuropathic pain (excluding trigeminal neuralgia)

1st line: Amitriptyline (PIL) – licensed for neuropathic pain (contraindications include: recent MI, arrhythmia)

- Analgesic effect usually seen after 2-4 weeks of dosing. Consider anticholinergic burden http://www.acbcalc.com/
- Dosing instructions: start 10mg 6-8pm to reduce hangover effect. Increase by 10 mg weekly to an effective or maximum tolerated dose. Dose range 25mg - 75mg nocte.

If inadequate response by 8 weeks or not tolerated, STOP treatment gradually & consider replacing with 2nd line treatment

2nd line: Choose from one of the following drugs based on individual patient factors (titrate to an effective dose)
If inadequate response by 8 weeks or not tolerated, STOP treatment gradually & consider alternative 2nd line drug

OR

Gabapentin (PIL) – licensed for peripheral neuropathic pain

- Dosing instructions – see BNF
- lower dose if CrCl < 80mL/min
- Consider slower titration to minimise adverse effects (week 1: 100mg tds, week 2: 200mg tds, week 3 300mg tds)
- MHRA alert: Rare risk of respiratory depression

OR

Pregabalin (PIL) - licensed for peripheral & central neuropathic pain

- Dosing instructions – see BNF
- lower dose if CrCl <60mL/min
- Consider lower dose to minimise adverse effects (start: 25mg BD, increase after 1-2 weeks to 50mg BD)

OR

Duloxetine (PIL) - licensed for diabetic peripheral neuropathy

Dosing instructions

- **Start** 60mg od (maintenance dose), up to max 60mg bd *(note: no evidence for higher dose)*
- Use with caution in patients with hypertension or cardiac disorder (monitor BP in 1st month of treatment)
- Avoid if CrCl <30mL/min

3rd line: Based on local pain clinic advice combination therapy may be a helpful option if adverse effects prevent the use of higher doses. For example: combining amitriptyline or duloxetine with pregabalin or gabapentin.

Discontinuing treatment:

- Pharmacological therapy should not be considered a long term management strategy and efforts should regularly be made to reduce the dosage and gradual withdrawal of treatment, particularly as many treatments are associated with safety or dependence issues following long-term use.
- Neuropathic pain medication should not be stopped abruptly due to risk of withdrawal reactions. This should be explained to patient at start of treatment. This can occur even after short duration of treatment with pregabalin.
  - Pregabalin: withdraw over minimum of 1 -2 weeks or slower taper* reduce daily dose by 50-100mg per week
  - Gabapentin: withdraw over minimum of 1 -2 weeks or slower taper* reduce daily dose at a maximum rate of 300mg every four days
  - Amitriptyline: withdraw over a period of a few weeks (reduce daily dose by 10mg each week
  - Duloxetine: withdraw over a minimum of 1-2 weeks

**Gabapentinoids: Slower taper allows observation of emergent symptoms that may have been controlled by the drug.*

Switching treatment: There is limited evidence with managing a switch between pregabalin and gabapentin (see UKMI Q&As for further advice). When introducing a new treatment, take into account any overlap with old treatments to avoid deterioration in pain control.

Other treatment options:

- **Continue simple analgesia where there is evidence of pain relief.**
- **Capsaicin 0.075% cream:** Consider using for localised neuropathic pain for people who wish to avoid, or cannot tolerate oral treatments. Licensed for post herpetic neuralgia after open skin lesions have healed and for the symptomatic management of painful diabetic peripheral polyneuropathy under the supervision of a hospital specialist. A pea-sized amount should be applied up to four times daily for 6-8 weeks.
- **Tramadol** - consider adding tramadol for acute rescue therapy whilst patient is awaiting assessment by specialist (unlicensed for neuropathic pain but licensed for moderate to severe pain)
- **Lidocaine patches** - NICE CG173 does not recommend the use of lidocaine patches as a treatment option in neuropathic pain due to limited clinical evidence. See Sheffield STOP list. Restrict use to post herpetic neuralgia where patient is intolerant of first line systemic therapies or where they have been ineffective. If in exceptional circumstances there is a clinical need, it should be with specialist input.
- **Do not start the following in non-specialist settings**: morphine, tramadol long-term, oxcarbazepine, topiramate, venlafaxine, lacosamide, lamotrigine, levetiracetam, cannabis sativa extract, capsaicin patch

Trigeminal neuralgia

First line – Carbamazepine first line

- Start 100mg od- bd slowly increasing until pain is relieved (usually 200mg 3-4 times daily). Maximum 1.6g / day. Once pain is in remission try to gradually reduce dose to lowest possible maintenance level. It may be possible to discontinue therapy. If not effective, not tolerated or contraindicated seek specialist advice and consider early referral to a specialist pain service.

Consider referral to specialist setting if pain is severe or significantly limits lifestyle, daily activities and participation, their underlying health condition has deteriorated, or their pain has not responded to medication

- **Referral letter should include: drug history of medication tried (strength and doses used), whether drug treatment was successful or not; and reasons for discontinuation.**

References:

- NICE CG173 Neuropathic pain – pharmacological management. http://guidance.nice.org.uk/CG173
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- PHE and NHS England: Advice for prescribers on the risk of the misuse of pregabalin and gabapentin. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/385791/PHE-NHS_England_pregabalin_and_gabapentin_advice_Dec_2014.pdf
- NHS England: Rescheduling of Gabapentin and Pregabalin as Schedule 3 Controlled Drugs https://www.england.nhs.uk/wp-content/uploads/2019/03/pregabalin-and-gabapentin-guidance-v1.pdf

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