CLINICAL GUIDELINE

NHSGGC Chronic Non Malignant Pain – Neuropathic Pain Guideline

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient

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GG&C Neuropathic Pain Guidelines

Neuropathic Pain

Defined as "Pain initiated or caused by a primary lesion or dysfunction of the nervous system"

Signs and symptoms

- Burning
- Electric shocks
- Numbness
- Tingling
- Shooting/stabbing

Neuropathic pain assessment tools are available to aid diagnosis e.g. s LANSS
Consider possibility of serious underlying pathology and refer for investigation as indicated.

Examples of Neuropathic Pain

- Post herpetic neuralgia (PHN)
- Peripheral neuropathy (e.g. diabetic, alcohol related, cancer/chemotherapy related)
- Trigeminal neuralgia (TN)
- Nerve root pain
- Post surgical
- Phantom limb pain

In General

- It is important to establish a diagnosis and explain implications and chronicity to the patient and the importance of compliance with treatment.
- Effective treatment is considered as 30% reduction in pain score and/or improved function.
- Discuss the benefits and possible adverse effects of pharmacological treatment including the importance of titration and review
- Distinguish analgesic from antidepressant or anti- epileptic drug activity
- Simple analgesics and non steroidal anti-inflammatory drugs (NSAIDs) are usually ineffective
- Start low and go slow
- Explain that side effects may improve with time
- Allow four weeks of maximum tolerated dose before effects judged and medication stopped
- If one drug is ineffective, it should be discontinued and an alternative option commenced. If, however, one drug is partially effective, consider adding a second drug, rather than substituting
- Medicines can be discontinued immediately if the patient is still having their medication titrated up and a significant side effect occurs
- **Patients should be weaned off medication gradually when discontinuing.** (See individual patient information leaflets below).
- Carry out regular assessment of effectiveness of treatment during titration period – including assessment of pain control: impact on lifestyle, daily activities and participation: physical and psychological well being: adverse effects; continued need for treatment
- **There is increasing awareness of the abuse potential of anti neuropathic medications and caution and increased supervision should be exercised when initiating in someone with addiction behaviours**
- Encourage self management and provide education
- Discuss coping strategies for flare up
- Physical treatments may be advised by specialist in a pain clinic: physiotherapy, acupuncture, TENS, nerve blocks

Step 1 treatments – Amitriptyline and/or Gabapentin

There is no strong evidence to choose one Step 1 drug over the other; this depends on patient factors and prescriber experience. If the first agent chosen is not effective, then a drug from the alternative class may be used **either** as sole agent or in combination.

Amitriptyline (PIL) (imipramine (PIL) or nortriptyline (PIL) can be prescribed instead if sedation or hypotension is a problem. Both have the same dose and titration schedule to amitriptyline). Use most cost effective product. Neuropathic pain is an unlicensed although recognised indication for all three drugs

- Take at night (two hours before sleep) to minimise drowsiness the following day
- Start with 10mg in frail, elderly and increase in 10mg increments every 3-7 days to maximum of 50mg per day
- In younger age groups start with 10-25mg and increase in steps of 25mg every 3-7 days to 100mg maximum per day
- Lower doses should be used if the patient is already on an alternative antidepressant e.g. Amitriptyline 25mg per day

Gabapentin (PIL)

- In adults start at 300mg at night and increase in 300mg increments at weekly intervals aiming for a dose of between 1200mg and 1800mg daily. Doses of up to 3600mg in 24 hours have been used, if beneficial and tolerated.
- Start with 100mg at night in frail, elderly and increase by the same amount weekly. Titrate to effect, but not above 1800mg per day

Carbamazapine (PIL) can be used as first line treatment in classical Trigeminal Neuralgia (TN) – see below

Step 2 treatment

Pregabalin (PIL) is an alternative in patients who have found no benefit from, or have not tolerated conventional first or second line agents(as per Scottish Medicines Consortium (SMC) restriction) i.e. gabapentin or amitriptyline

- Start at dose of 75mg twice a day, or 75mg once daily in frail/elderly
- Titrate up to a maximum dose of 300mg twice a day using the most cost effective preparation. (One capsule twice daily is always the most cost effective regimen).
- Treatment should be discontinued if the patient has not shown sufficient benefit within eight weeks of reaching the maximally tolerated therapeutic dose. The oral solution is further restricted to those patients who find it difficult to or are unable to swallow tablets.

If pregablin is replacing gabapentin there are two options for the changeover.

1. Gradually reduce and stop gabapentin over a minimum of one week, then start pregabalin
2. Replace gabapentin with pregabalin equivalent dose as per example below
    - replace gabapentin 300mg three times a day with pregabalin 75mg twice a day
    - replace gabapentin 600mg three times a day with pregabalin 150mg twice a day
    - replace gabapentin 900mg three times a day with pregabalin 225mg twice a day
    - replace gabapentin 1200mg three times a day with pregabalin 300mg twice a day

If you are changing from pregabalin to gabapentin do the above in reverse.

Step 3 treatment

- **Duloxetine** (PIL) - This has been accepted by the SMC for painful diabetic neuropathy and is restricted to initiation by prescribers experienced in the management of diabetic peripheral neuropathic pain as second or third line therapy. Start with 30mg per day for two weeks and titrate up to a max of 120mg per day
- **Carbamazepine** (can be used as first line treatment for Trigeminal Neuralgia)
    - Initial dose of 100-200mg daily, increasing slowly in increments of 100-200mg at weekly intervals
    - Usual maintenance dose range 600-1200mg in 24 hours
    - Maximum dose of 1600mg per day

Step 4 - Topical treatments

- **Lidocaine** 5% medicated plaster (Versatis®) is for use only in patients who are intolerant of first line therapies for PHN or where these therapies have been ineffective. Lidocaine patches should be worn for 12 hours on and 12 hours off and reviewed after 4 weeks and stopped if ineffective. If the patient has responded to treatment and the plaster has alleviated pain completely then a plaster-free period should be trialed after seven days of plaster use (remove for 24 hours and assess need to restart). Treatment should be reassessed every four weeks to decide whether the amount of plasters needed to cover the painful area can be reduced, or if the plaster-free period can be extended http://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/neuropathic-pain.aspx
- **Capsaicin** 0.075% cream can be used for people with localised neuropathic pain who wish to avoid, or cannot tolerate, oral treatments. Capsaicin 8% patch is restricted to specialist use in pain management for the treatment of postherpetic neuralgia (PHN) and peripheral neuropathic pain (PNP) in non-diabetic adults who have not achieved adequate pain relief from, or who have not tolerated conventional first and second-line treatments.

Step 5

Tramadol and potent Opioids – Follow local NHS GG&C Opioid guidelines

Step 6 When to refer

Consider referral to pain services and/or other condition specific specialists if the person has severe pain or

- their pain significantly limits their lifestyle, daily activities (including sleep disturbances and participation)
- their underlying health condition has deteriorated

References and resources

SIGN 136 – Management of chronic pain
NICE – Neuropathic pain http://www.nice.org.uk/guidance/cg173 – Pharmacological management
www.paindata.org NHS GG&C Chronic Pain MCN Website. Site hosts patient and GP drug information leaflets