



Neuropathic Pain in Adults- Guideline for Primary Care

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Document Control

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The latest version will be held on the GMMMG website.

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Approval:

This document must be approved by the following before distribution:

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FOREWORD

Neuropathic pain is managed in many patients by the use of simple scales to measure the pain itself, a review of both physical and psychological functional impairment, and pharmacological and non-pharmacological treatments coupled with an idea of the patient's goals/expectations for the management of his/her pain. Some patients who suffer from pain that does not respond to standard therapies may require a more in-depth assessment and will need to be referred to secondary care.

One of the aims of this document is to aid with differentiating those patients who can be managed very successfully in primary care and those who require involvement of healthcare professionals in secondary care. Many patients who are already within a secondary care setting but go on to develop neuropathic pain (whilst under another speciality e.g. orthopaedics) are often referred directly to pain clinics when they can be managed quite effectively by primary care in the first instance.

This document has been developed utilising the latest clinical evidence. It has been adapted to include treatments based on clinical experience whilst also considering the best use of scarce NHS resources for the whole GM population.

Whilst this guideline is primarily for primary care, we would expect the same principles to apply in a secondary care setting.

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AIM

To promote the rational use of analgesics, and associated adjuvant treatment, so that neuropathic pain is optimally managed.

Implementation of the guidance aims to improve the safe and effective use of treatments for the symptomatic relief of neuropathic pain.

This guideline is based on the [Neuropathic Pain –The pharmacological management of neuropathic pain in adults in non-specialist settings NICE CG 173](#) (updated July 2019) with some local adaptation.

1. Introduction

- 1.1 The International Association for the Study of Pain (IASP 2011) defines neuropathic pain as 'pain caused by a lesion or disease of the somatosensory nervous system'. Central neuropathic pain is defined as 'pain caused by a lesion or disease of the central somatosensory nervous system', and peripheral neuropathic pain is defined as 'pain caused by a lesion or disease of the peripheral somatosensory nervous system'.
- 1.2 Neuropathic pain is very challenging to manage because of the heterogeneity of its aetiologies, symptoms and underlying mechanisms. There is often uncertainty regarding the nature and exact location of a lesion or health condition associated with neuropathic pain, particularly in non-specialist settings.
- 1.3 Examples of common conditions that have peripheral neuropathic pain as a symptom are painful diabetic neuropathy, post-herpetic neuralgia, trigeminal neuralgia, radicular pain, post-surgical chronic neuropathic pain, and neuropathic cancer pain (such as chemotherapy-induced neuropathy, neuropathy secondary to tumour antigens, or caused by direct invasion or compression of neural structures). Examples of conditions that can cause central neuropathic pain include stroke, spinal cord injury and multiple sclerosis.
- 1.4 Neuropathic pain can be intermittent or constant, and spontaneous or provoked. Typical descriptions of the pain include terms such as shooting, stabbing, like an electric shock, burning, tingling, tight, numb, prickling, and itching and a sensation of pins and needles.
- 1.5 The prevalence of neuropathic pain is difficult to quantify and varies depending on the cause of pain. For example, it may affect up to a quarter of people with diabetes, and 10-50% of people who have received surgery. Patients' beliefs and perceptions of the pain and its cause, coping strategies, mood changes, disturbed sleep, and anxiety all need to be addressed. Therefore, treating anxiety or depression first might also reduce the need for analgesics. **Set realistic expectations and treatment goals.** Achieving pain free status is not always achievable. **Reduction in pain by 50% is a commonly used endpoint in clinical trials.** See information for patients section for example leaflets that are available that could be used to aid these discussions.
- 1.6 Screening tools can be useful to aid diagnosis: the Neuropathic Pain Scale (NPS) is a well-known validated scale (see [appendix 1](#)). Evidence supports the validity of the NPS for detecting change in pain after treatments; however other pain scales are available.
- 1.7 **For all drugs, recommendations are based on evidence of clinical and cost effectiveness and reflect whether their use for the management of neuropathic pain is a good use of NHS resources.**

2. Key Principles of Care

- 2.1 When agreeing a treatment plan with the person, take into account their concerns and expectations, and discuss:
- The severity of the pain, and its impact on lifestyle, daily activities (including sleep disturbance) and participation.
 - The underlying cause of the pain and whether this condition has deteriorated
 - Why a particular pharmacological treatment is being offered.
 - The benefits and possible adverse effects of pharmacological treatments, taking into account any physical or psychological problems, and concurrent medications.
 - The importance of dosage titration and the titration process, providing the person with individualised information and advice.
 - Setting realistic expectations of treatment. Achieving pain free status may not be achievable. Response to drug treatment is often inadequate, with no more than 40-60% of people obtaining partial pain relief.
 - Coping strategies for pain and for possible adverse effects of treatment.
 - **Non-pharmacological treatments, for example, physical and psychological therapies (which may be offered through a rehabilitation service) and surgery (which may be offered through specialist services).**
- 2.2 Consider referring the person to a specialist pain service and/or a condition specific Service at any stage, including at initial presentation and at the regular clinical reviews if:
- No significant improvement after a suitable trial period (see relevant drug sections below), or
 - Their underlying health condition has deteriorated, or
 - They have severe pain, or
 - Their pain significantly limits their lifestyle, daily activities (including sleep disturbance) and participation.
- It is important that patients' expectations are realistic when considering the management of pain. Achieving pain free status is not always achievable, despite referral to the pain clinic.***
- 2.3 Carry out regular clinical reviews to assess and monitor the effectiveness of the treatment. Each review should include an assessment of:
- pain control
 - impact on lifestyle, daily activities (including sleep disturbance) and participation
 - physical and psychological wellbeing
 - adverse effects
 - continued need for treatment
- 2.4 After starting or changing a treatment, carry out an early clinical review of dosage titration, tolerability and adverse effects to assess the suitability of the chosen treatment.
- 2.5 All treatments should be titrated appropriately and given for an adequate duration prior to moving to the next option.

3. Pharmacological Treatment

Please note that this information is a summary to guide prescribers – for further information please consult individual SPCs at www.medicines.org.uk

3.1 Effects on ability to drive and use machines

- Pharmacological treatment options for neuropathic pain are associated with sedative properties; particularly gabapentin and pregabalin for which dizziness and somnolence are the most commonly reported side effects.
- **Patients should be advised not to drive, operate heavy machinery, or engage in other potentially hazardous activities until it is known whether the medication affects their ability to perform these activities.**
- If patients are prescribed tramadol, then they should be appropriately cautioned on the legality of driving as per [DVLA legislation](#).

3.2 All neuropathic pain (except trigeminal neuralgia; see 3.3)

Some products are not specifically licensed for all types of neuropathic pain and it is important to advise patients of this. Information and advice on prescribers' responsibilities when prescribing off-label medicines can be found [here](#).

3.2.1 Offer patients amitriptyline first line

- Analgesic effect of amitriptyline is separate from its antidepressant effect.
- Amitriptyline is licensed for neuropathic pain in adults.
- It is best taken in the evening to reduce 'hangover effect' e.g. 6-8pm.
- Titrate slowly to reduce side-effects. Slow titration should also apply to dose reduction/discontinuation.
- The titration below is more gradual than that recommended in the BNF and product literature and is suggested to optimise tolerance.

Suggested titration:

- Step 1 Amitriptyline 10mg at night* for 2 weeks
 - Step 2 Amitriptyline 20mg at night* for 6 weeks
 - Step 3 Amitriptyline 30mg at night*
 - Step 4 Amitriptyline 40mg at night*
 - Step 5 Amitriptyline 50mg at night*
- * Ensure patient tolerates dose at each step before increasing dose.
- After step 2 the dose can be increased gradually according to tolerance and the patient's needs.
 - The normal maximum dose is 75mg daily but up to 100mg can be used with caution, and on specialist advice, if the patient is deriving benefit with limited side-effects.
 - Doses higher than 75mg should only be considered in consultation with a specialist pain service and should be used with caution in the elderly and in patients with cardiovascular disease.
 - Consider trialling amitriptyline for 6-8 weeks, with at least 2 weeks at the maximum dose before deciding it is not effective.
 - If amitriptyline is not tolerated it should be withdrawn gradually over a minimum of 4 weeks to prevent discontinuation symptoms (such as dizziness, nausea, paraesthesia, anxiety, diarrhoea, flu-like symptoms, and headaches). There is no typical reducing regimen for amitriptyline; approach to down-titration will depend on patient specific factors including severity of pain, duration of therapy, magnitude of dose, incidence of adverse effects or discontinuation symptoms.

3.2.2 Offer patients gabapentin second line

- If the maximum dose of amitriptyline is unsuccessful in controlling pain then the patient should be switched to gabapentin, titrating the dose gradually to prevent adverse effects, until effective pain relief is achieved.
- Gabapentin is licensed for the treatment of peripheral neuropathic pain in adults such as diabetic neuropathy and post herpetic neuralgia. Use for other conditions is off-label. Information and advice on prescribers' responsibilities when prescribing off-label medicines can be found [here](#).
- Gabapentin has been associated with a rare risk of severe respiratory depression, even in patients not receiving concomitant opioid medicines. [Caution is advised in patients at risk of respiratory depression](#).
- Various dose titrations may be used for gabapentin, depending on the person taking it and how well they tolerate it. The speed of titration will vary among individuals and should be tailored to the individual; if the person is elderly or frail they are more likely to experience adverse effects and will require slower titration. The dose should be adjusted for renal impairment (see table below). See examples of suggested approaches below.

Fast titration (usually suitable for otherwise healthy younger adults):

- Start with 300 mg once a day on day 1, then 300 mg twice a day on day 2, then 300 mg three times a day on day 3.
- Alternatively, start with 300 mg three times a day on day 1, then increased according to response in steps of 300 mg (in 3 divided doses) every 2–3 days up to maximum of 3600 mg a day (1200 mg three times a day).
- If the person experiences adverse effects during daily titration, a slower titration may help or a lower maximum dose may be appropriate.

Slow titration (suitable if the person is elderly, frail, or has experienced adverse effects with higher doses):

- Start with 100 mg at night, increasing by 100 mg a day until pain is significantly reduced, intolerable adverse effects occur, or a maximum daily dosage of 3600 mg (1200 mg three times a day) is reached.
- If the person experiences adverse effects during daily titration, a slower titration (for example increasing the dose every 3–7 days) may help or a lower maximum dose may be appropriate.

Renal impairment (recommended dose adjustment as per [BNF](#) and [CKS](#)):

Renal function eGFR (mL/min/1.73m ²)	Maximum starting daily dose	Maximum daily dosage
50-80	200mg TDS	600mg TDS
30-49	100mg TDS	300mg TDS
15-29 (stage 4, severe impairment)	100mg TDS on alternate days	200mg TDS
<15 (stage 5, very severe or endstage)	100mg TDS on alternate days	100mg TDS

- It may take several weeks to reach an effective dosage (usually 1200 mg to 3600 mg daily). Onset of action may be seen as early as the second week of treatment with rapid titration, but the peak effect usually occurs about 2 weeks after a therapeutic dosage is achieved (therefore an adequate trial may be 2 months or longer).

- Consider trialling gabapentin for 3–8 weeks, with at least 2 weeks at the maximum **tolerated** dose, before deciding it is not effective.
- Gabapentin should be discontinued gradually over a minimum of 1 week. **There is no typical reducing regimen for gabapentin; approach to down-titration will depend on patient specific factors including severity of pain, duration of therapy, magnitude of dose, incidence of adverse effects or discontinuation symptoms.**
- Discontinuation symptoms may include: anxiety, insomnia, nausea, pains, sweating, and chest pain.
- Controlled drug prescription requirements apply- see [section 3.2.9](#).

3.2.3 Offer pregabalin if gabapentin is not tolerated

- Pregabalin may be considered in patients who cannot tolerate gabapentin, or who have not responded fully despite an adequate, fully documented trial. Advice on switching between gabapentin and pregabalin can be found [here](#).
- Pregabalin is licensed for the treatment of peripheral and central neuropathic pain in adults. Use for other conditions is off-label. Information and advice on prescribers' responsibilities when prescribing off-label medicines can be found [here](#).

Typical titration:

- Start pregabalin treatment at 150 mg a day (given in two to three divided doses).
- If necessary, increase the dose after 3 to 7 days to 300 mg a day (given in two to three divided doses).
- The dose can be increased further to a maximum dose of 600 mg a day (given in two to three divided doses) after an additional 7-day interval.
- A lower starting dose may be appropriate for some people, for example people who cannot initially tolerate 150 mg a day or people with reduced renal function (see below). A lower maximum dose may also be appropriate.

Renal impairment (recommended dose adjustment as per [BNF](#) and [CKS](#)):

Renal function eGFR (mL/min/1.73m ²)	Maximum starting daily dose	Maximum daily dosage
30-60	75 mg a day (divided in two or three doses)	300 mg a day (divided in two or three doses)
15-29 (stage 4, severe impairment)	25–50 mg a day (as one daily dose or divided in two doses)	150 mg a day (as one daily dose or divided in two doses)
<15 (stage 5, very severe or endstage)	25 mg once a day	75 g once a day

- Consider trialling pregabalin for 4 weeks before deciding it is not effective.
- If pregabalin is not effective or tolerated, discontinue treatment gradually over a minimum of 1 week. **There is no typical reducing regimen for pregabalin; approach to down-titration will depend on patient specific factors including severity of pain, duration of therapy, magnitude of dose, incidence of adverse effects or discontinuation symptoms.**
- Discontinuation symptoms may include: insomnia, headache, nausea, anxiety, diarrhoea, flu syndrome, nervousness, depression, pain, convulsion, hyperhidrosis and dizziness suggestive of physical dependence; incidence and severity may be dose related.
- Controlled drug prescription requirements apply- see [section 3.2.9](#).

3.2.4 **Due to a lack of evidence for the safety and cost-effectiveness of combining treatments, do not prescribe more than one neuropathic pain drug at the same time, unless on the advice of an NHS pain specialist.** For example do not prescribe amitriptyline concurrently with duloxetine, gabapentin, or pregabalin.

3.2.5 Offer duloxetine as third line, or second line for diabetic neuropathy

- Duloxetine may be considered as an option where other treatments have failed or for a clear diagnosis of diabetic neuropathy.
- Duloxetine is licensed for the treatment of diabetic peripheral neuropathic pain. Use for other conditions is off-label. Information and advice on prescribers' responsibilities when prescribing off-label medicines can be found [here](#).

Typical titration:

- Start at 60 mg per day. A lower starting dose of 30mg may be appropriate for some people (for example, if tolerability is a problem).
- Titrate upward to an effective dose or the person's maximum tolerated dose of no higher than 120 mg per day.

Renal impairment (recommended dose adjustment as per [BNF](#) and [CKS](#)):

- No dosage adjustment is necessary for people with mild or moderate renal impairment (eGFR >30mL/min/1.73m²). At more advanced levels of renal impairment, elevated plasma concentrations occur and use should be avoided unless on specialist advice and providing the patient is closely monitored.
- Consider trialling duloxetine for up to 8 weeks before deciding it is not effective. Additional response after 8 weeks is unlikely.
- Treatment should be assessed at least every three months.
- If duloxetine is not effective or not tolerated, discontinue treatment gradually over a minimum of 1 to 2 weeks in order to reduce the risk of withdrawal reactions. **There is no typical reducing regimen for duloxetine; approach to down-titration will depend on patient specific factors including severity of pain, duration of therapy, magnitude of dose, incidence of adverse effects or discontinuation symptoms.**
- Discontinuation symptoms may include: dizziness, sensory disturbances (including paraesthesia or electric shock-like sensations, particularly in the head), sleep disturbances (including insomnia and intense dreams), fatigue, somnolence, agitation or anxiety, nausea and/or vomiting, tremor, headache, myalgia, irritability, diarrhoea, hyperhydrosis and vertigo.

3.2.6 Tramadol for acute rescue therapy

- Consider tramadol **only** if acute rescue therapy is needed
- Tramadol is licensed for the treatment of moderate to severe pain but is not specifically licensed for neuropathic pain.
- It should be reserved for people awaiting referral to specialist pain services, after initial treatments have failed.
- Tramadol should be prescribed as a short course, cautiously, and bearing in mind the potential for misuse. Patients should be appropriately cautioned on the legality of driving while taking tramadol, as per [DVLA legislation](#). Controlled drug prescription requirements apply- see [section 3.2.9](#).

*Prescribers are reminded that tramadol is a schedule 3 CD due to increases in the numbers of deaths relating to its misuse over the last few years. **TRAMADOL IS NOT RECOMMENDED FOR LONG TERM USE.***

3.2.7 Non-oral options

- For patients with localised neuropathic pain who wish to avoid, or cannot tolerate oral treatments, consider prescribing capsaicin cream 0.075%; a pea-sized amount to be applied to the affected area 3 or 4 times daily for a maximum of 8 weeks. After this time, it is recommended that the patient's condition should be re-assessed before continuation of therapy. There are no efficacy data available to support treatment beyond 8 weeks.

3.2.8 If pain is well controlled, continue treatment. Consider gradually reducing the dose over time if the improvement is sustained.

3.2.9 Prescription writing requirements

- Following concerns about abuse, [gabapentin and pregabalin have recently been reclassified as a Class C controlled substances and Schedule 3 controlled drugs](#). Tramadol was re-classified as a Schedule 3 Controlled drug in 2014.

Prescription writing requirements- <i>gabapentin, pregabalin tramadol</i>	
Designation:	Schedule 3 CD No Reg POM
Additional CD prescription requirements	<ul style="list-style-type: none"> Prescriber's signature must be handwritten Form must be specified: <i>i.e. 'tablets' or 'capsules'</i> Total amount to be supplied must be specified in words and figures: <i>i.e. 'fifty six (56) capsules'</i>. For liquids this must be the total volume in millilitres: <i>i.e. 'one hundred (100) millilitres'</i> Dose must be clearly defined: <i>i.e. 'one capsule every 6 hours as directed'</i>. 'As directed' alone is not sufficient. If prescribed by a dentist <i>'for dental treatment only'</i> must be included.
Prescription valid for	28 days
Prescription is repeatable	No
Safe custody regulations apply	No
Maximum quantity prescribable	The Department of Health and Social Care has issued strong recommendations that the maximum quantity of Schedule 3 drugs prescribed should not exceed 30 days

- Healthcare professionals should evaluate patients carefully for a history of drug abuse before prescribing gabapentin, and observe patients for signs of abuse and dependence. Patients should be informed of the potentially fatal risks of interactions between gabapentin and alcohol, and with other medicines that cause CNS depression, particularly opioids.

3.3 Trigeminal neuralgia

- If there are red flag symptoms and signs that may suggest a serious underlying cause, admit, or refer urgently for specialist assessment, using clinical judgement e.g:
 - Sensory changes
 - Deafness or other ear problems
 - History of skin or oral lesions that could spread perineurally
 - Pain only in the ophthalmic division of the trigeminal nerve (eye socket, forehead, and nose), or bilaterally
 - Optic neuritis
 - Family history of multiple sclerosis
 - Age of onset before 40 years

3.3.1 If there are no red flag symptoms and signs, offer carbamazepine as initial treatment for trigeminal neuralgia. Carbamazepine is licensed for the paroxysmal pain of trigeminal neuralgia in adults.

- Start at 100 mg twice daily and slowly titrate the dosage up in steps of 100mg - 200mg every two weeks, until pain is relieved
- In the majority of people a dosage of 200 mg three or four times a day is sufficient to prevent paroxysms of pain (maximum dosage 1600 mg daily).
- Modified-release preparations may be useful at night if the person experiences breakthrough pain.
- Once pain is in remission, the dosage should be gradually reduced to the lowest possible maintenance level, or the drug can be discontinued until a further attack occurs.
- Carbamazepine is associated with a number of cautions and drug interactions; prescribers are directed to consult individual [SPCs](#).

3.3.2 If initial treatment with carbamazepine is not effective, is not tolerated or is contraindicated, consider seeking expert advice from a specialist and consider early referral to a specialist pain service or a condition-specific service; **do not offer any other drug treatment unless advised to do so by a specialist.**

4. Treatments not supported for use

These recommendations are aligned with [NICE CG173](#).

- 4.2 The following treatments should not be routinely prescribed for the treatment of neuropathic pain unless advised by a specialist to do so (but see points 4.4 to 4.7 below)
- **capsaicin patch**
 - **lacosamide**
 - **lamotrigine**
 - **levetiracetam**
 - **morphine**
 - **oxycodone**
 - **oxcarbazepine**
 - **topiramate**
 - **tramadol (long-term use)**
 - **venlafaxine**
 - **sodium valproate (see 4.8 below)**
 - **lidocaine plasters**
- 4.3 NICE guidance states that the health economic model provided no support for the use of the above treatments. In all analyses, these treatments were dominated by a number of other alternatives and, in some cases, they were dominated by placebo (that is, they were predicted to have higher costs and lower net health gains than treatment with placebo).
- 4.4 Some of the listed treatments (lacosamide, levetiracetam, oxycodone and venlafaxine) do not appear to be more effective than placebo or there is a lack of evidence and/or inconsistent evidence about whether they are better than placebo at reducing pain.
- 4.5 Lidocaine medicated plasters (700mg) are only licensed for use for post-herpetic neuralgia. They are listed as a GREY drug by GMMM; only to be used in patients who have been treated in line with NICE CG173 but are still experiencing neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia). **Use of lidocaine medicated plasters for indications other than post-herpetic neuralgia is not supported by GMMM, or by NHSE in their Guidance for CCGs on [Items which should not routinely be prescribed in primary care](#).**
- 4.6 **Whilst the above list applies primarily to primary care; it is important to note that there is an absence of any positive evidence of efficacy for use of these drugs in neuropathic pain. They should therefore be reserved for use after other standard treatments have failed. If any of the treatments discussed above are used in a specialist setting then there should be clear documentation of benefit for that individual patient prior to continuing therapy.**
- 4.7 If clear evidence of continuing benefit (e.g. a reduction in the neuropathic pain scale) for the patient is not supplied to primary care then secondary care will be expected to continue prescribing until such information can be supplied.
- 4.8 Sodium valproate should only be used in women in line with the MHRA regulatory measures around pregnancy prevention. Full information can be accessed from: www.gov.uk/guidance/valproate-use-by-women-and-girls.

5. Algorithm for Management of Neuropathic Pain

1st line:

Amitriptyline: 10-50mg for 6-8 weeks (usual max 75mg)

- Doses \leq 100mg can be used cautiously in consultation with a specialist pain service if the patient is deriving benefit with limited side effects.

- **Amitriptyline** is licensed for neuropathic pain in adults
- For suggested dose titration see [3.2.1](#)
- Titrate slowly to reduce side effects; this also applies to dose reduction/discontinuation
- Best taken in the evening to reduce hangover effect e.g. 6-8pm

Continue if pain is well controlled. Consider gradual dose reduction if improvement is sustained.

If treatment is ineffective, **stop** and consider:

2nd line:

Gabapentin: 1200mg-3600mg/day in three divided doses for 3-8 weeks.

- An adequate trial should include at least 2 weeks at the **maximum tolerated** dose before deciding gabapentin is ineffective.
- Consider switching to **pregabalin**: 75mg to 600mg/day for 8 weeks if intolerable side-effects occur. Advice on switching can be found [here](#).

- **Gabapentin** is licensed for peripheral neuropathic pain (diabetic neuropathy/post-herpetic neuralgia).
- For suggested dose titration see [3.2.2](#)
- **Pregabalin** is licensed for peripheral and central neuropathic pain.
- For suggested dose titration see [3.2.3](#)
- **Pregabalin** and **gabapentin** are controlled drugs. Prescription requirements apply, see [3.2.9](#). A maximum of 30 days treatment should be prescribed at a time.
- For advice on driving or operating machinery, see [3.1](#)

Continue if pain is well controlled. Consider gradual dose reduction if improvement is sustained.

If treatment is ineffective, **stop** and consider:

3rd line:

Duloxetine: 30mg-120mg/day titrated slowly.

- **Duloxetine** may be considered **2nd line** for patients with a clear diagnosis of diabetic neuropathy.
- **Duloxetine** may also be an option in patients with a history of substance misuse, particularly in a prison setting.

- **Duloxetine** is licensed for diabetic peripheral neuropathic pain.
- For suggested dose titration see [3.2.5](#)
- Treatment should be assessed at least every three months

Non-oral options:

Capsaicin 0.075% cream: may be considered for localised neuropathic pain in patients who wish to avoid or cannot tolerate oral options.

- Apply a pea-sized amount four times a day to the affected area (max 8 weeks). It is recommended the patient is re-assessed prior to continuation beyond 8 weeks.

Consider referral to specialist pain services/condition specific services if any of the following:

- pain is severe
- pain significantly limits lifestyle, daily activities (including sleep disturbance) and participation
- deterioration of underlying health condition(s)

Tramadol should only be considered for short-term as rescue therapy in patients awaiting referral to specialist pain services, where initial treatments have failed.

LONG TERM USE IS NOT RECOMMENDED.

6. Information for Patients

What is neuropathic pain?

- Neuropathic pain happens when the nerves don't work properly and send the wrong signals to the brain.
- A common cause is a trapped nerve, for example, in the back or neck. Neuropathic pain can also be caused by conditions such as diabetes, shingles or by a painful nerve in the face (trigeminal neuralgia). Neuropathic pain can sometimes occur after a stroke, after amputation of an arm or a leg, and in people with cancer or multiple sclerosis.
- It can feel like shooting, stabbing, an electric shock, burning, tingling, tight, numb, prickling, itching or a sensation of pins and needles. The pain can come and go, or be there all the time.
- Because the causes of neuropathic pain can be complicated and difficult to treat, it is often not possible to completely cure the source of the pain.

What are the treatments for neuropathic pain?

- **Neuropathic pain can be very painful and troublesome. Medicines might only partly help the symptoms.**
- Treatment might include non-drug options such as physiotherapy to help strengthen muscles. If you have diabetes, then making sure it is well controlled may help improve the pain, or at least stop it getting worse.
- Neuropathic pain is not like pain caused by a pulled muscle or a sprain, so the medicines used to treat it are different from common painkillers like paracetamol and ibuprofen. Medicines used to treat neuropathic pain are different in both the way that they work, and how long they take to work.
- To begin with, your doctor might prescribe you a drug called amitriptyline, gabapentin, pregabalin, or duloxetine. These are sometimes also used for treating other health conditions, such as depression, epilepsy, anxiety or headaches. When deciding on the best choice for you, your doctor will consider any other health problems you may have and any other medications you might be taking.
- When you start drug treatment for neuropathic pain it will usually be at a low dose, which is then increased gradually until you get the most benefit. Some people find that the dose can't be increased because they get side effects that are difficult to manage. For some patients changing to a different drug might be an option.
- The most common side effects are tiredness, dizziness, or feeling "drunk". If you get these, it may be necessary to reduce your dose. The side effects should improve after a week or two as your body gets used to the medicine. Do not drive or operate machinery if you experience drowsiness or blurred vision. You also may become more sensitive to the effects of alcohol.
- Some people who take pregabalin or gabapentin become physically dependent after long-term use. This means they experience withdrawal symptoms when they stop taking the medicine. If you are concerned about physical dependence with these medicines then speak to your doctor or pharmacist
- Everyone is different and responds differently to drug treatment – some people find that the drugs start to help straight away, and for others it takes a bit more time. It is important to keep talking to your doctor about how you are feeling, whether things are improving, and what you can do to help yourself.

Adapted from: NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings '[Information for the public](#)' July 2019.

Patient information- medicine specific

NHS.uk: *Amitriptyline - for pain and migraine*

<https://www.nhs.uk/medicines/amitriptyline-for-pain/>

Faculty of Pain Medicine: *Information for Adult Patients Prescribed Amitriptyline for the Treatment of Pain* (Leaflet)

<https://www.britishpainsociety.org/british-pain-society-publications/patient-publications/>

NHS.uk: *Gabapentin*

<https://www.nhs.uk/medicines/gabapentin/>

Faculty of Pain Medicine: *Information for Adult Patients Prescribed Gabapentin for the Treatment of Pain* (Leaflet)

https://www.britishpainsociety.org/static/uploads/resources/files/FPM-Gabapentin_0.pdf

NHS.uk: *Pregabalin*

<https://www.nhs.uk/medicines/pregabalin/>

Faculty of Pain Medicine: *Information for Adult Patients Prescribed Pregabalin for the Treatment of Pain* (Leaflet)

https://www.britishpainsociety.org/static/uploads/resources/files/FPM-Pregabalin_2.pdf

NHS.uk: *Duloxetine*

<https://www.nhs.uk/medicines/duloxetine/>

Faculty of Pain Medicine: *Information for Adult Patients Prescribed Duloxetine for the Treatment of Pain* (Leaflet)

https://www.britishpainsociety.org/static/uploads/resources/files/FPM-Duloxetine_0.pdf

Patient information- general resources

The British Pain Society: Patient Publications

<https://www.britishpainsociety.org/british-pain-society-publications/patient-publications/>

Pain UK

Find out about other organisations helping people living with pain.

www.painuk.org

Pain Concern UK

<http://painconcern.org.uk/resources/information-leaflets/>

7. References

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7. Safer Prescribing in Prisons: Guidance for Clinicians – RCGP secure environments group (November 2011) https://www.rcgp.org.uk/clinical-and-research/resources/a-to-z-clinical-resources/~/_media/106D28C849364D4CB2CB5A75A4E0849F.ashx

Appendix 1

Neuropathic pain scale

There are scales for measuring different aspects of pain. For one patient, a pain might feel extremely hot, but not at all dull, while another patient may not experience any heat, but feel like their pain is very dull. We expect you to rate very high on some of the scales below, and very low on others. We want you to use the measures that follow to tell us exactly what you experience.

1. Please use the scale below to tell us how intense your pain is. Place an "X" through the number that best describes the intensity of your pain.

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not sharp

The most intense pain sensation imaginable

2. Please use the scale below to tell us how sharp your pain feels. Words used to describe "sharp" feelings include "like a knife," "like a spike," "jabbing" or "like jolts."

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not sharp

The sharpest sensation imaginable ('like a knife')

3. Please use the scale below to tell us how hot your pain feels. Words used to describe very hot pain include "burning" and "on fire."

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not hot

The hottest sensation imaginable ('on fire')

4. Please use the scale below to tell us how dull your pain feels. Words used to describe very dull pain include "like a dull toothache," "dull pain," and "like a bruise."

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not dull

The most dull sensation imaginable

5. Please use the scale below to tell us how cold your pain feels. Words used to describe very cold pain include "like ice" and "freezing."

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not cold

The most cold sensation imaginable ('freezing')

6. Please use the scale below to tell us how sensitive your skin is to light touch or clothing. Words used to describe sensitive skin include “like sunburned skin” and “raw skin.”

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not sensitive

The most sensitive sensation imaginable ('raw skin')

7. Please use the scale below to tell us how itchy your pain feels. Words used to describe itchy pain include “like poison oak” and “like a mosquito bite.”

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

Not itchy

The itchiest sensation imaginable

8. Which of the following best describes the time quality of your pain? **Please tick only one answer.**

() I feel a background pain all of the time and occasional flare-ups (break-through pain) some of the time.

Describe the background pain: _____

Describe the flare-up (break-through) pain: _____

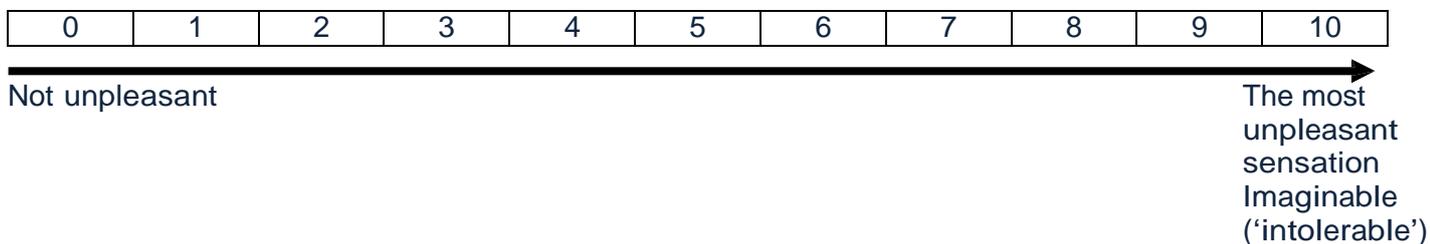
() I feel a single type of pain all the time. Describe this pain: _____

() I feel a single type of pain only sometimes. Other times, I am pain-free.

Describe this occasional pain: _____

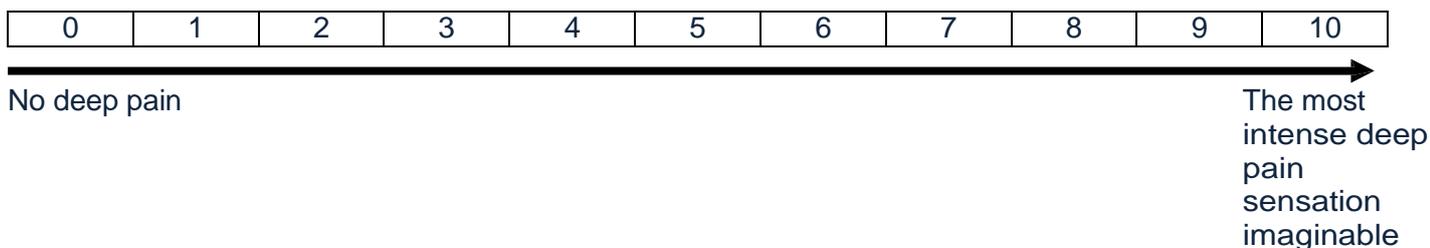
9 . Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how unpleasant your pain is to you. Words used to describe very unpleasant pain include “miserable” and “intolerable.” Remember, pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable.

With this scale, please tell us how unpleasant your pain feels.



10. Lastly, we want you to give us an estimate the severity of your deep versus surface pain. We want you to rate each location of pain separately. We realise that it can be difficult to make these estimates, and most likely it will be a “best guess,” but please give us your best estimate.

How intensive is your deep pain?



How intensive is your surface pain?

