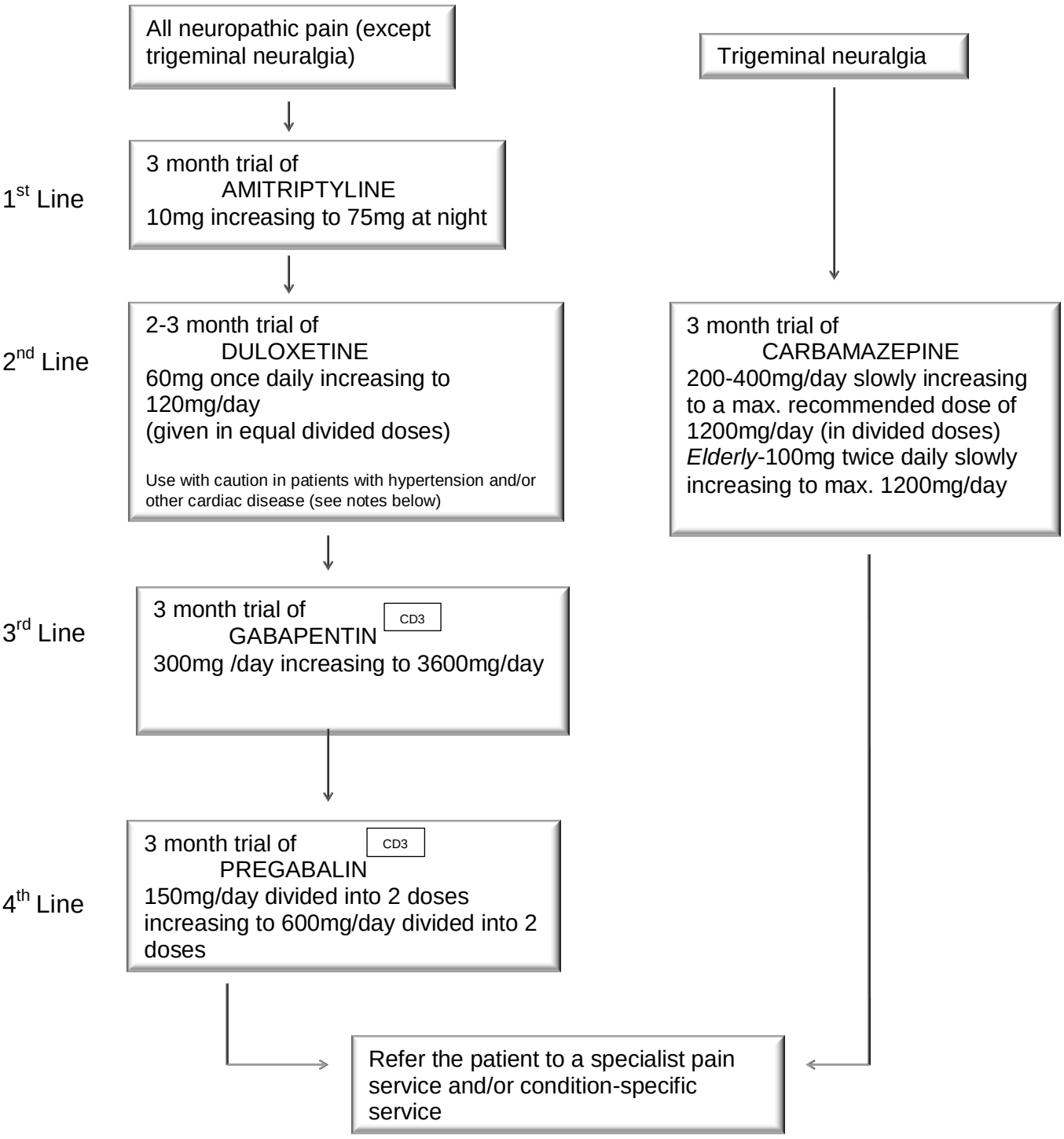
NHS
Rotherham
Clinical Commissioning Group

Guidelines for the Treatment of Neuropathic Pain in Adults (Over 18 years) in Primary Care

Consider referring the person to a specialist pain service at any stage, including at initial presentation and at the regular clinical reviews if their pain is severe, significantly limits their daily activity, or their underlying health condition has deteriorated.



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Key Principles of Care

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.

When agreeing a treatment plan with a patient, 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
- 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).

Choice of Therapy

These guidelines will assume that prescribers will use a drug's Summary of Product Characteristics (SPC) and the British National Formulary (BNF) to inform decisions made with individual patients (this includes obtaining information on special warnings, precautions for use, contraindications and adverse effects of pharmacological treatments). These are available via the links https://www.medicines.org.uk/emc and https://www.medicinescomplete.com/#/

Amitriptyline

Patients receiving TCAs were significantly more likely to report at least 30% pain reduction and global improvement compared with patients receiving placebo. Amitriptyline is licensed for neuropathic pain and the evidence base for treatment efficacy is deemed sufficient to make this positive recommendation[1].
If amitriptyline is not tolerated it should be withdrawn gradually over a minimum of 4 weeks to prevent discontinuation symptoms. 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.
Prescribers are reminded of the anti-cholinergic burden of amitriptyline being greater than the other options in these guidelines.

Duloxetine

Duloxetine has been associated with an increase in blood pressure, and clinically significant hypertension in some patients. Cases of hypertensive crisis have been reported with duloxetine, especially in patients with pre-existing hypertension. Therefore, in patients with known hypertension and/or other cardiac disease, blood pressure monitoring is recommended, especially during the first month of treatment. Duloxetine should be used with caution in patients whose conditions could be compromised by an increased heart rate or by an increase in blood pressure[2]. Patients receiving SNRIs were significantly more likely to report at least 30% pain reduction. Response to treatment should be evaluated after 2 months. In patients with inadequate initial response, additional response after this time is unlikely. Its use in neuropathic pain of a non-diabetic origin is unlicensed. 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.

Gabapentin

Patients receiving gabapentin were significantly more likely to report at least 50% pain reduction and global improvement compared with patients receiving placebo[1]. 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. 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.

Pregabalin

Patients receiving pregabalin were significantly more likely to report at least 30% pain reduction, at least 50% pain reduction and global improvement compared with patients receiving placebo[1]. If pregabalin is not effective or tolerated, discontinue treatment gradually over a minimum of 1 week.

Combination Therapy

Whilst the current NICE guidelines do not recommend the use of combination therapy the Guideline Development Group recognise that this may be of benefit allowing lower doses to be used resulting in fewer adverse effects[1]. It is not recommended in the initial treatment stages but can be considered after third line where some response has been seen to two agents from different classes. Gabapentin and pregabalin should not be used together neither should amitriptyline and duloxetine.

Capsaicin Cream

Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate oral treatments.

Tramadol

Consider tramadol only if acute rescue therapy is needed. This rescue course *should not* continue long-term and should only be considered as rescue medication when people are awaiting referral to specialist pain services after initial treatment has failed.

Simple analgesia

It may be appropriate to initially try regular paracetamol or an NSAID. Simple analgesics are usually ineffective in pure neuropathic pain but may help with a coexisting nociceptive condition. This can be considered at any treatment stage.

References

1. NICE clinical guideline 173-Neuropathic Pain in Adults: pharmacological management in non-specialist settings: Nov 2013 (updated 19th July 2019). Available at: https://www.nice.org.uk/guidance/cg173/chapter/2-List-of-all-research-recommendations [accessed 2.9.20].

2. SPC Cymbalta 30mg hard gastro-resistant capsules, Cymbalta 60mg hard gastro-resistant capsules (http://www.medicines.org.uk/EMC/medicine/15694/SPC/Cymbalta+30mg+hard+gastro-resistant+capsules%2c+Cymbalta+60mg+hard+gastro-resistant+capsules/) [accessed 2.9.20].