What is Neuropathic Pain (NeP)?

- “Pain initiated or caused by a primary lesion or dysfunction in the nervous system” (IASP 1997).
- NeP is very different from nociceptive (inflammatory pain). While nociceptive pain is due to tissue destruction, NeP is due to abnormally functioning nerves due to numerous causes.

How common is Neuropathic Pain?

- It is thought to affect 2-4% of the general population (1-2 million people suffer with neuropathic pain in the UK)
- It can affect up to 20-25% of diabetic patients and 30-40% of patients with cancer
- The average GP may have 35-70 patients suffering with neuropathic pain

Neuropathic Symptoms

- PRIMARY – PAIN
  - Can be spontaneous or evoked, continuous or intermittent
  - Trigger words to aid diagnosis “burning, shooting, stabbing” (see DN4 tool)

- SECONDARY CO-MORBIDITY
  - Sleep interference, lack energy, drowsiness, concentration/memory difficulties, mood swings, depression, anxiety, physical disability

Neuropathic Symptoms

- Allodynia: pain produced by an innocuous stimulus e.g. touch, pressure
- Hyperaesthesia: increased sensitivity to touch
- Hyperalgesia: increased response to stimulus which is normally painful
- Dysaesthesia: an unpleasant abnormal sensation
PATHWAY FOR MANAGING NEUROPATHIC PAIN
IN PRIMARY CARE

- This is a new guideline with resources for both patient and clinician to manage long term neuropathic pain. It covers both post herpetic neuralgia and neuropathic pain.

- Use this treatment guidance and the resources before considering referral.

- If complex regional pain syndrome is suspected, refer early to pain specialist team

  (see guidance http://www.patient.co.uk/doctor/Complex-Regional-Pain-Syndrome-(CRPS).htm)

- The Neuropathic pain diagnostic DN4 tool is useful to aid diagnosis and for detecting change in pain after treatment.  (see patient clinical resources on pathway)

- All of the drugs in the guideline can cause significant adverse effects in some patients. If this occurs, try an alternative from the same therapeutic group. For example, with tricyclic antidepressants (TCA) try nortriptyline or imipramine instead of amitriptyline. Use patient leaflets provided to guide patients in their effective use.
**Post-herpetic Neuralgia**

**1st Line:** Amitriptyline (minimum of 2 to 4 weeks on an evidence based dose)

Depending on response switch to or add:

**2nd Line:** Capsaicin Cream 0.075% (4 week trial),

If resistant to Amitriptyline & Capsaicin:

**3rd line:** Lidocaine 5% Plasters *(Balance use against cost of treatment)* (maximum 4 week trial),

If inadequate response – consider referral

**Treatment discontinuation**

Note – where a patient derives minimal or no clinical benefit from a drug treatment after an appropriate dose and trial period, it **must be stopped**, and the next step of the pathway followed.

Where sub optimal response is achieved, **add** the next drug in the pathway.

Consider nortriptyline if side effects from Amitriptyline are significant and affect patient compliance.

**Dose recommendations (use patient leaflets)**

**Amitriptyline:**
- Commence at 10mg at night
- Increase dose by 10mg each week to a dose of **50mg at night**.
- (2 to 4 week trial at this 50mg dose).
- If a sub-optimal response achieved, consider increasing the dose to 75mg at night.
- (if no response reduce slowly over 4 weeks)

**Capsaicin cream (Axsain) 0.075%:**
- Apply sparingly three to four times a day in pain area

**Lidocaine 5% plaster (Versatis):**
- Apply one patch for 12 hours each day (for large areas up to 3 patches may be used)

**Relative Cost (28 days treatment):**

- **Amitriptyline** 50mg at night **£1.30 - £5.60**
- Capsaicin (tube of 45g) **£14.58**
- Lidocaine plaster (1 – 3) **£72.40 – £217.20**

Patient drug information leaflets for tricyclic antidepressants and antiepileptics

Please see separate link on the website
ALGORITHM FOR PHARMACOLOGICAL MANAGEMENT OF NEUROPATHIC PAIN

Patient resources:
- Pain Scale (VAS) & Body Chart
  Please see separate link on the website
- Diagnosis tools
  Please see separate link on the website
- Neuropathic pain resources
  Please see separate link on the website
- Pain Toolkit
  www.paintoolkit.org/
  Please see separate link on the website
- Using medication leaflets
  Please see separate link on the website

Clinician resources:
- Drug & dose guide
  Please see separate link on the website
- Drug Cost Comparison Charts
  Please see separate link on the website
- Medicines review resources DRT2010
  Please see separate link on the website

Other Management Options:
- Encourage self management skills; use Pain Toolkit + resources above
- Use NHS Kirklees Self Care resources: Health Trainers, Expert Patient Programme for Pain
- Kirklees PALS Revive scheme
- Self help resources in Libraries
- Multidisciplinary assessment to assess health needs via Step 2 Pain pathway (2011)

Treatment review
At each patient review, assess the effect of the treatment on pain relief using the visual analogue pain scale in patient resources. Stop the drug where a patient derives minimal or no clinical benefit from the drug at an appropriate dose and trial period. Then try next drug in the pathway.

(Note: Reduce Tricyclic Antidepressants (TCA) over 4 weeks)

Peripheral Neuropathic Pain including diabetic neuropathic pain

1. Contra-indication to TCAs?
   - YES
   - NO

   Duloxetine – 4 wk trial
   Dose range 60 – 120mg

   1st Line: Antidepressants
   1. Amitriptyline
      If adverse side effects consider:
   2. Nortriptyline (for 6 – 8 weeks)
      If no response to trial of 2 different TCAs, consider:
   3. Duloxetine & reduce TCAs over 4 weeks

   Treatment ineffective
   Treatment sub-optimal

   2nd line: Anti-epileptics
   1. Gabapentin
      (increase dose to a point where patient gains good clinical effect – 8 week trial period)
      If not tolerated consider:
   2. Pregabalin: 4-6 week trial period

   Treatment ineffecttive
   Treatment ineffective

   3rd Line – Opioid Drugs in use order:
   1. Codeine/ Dihydrocodeine /Tramadol
      (full daily dose paracetamol 4g is of benefit)
   2. Oral Morphine (see strong opioids guidance for long term pain).
   3. Opiate patches should only be considered for those patients who cannot take oral medicines, or who have severe renal impairment.

   Treatment ineffective
   Treatment sub-optimal

   Consider referral to Specialist services – see chronic pain pathway

British Pain Society Opioid Guidelines for clinicians 2010
Please see separate link on the website

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