Lancashire & South Cumbria Medicines Management Group

Neuropathic Pain: Primary Care Management

Version 3.1 – November 2024

Introduction

VERSION CONTROL		
Version	**Date**	**Amendments made**
2.0	March 2021	Complete revision of the LSCMMG guideline: 'The Pharmacological Management of Neuropathic Pain in Adults'. AG.
3.0	September 2024	Update following specialist consultation
3.1	November 2024	Removal of capsaicin cream due to product shortage. Title updated to allow easier referencing

Contents

Midlands and Lancashire Commissioning Support Unit,
Leyland House, Lancashire Business Park, Leyland, PR26 6TY
Tel: 01772 644 400 | www.midlandsandlancashirecsu.nhs.uk

Neuropathic Pain: Primary Care Management

Lancashire & South Cumbria Medicines Management Group

Assess pain – see box 1

Box 1: Assessing and defining neuropathic pain
Consider using a validated assessment tool (e.g. LANSS pain scale) to determine the pain type and impact on function. Pain is typically considered severe from 7-10 on a VAS or numeric rating scale. An example can be found here.

Does the patient have severe pain **or** does their pain significantly limit their lifestyle, daily activities (including sleep disturbance) and participation **or** has their underlying health condition deteriorated?

Yes

Refer – continue to manage the patient in primary care pending specialist review

No

Box 2: Causes of neuropathic pain

- Trigeminal neuralgia.
- Some types of facial pain
- Postherpetic neuralgia
- Diabetic neuropathy
- MS
- Phantom limb pain
- Cancer
- Pain following chemotherapy
- Alcoholism
- HIV infection
- Covid infection

Type of neuropathic pain?

Trigeminal neuralgia

Is carbamazepine contraindicated?

Yes

No

Trial carbamazepine
Initially 100 mg 1–2 times a day, increase gradually according to response; usual dose 200 mg 3–4 times a day

If carbamazepine is not tolerated or not effective

Refer (if not already done so) to specialist pain service or specialist palliative care (if relevant)

Non-trigeminal neuralgia neuropathic pain

See page 2

Adapted from NICE CG 173 and associated NICE pathways

Neuropathic Pain: Primary Care Management

Non-trigeminal neuralgia neuropathic pain – for doses see box 3

Offer oral agents from a choice of amitriptyline, duloxetine, gabapentin or pregabalin - **see box 3 and 4**

Those patients with diabetes should be considered for duloxetine **first** (duloxetine is not licensed for analgesia other than in diabetic peripheral neuropathic pain)

All other patients should be considered for amitriptyline

Is the pain controlled and is the agent tolerated?

Yes

End of pathway

No – offer an alternative/additional agent

No – after intolerance/ineffectiveness of amitriptyline and gabapentinoids

Consider nortriptyline

Not effective or tolerated

Refer (if not already done so) to specialist pain service or specialist palliative care (if relevant)

- Lidocaine 5% medicated plasters are recommended as an option for the treatment of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia) in adults
  https://www.lancsmmg.nhs.uk/medicines-library/lidocaine-5-medicated-plasters-post-herpetic-neuralgia/#gsc.tab=0

Box 3: initiation and maximum daily doses of oral management options for neuropathic pain

Medication	Initiation dose	Maximum daily dose
Amitriptyline	10mg ON titrate in 10mg weekly increments	75mg*
Duloxetine	30mg titrate in 30mg increments fortnightly	90mg* as single or divided doses
Nortriptyline	10mg ON titrate in 10mg weekly increments	75mg*
Pregabalin	50mg BD* titrate in 25mg increments every 5-7 days as tolerated (dosing is based on patient's current eGFR)	600mg in divided doses
Gabapentin	100-300mg TDS titrate in 100-300mg increments every 5-7 days (dosing is based on patient's current eGFR)	3600mg in divided doses

Doses based on consensus of local specialist pain clinicians
*Higher doses under specialist supervision. To be read in conjunction with the SPC and current version of the BNF.

Box 4: Treatments that should not be started in non-specialist settings

Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so AND has been approved locally:
Capsaicin patch, lacosamide, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, tramadol (Consider only if acute rescue therapy is needed), venlafaxine, sodium valproate.

Box 5: Gabapentin, pregabalin and antidepressants

Gabapentin and pregabalin: Gabapentinoids are schedule 3 controlled drugs. Evaluate patients carefully for a history of drug abuse before prescribing and observe patients for development of signs of abuse and dependence. Prior approval for use should be obtained where this exists. Concurrent use of opioids and gabapentinoids carries a higher risk of opioid induced adverse events including OIVI (opioid induced ventilatory impairment).
Antidepressants: For patients using antidepressants,

- **serotonin syndrome** is a dangerous side effect unless treated quickly. Risks include mixing SSRIs, SNRIs, tricyclic antidepressants, MAOIs, lithium, opioids (including tramadol) and anti-migraine medications (including carbamazepine). handyfactsheetserotoninsyndromeuk.pdf (choiceandmedication.org)
- Concurrent use of duloxetine and amitriptyline can cause hyponatraemia
- Patient should be made aware that mixing antidepressants with opioids causes sedation and may impair driving..

Adapted from NICE CG 173 and associated NICE pathways