Guidelines for the management of neuropathic pain in Primary Care

Use neuropathic pain screening questionnaires to make the diagnosis (LANNS, Pain detect, DN4).

The NICE guidelines emphasise establishing an underlying diagnosis and initiating treatment (such as diabetes) and on tailoring pharmacological treatment to the individual.

If diagnosis uncertain or pain is severe or has a significant impact on daily activities, consider referral to pain specialist or disease specific service if underlying condition clear.

Pay attention to psychological and social factors (such as depression or joblessness). – "yellow flags"

In choosing a pharmacological agent to treat NP consider patient co-morbidity, patient preference, occupation and mental health. Consider the following points:

- Vulnerability to specific side effects (dizziness or sedation in the elderly – particularly with tricyclics).
- Comorbidity and specific contra-indications (the effects of renal impairment on drug excretion, use of tricyclics or SNRI drugs in patients with cardiac disease).
- Impact on driving or shiftwork.
- Mental health – consider drugs with antidepressant activity in patients with low mood (Duloxetine) . Consider Pregabalin in patients with significant anxiety.
- Sleep – tricyclics or Pregabalin in patients with poor sleep.

Once established, frequent clinical reviews are required. Ideally 30-50% reduction in VAS pain score. However, also need to assess and record improvements in daily activities, patient global impression of improvement, sleep and mood. Dose should be titrated to achieve maximum benefit with minimum side effects.

First line options:

1. Amitriptyline or gabapentin (Pregabalin not recommended locally for first line – Amber drug).
    a. Amitriptyline. Start at 10mg at 7-8 pm with upward titration to an effective dose or the person's maximum tolerated dose of no higher than 75mg as a single evening dose. If anticholinergic side effects are excessive consider nortriptyline or imipramine. See notes above, caution in the elderly.
    b. Gabapentin. Start at 300mg at night, with upward titration to an effective dose or the person's maximum tolerated dose of no higher than 1800 mg per day (divided into three doses as 300mg capsules). Some patients may need significantly lower doses.
    c. For painful diabetic neuropathy, Duloxetine is first line. Start at 60 mg per day (a lower starting dose may be appropriate for some people), with upward titration to an effective dose or the person's maximum tolerated dose of no higher than 120 mg per day.

Second line options:

1. Add in an alternate first line agent.
2. Consider Duloxetine. Start at 60 mg per day (a lower starting dose may be appropriate for some people), with upward titration to an effective dose or the person's maximum tolerated dose of no higher than 120 mg per day
3. Switch to Pregabalin. Start at 150 mg per day (divided into two doses; a lower starting dose such as 25mg bd may be appropriate for some people), with upward

titration to an effective dose or the person's maximum tolerated dose of no higher than 600 mg per day (divided into two doses).

4. Pregabalin may be combined with either tricyclic antidepressants or Duloxetine.

Third line options:

1. If second line treatment not effective consider adding in Tramadol 50mg, with upward titration to a maximum daily dose of 400mg in four divided doses. Do not combine tramadol with Duloxetine (risk of serotonergic syndrome).
2. Consider 5% lignocaine patch for localized neuropathic pain.

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