Neuropathic pain

A. Possible neuropathic pain

If pain distribution is neuroanatomically plausible and history suggests
neuropathic pain (e.g. post herpetic neuralgia)

B. History and examination

Neurological or peripheral sensory signs, confined to the territory of
the lesions nervous structure [1]

C. Red flag and 40 risk assessment

Refer to specialists if there is diagnostic uncertainty, they have severe pain, pain significantly limits daily
activities, or the underlying etiology is demonstrable.

Continue to handle through neuropathic flow chart whilst waiting

D. Complex Regional Pain Syndrome

Rapid therapy for CRPS is likely to reduce long-term disability.

- refer for medical specialist assessment for intensive physiotherapy and management

- carefully manage with antidepressants from over counter

E. Localised areas of neuropathic pain may need to localised lidocaine plaques or capsaicin (e.g. 0.025%) cream 4 times a day without the need for systemic therapy. Examples of this are

- demineralized post haemorrhagic neuralgia

- a tender area from nerve laceration

F. Develop and agree a management plan with patient

Discuss the options for treatment available to allow for patient choice

- self-help

- medication

- cognitive behavioural multidisciplinary pain management

There are considerable numbers of studies supporting CBT in chronic pain but very few looking at the subset
with neuropathic pain [7]

G. First line drug

- Start amitriptyline 10mg at night, increasing gradually to an effective dose or a maximum tolerated dose (not above 75mg).
  Consider alternative triyclic antidepressants such as mirtazapine. Aim for at least 25mg and increment at night, i.e.
  - Start gabapentin 75mg at night, increasing to twice daily and then gradually to an effective dose or possible
  maximum tolerated dose (no higher than 600mg) daily. Aim for at least 100mg twice a day, or
  - Start gabapentin 100mg at night, increasing gradually, for three times daily or twice daily and then an effective dose
  - or maximum tolerated dose (no higher than 3.0g daily total). Aim for at least 600mg 3 times a day.
  - In the case of painful diabetics neuropathically, start donepezil 10mg, increasing to an effective dose or possible
  maximum tolerated dose (no higher than 30mg daily). Aim for 20mg twice a day.

- In the case of enteral benzodiazepine, consider benzodiazepine as first line starting at 30mg twice a day
  increasing to an effective dose or maximum tolerated dose (no higher than 1.6g daily total). Aim for 2mg
  four times a day. Oxcarbazepine is an alternative

H. Reassessment two weekly until pain is well controlled.

Add or change to another first line drug.

- Amitriptyline or other gabapentinoids or pregabalin may be combined if partially effective.

- If gabapentin or pregabalin have not been effective or limited by side effects, it is reasonable to try the other of the
two. When withdrawing or switching treatments, taper the withdrawal regimen to take account of dosage
and any discontinuation symptoms.

- Combinations of antidepressants are not generally recommended. However, if a patient is already taking an
  SSRI or SNRI for their mood, some specialists would consider adding amitriptyline starting at 10mg but not
giving above 25mg daily.

I. Consider third line treatment

- Reassessment should be within two weeks until pain is better controlled.

- NICE/EMCOP use the term formalised in neuropathic pain (5)

- Tramadol should be used with caution for people on SRIs antidepressants as there is the potential for a serious
  serotonin syndrome

J. Review and consider specialist referral

- Refer if there is no significant improvement and to clarify the diagnosis

- Stronger opioids can be considered if the patient is confident with long term management of opioids and
  problems arising. This must include an understanding of equivalent doses. Please see British Pain Society's
  guidelines on Long term opioids in non cancer pain (6)

K. Confirm diagnosis and consider MDT referral

- Specialised trials will be required (e.g. imaging and nerve conduction studies as appropriate)

L. Care should be provided in the context of a multidisciplinary team.

- Combinations of drugs should be considered. Cognitive behavioural therapy based techniques may be useful.

- Drugs less widely available can be differed by a variety of routes and may have to treated in the most
  resistant cases e.g. lidocaine, ketamine. High dose caudal injection (e.g. Qoltenrol), focal diagnostic or therapeutic
  intervention (e.g. with steroids or botulin)

- Consider drugs and interventional pain therapies.

- Stronger opioids may have value and need careful management, especially when switching from one to
  another e.g. morphine, oxycodone, methadone, fentanyl, hydromorphone. Interventional pain
  therapies for vascular pain e.g. nerve root block should be considered

- Spinal cord stimulation is recommended as a treatment option for adults with chronic pain of neuropathic
  origin (9) Spinal drug delivery may be appropriate for the most intractable cases.

G. Self care management with patient

- Univariate pain information leaflets and self guided websites e.g.

  - British pain society (7)

  - Neil Berry’s online audio descriptions of pain (8)

  - Other material as available

- Patient information is known to improve the patient experience and involvement with their care (4)

  - Address patients concerns about understanding their pain with the aim of reducing their fears about pain.

- NICE guidelines were produced for non-specialist pharmacological management (5) These have been
  superseded by further systematic reviews (6). There has been much controversy around the exclusion of
  gabapentin from the NICE guidelines, this was done following an economic analysis showing that the other
  recommendations drugs were more efficient use of resource; the evidence for efficacy (without an economic
  analysis) supports the use of gabapentin as a first line agent

Reference:


[3] https://www.bmj.com


[8] http://www.bmj.com/content/351/bmj.39338.6369

