NICE National Institute for Health and Care Excellence

NICE Pathways

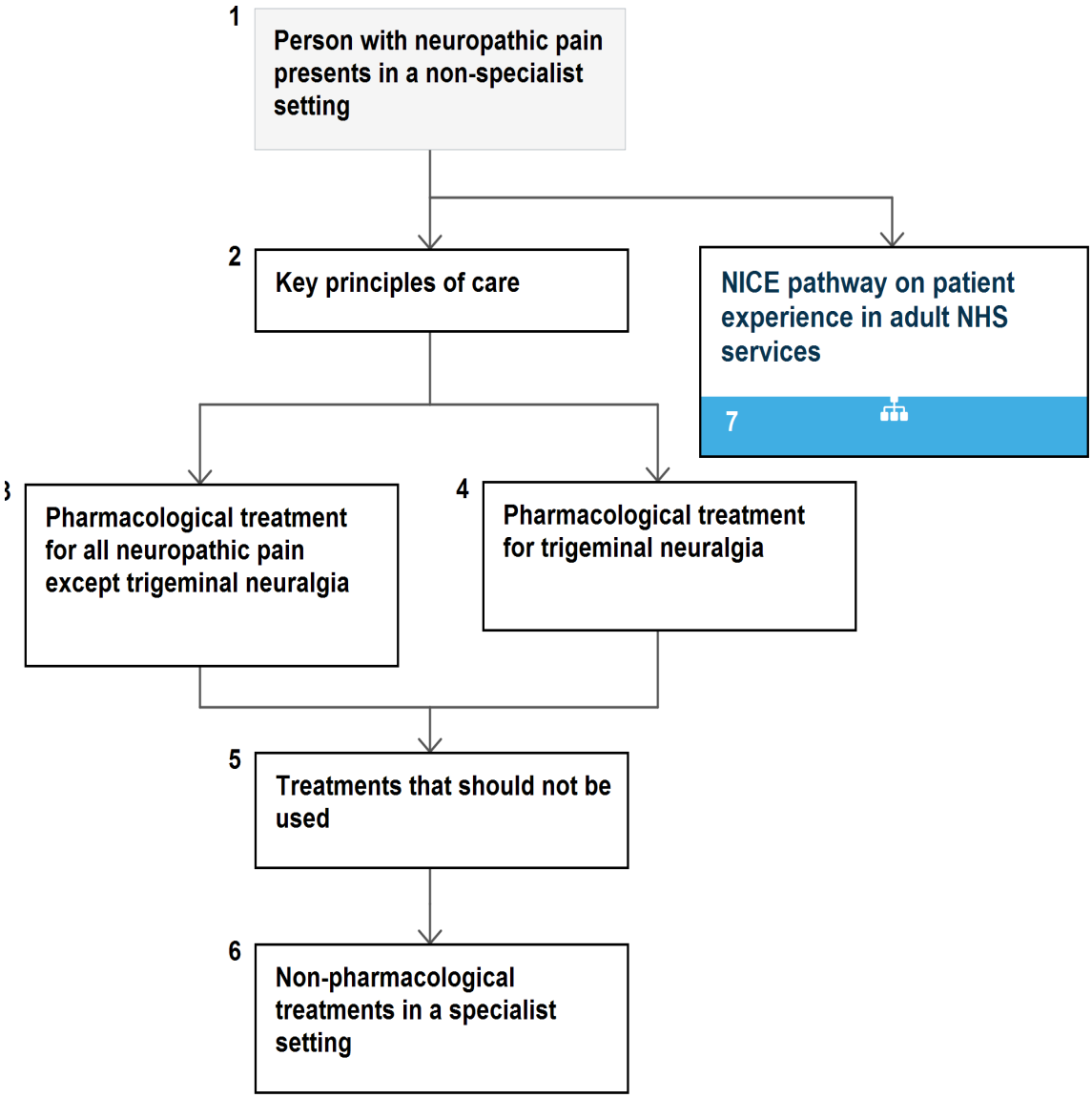
Neuropathic pain overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/neuropathic-pain
Pathway last updated: 21 September 2015

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 Person with neuropathic pain presents in a non-specialist setting

No additional information

2 Key principles of care

When agreeing a treatment plan with the person, 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).

For more information about involving people in decisions and supporting adherence, see the NICE pathway on medicines optimisation.

Consider referring the person to a specialist pain service and/or a condition-specific service at any stage, including at initial presentation and at the regular clinical reviews, if:

- they have severe pain **or**
- their pain significantly limits their lifestyle, daily activities (including sleep disturbance) and participation **or**
- their underlying health condition has deteriorated.

Continue existing treatments for people whose neuropathic pain is already effectively managed, taking into account the need for regular clinical reviews.

When introducing a new treatment, take into account any overlap with the old treatments to avoid deterioration in pain control.

After starting or changing a treatment, carry out an early clinical review of dosage titration, tolerability and adverse effects to assess the suitability of the chosen treatment.

Carry out regular clinical reviews to assess and monitor the effectiveness of the treatment. Each review should include an assessment of:

- pain control
- impact on lifestyle, daily activities (including sleep disturbance) and participation
- physical and psychological wellbeing
- adverse effects
- continued need for treatment.

When withdrawing or switching treatment, taper the withdrawal regimen to take account of dosage and any discontinuation symptoms.

3 Pharmacological treatment for all neuropathic pain except trigeminal neuralgia

Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)[1].

If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.

Consider tramadol only if acute rescue therapy is needed (see Treatments that should not be used [See page 6] about long-term use).

Consider capsaicin cream[2] for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

4 Pharmacological treatment for trigeminal neuralgia

Offer carbamazepine as initial treatment for trigeminal neuralgia.

If initial treatment with carbamazepine is not effective, is not tolerated or is contraindicated, consider seeking expert advice from a specialist and consider early referral to a specialist pain service or a condition-specific service.

[1] At the time of publication (November 2013), amitriptyline did not have a UK marketing authorisation for this indication, duloxetine is licensed for diabetic peripheral neuropathic pain only, and gabapentin is licensed for peripheral neuropathic pain only, so use for other conditions would be off-label. In addition, the Lyrica (Pfizer) brand of pregabalin has patent protection until July 2017 for its licensed indication of treatment of peripheral and central neuropathic pain; until such time as this patent expires generic pregabalin products will not be licensed for this indication and their use for this condition would be off-label and may infringe the patent. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Good practice in prescribing and managing medicines and devices for further information.

[2] At the time of publication (November 2013), capsaicin cream (Axsain) had a UK marketing authorisation for post-herpetic neuralgia and painful diabetic peripheral polyneuropathy, so use for other conditions would be off-label. The summary of product characteristics states that this should only be used for painful diabetic peripheral polyneuropathy 'under the direct supervision of a hospital consultant who has access to specialist resources'. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the Good practice in prescribing and managing medicines and devices (2013) guidance for doctors for further information.

5 Treatments that should not be used

Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:

- cannabis sativa extract
- capsaicin patch
- lacosamide
- lamotrigine
- levetiracetam
- morphine
- oxcarbazepine
- topiramate
- tramadol (this is referring to long-term use; see Pharmacological treatment for all neuropathic pain except trigeminal neuralgia [See page 4] for short-term use)
- venlafaxine.

6 Non-pharmacological treatments in a specialist setting

NICE has issued guidance on the following procedures, which may be among treatments offered in a specialist pain service or a condition-specific service.

Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin

Spinal cord stimulation is recommended as a treatment option for adults with chronic pain of neuropathic origin who:

- continue to experience chronic pain (measuring at least 50 mm on a 0–100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management, and
- who have had a successful trial of stimulation as part of the assessment specified below.

Spinal cord stimulation is not recommended as a treatment option for adults with chronic pain of ischaemic origin except in the context of research as part of a clinical trial. Such research should be designed to generate robust evidence about the benefits of spinal cord stimulation (including pain relief, functional outcomes and quality of life) compared with standard care.

Spinal cord stimulation should be provided only after an assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed.

When assessing the severity of pain and the trial of stimulation, the multidisciplinary team should be aware of the need to ensure equality of access to treatment with spinal cord stimulation. Tests to assess pain and response to spinal cord stimulation should take into account a person's disabilities (such as physical or sensory disabilities), or linguistic or other communication difficulties, and may need to be adapted.

If different spinal cord stimulation systems are considered to be equally suitable for a person, the least costly should be used. Assessment of cost should take into account acquisition costs, the anticipated longevity of the system, the stimulation requirements of the person with chronic pain and the support package offered.

People who are currently using spinal cord stimulation for the treatment of chronic pain of ischaemic origin should have the option to continue treatment until they and their clinicians consider it appropriate to stop.

These recommendations are from spinal cord stimulation for chronic pain of neuropathic or ischaemic origin (NICE technology appraisal guidance 159).

NICE has written information for the public explaining its guidance on spinal cord stimulation for chronic pain of neuropathic or ischaemic origin.

Interventional procedures guidance

NICE has published interventional procedures guidance on the use of the following procedures with **normal arrangements** for consent, audit and clinical governance:

- Percutaneous electrical nerve stimulation for refractory neuropathic pain (NICE interventional procedure guidance 450).
- Deep brain stimulation for refractory chronic pain syndromes (excluding headache) (NICE interventional procedure guidance 382).
- Stereotactic radiosurgery for trigeminal neuralgia using the gamma knife (NICE interventional procedure guidance 85).

7 NICE pathway on patient experience in adult NHS services

See Patient experience in adult NHS services

Glossary

Condition-specific service

A specialist service that provides treatment for the underlying health condition that is causing neuropathic pain. Examples include neurology, diabetology and oncology services.

Participation

The World Health Organization ICF (International Classification of Functioning, Disability and Health) (2001) defines participation as 'A person's involvement in a life situation'. It includes the following domains: learning and applying knowledge, general tasks and demands, mobility, self-care, domestic life, interpersonal interactions and relationships, major life areas, community, and social and civil life.

Non-specialist settings

Non-specialist settings are primary and secondary care services that do not provide specialist pain services. Non-specialist settings include general practice, general community care and hospital care.

Specialist pain services

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Sources

Neuropathic pain – pharmacological management (2013) NICE guideline CG173

Spinal cord stimulation for chronic pain of neuropathic or ischaemic origin (2008) NICE technology appraisal guidance 159

Percutaneous electrical nerve stimulation for refractory neuropathic pain (2013) NICE interventional procedures guidance 450

Deep brain stimulation for refractory chronic pain syndromes (excluding headache) (2011) NICE interventional procedures guidance 382

Stereotactic radiosurgery for trigeminal neuralgia using the gamma knife (2004) NICE interventional procedures guidance 85

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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