Initial Management of Neuropathic Pain

Neuropathic pain can arise due to multiple underlying central or peripheral causes. Lumbar radiculopathy is not within the scope of this pathway. ***Please see Back Pain Pathway***

Professional Guidance

Patient Guidance

Patient presents with symptoms suggestive of neuropathic pain

History and Examination (Click for more)

RED FLAGS (Click for more)

URGENT Referral via appropriate channels depending on RED FLAGS E.g 2WW or discussion with Neurology and Orthopaedics Teams

Sciatica or Lumbar Radiculopathy

Back Pain Pathway

Differentials (Click for more)

Post Herpetic Neuralgia Management (Click for more)

Other Neuropathic Pain Management (Click for more)

Trigeminal Neuralgia Management (Click for more)

Referral Criteria (Click for more)

No

YES

If no referral required, agree and arrange early follow up for review. Check that they know who to contact if they have problems Or concerns.

Review Neuropathic Pain Pathway

Escalation Routes (Click for more)

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Professional Guidance

- Neuropathic Pain NICE Recommendations ***– Recommendations | Neuropathic pain in adults: pharmacological management in non-specialist settings | NICE***
- PAIN DETECT Questionnaire ***– PainDetect.pdf(cheringtonpractice.co.uk)***
- British Pain Society Pain Scales – ***Pain scales in multiple languages | British Pain Society***
- Initial Management of Neuropathic Pain NICE CKS – Scenario: Neuropathic pain ***– drug treatment | Management | Neuropathic pain – drug treatment | CKS | NICE***
- Trigeminal Neuralgia NICE CKS – ***Trigeminal neuralgia | Health topics A to Z | CKS | NICE***
- Post herpetic Neuralgia NICE CKS ***– Post Herpetic Neuralgia | Health topics A to Z | CKS | NICE***
- BNF treatment summary for Neuropathic Pain ***– Neuropathic pain | Treatment summaries | BNF | NICE***
- Local Treatment guidelines – ***https://hertsvalleysccg.nhs.uk/application/files/7615/3633/3735/Neuropathic_Pain_Treatment_Guidelines_updated_201612_HMMC.pdf***

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Patient Guidance

- Post Herpetic Neuralgia – ***Postherpetic Neuralgia | Symptoms and Treatment | Patient***
- Trigeminal Neuralgia – ***Trigeminal Neuralgia: Causes, Symptoms and Treatment | Patient***
- Peripheral Neuropathy – ***peripheral Neuropathy. Neuropathy treatment and symptoms | Patient***

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Red Flags

Trigeminal Neuralgia red flags:

- Sensory changes
- Deafness or other ear problems
- History of skin or oral lesions that could spread perineurally
- Pain only in the ophthalmic division of the trigeminal nerve (eye socket, forehand, and nose), or bilaterally.
- Optic neuritis
- Family History of multiple sclerosis
- Age of onset before 40 years

Radiculopathy red flags:

- Age <16 or >50 with NEW onset back pain
- Non-mechanical pain (worse at rest, interferes with sleep)
- Thoracic pain
- Previous history of malignancy
- Unexplained weight loss
- Recent serious illness
- Recent significant infection
- Fever/rigors
- Urinary retention/incontinence
- Faecal incontinence
- Saddle anesthesia /Altered perianal sensation (wiping bottom)
- Limb weakness
- New/progressive spinal deformity
- Hyper-reflexia, clonus, extensor plantar responses
- Generalised neurological deficit
- Reduced anal tone/squeeze
- Palpable full bladder or urinary retention

Neuropathy red flags:

- Autonomic dysfunction – consider differentials for underlying cause
- Progressive neuropathy
- Fever, night sweats, unexplained weight loss
- Unexplained lymphadenopathy
- nausea or vomiting.
- New or severe headache.
- Photophobia or phonophobia.
- Visual loss
- Altered cognitive State
- A history of immunosuppression, tuberculosis, or intravenous drug abuse (consider spinal abscess, discitis, or osteomyelitis).

References

- ***https://cks.nice.org.uk/topics/neck-pain-non-specific/diagnosis/signs-symptoms/#red-flags***
- ***https://cks.nice.org.uk/topics/sciatica-lumbar-radiculopathy/diagnosis/red-flag-symptoms-signs/***
- ***https://cks.nice.org.uk/topics/trigeminal-neuralgia/diagnosis/diagnosis/***

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History and Examination

Neuropathic pain is characterised by continuous or intermittent spontaneous pain, typically described as burning, aching or shooting in nature. The pain may be provoked by normally innocuous stimuli (allodynia). Neuropathic pain is also commonly associated with hyperalgesia (increased pain intensity evoked by normally painful stimuli), paraesthesia and dysesthesia.

Initial assessment should include:

- Exclude serious pathology or red flags
- Investigate and manage any underlying condition
- Determine pain type (nociceptive vs neuropathic vs radiculopathy or mixed)
  - Typical features of neuropathic pain: burning, shooting, allodynia, hyperalgesia, unpredictable, abnormal sensations.
  - ***Use Pain DETECT questionnaire*** to help identify pain type - diagnosis is made by clinical judgement based on a comprehensive and holistic approach.
- Determine baseline severity of pain and functional impact
- ***British Pain Society Pain scales – please click on link***
- Determine use of Over-the-counter or complementary treatments
- Conduct a psychological and social assessment if appropriate
- For suspected Trigeminal Neuralgia, please see ***NICE CKS***
- For suspected Post-Herpetic Neuralgia, please see ***NICE CKS***
- ***For sciatica/lumbar radiculopathy, please refer to back pain pathway***
- ***Please see local treatment guidelines for further information***

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Differentials

Causes of neuropathic pain can include central and peripheral causes such as:

Central Causes

- Post -stroke pain
- Multiple Sclerosis
- Chemotherapy induced

Peripheral Causes

- Diabetic Neuropathy
- Trigeminal Neuralgia
- Post Herpetic Neuralgia
- Lumbar Radiculopathy
- Nerve damage
- Tumour infiltration
- Alcohol Related neuropathy

Differentials may include:

- Nociceptive pain such as MSK Pain
- Stress, anxiety and depression

Investigation of potential underlying causes of pain should be undertaken if cause is unknown.

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Management: Post Herpetic Neuralgia

See NICE CKS for further guidance

Non-pharmacological:

- PIL: ***https://patient.info/skin-conditions/shingles-herpes-zoster-leaflet/postherpetic-neuralgia***

- Offer self-management advice, including information on the nature of post-herpetic neuralgia. Advise people with post-herpetic neuralgia they may find it helpful to:
  - Wear cotton or silk fabrics, as these may cause the least irritation.
  - Protect sensitive areas by applying a protective layer (such as a firm bandage, compression clothing, cling film)
  - Consider frequent application of cold packs, unless this causes pain (allodynia).

Pharmacological:

- Initial treatment with paracetamol should be offered, either alone or in combination with codeine, although these options are usually of minimal benefit on their own.
- Consider prescribing a topical treatment such as capsaicin cream or lidocaine plasters if pain is mild, if allodynia is a prominent feature, in older people if there are concerns about central nervous system side effects of oral medications, or as an adjunct to oral therapy if pain is severe.
- If pain remains uncontrolled, consider offering a drug to treat neuropathic pain – see management o f neuropathic pain section

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Management: Other Neuropathic Pain

NICE CKS

NICE recommendations

Non pharmacological:

- Address common psychological comorbidities (e.g. anxiety/ depression), consider referring/signposting to psychological therapies such as cognitive behavioural therapy
- If sleep is disturbed discuss sleep restoration strategies
- Physiotherapy
- Manage underlying condition e.g. optimise blood glucose in patients with diabetes.

Pharmacological: Offer a choice of

- Trial of conventional analgesics – paracetamol / codeine with review within 2 weeks.
- If codeine ineffective consider tramadol for paroxysmal pain and review within 2 weeks
- ***1) Amitriptyline***
- ***2) Gabapentin ****
- ***Or Pregabalin ****
- ***3) Duloxetine***

In diabetic peripheral neuropathy consider duloxetine as second line.

Consider ***capsaicin*** 0.075% cream (Axsain) for people with localized neuropathic pain who wish to avoid, or cannot tolerate, oral treatments.

- Do not prescribe more than one neuropathic pain drug at the same time. For example, do not prescribe amitriptyline concurrently with duloxetine, gabapentin, or pregabalin.
- Titrate the dosage according to response and tolerability.
- Ensure discussion with each patient includes:
  - Importance of dosage titration, and the titration process, providing written information if possible. Explain that the treatment does not work immediately; it commonly takes weeks to titrate up to an effective dose.
  - The possible adverse effects associated with use of medication.
  - That a daily pain diary may be useful to help people learn to manage their pain.

**If patient is unable to reach maximum effective dose of Gabapentin despite titration consider pregabalin. Pregabalin works on the same pathway as gabapentin. Evaluate people carefully for a history of drug abuse before prescribing gabapentin or pregabalin and observe them for development of signs of abuse and dependence*

- ***Anticholinergic burden should be considered where relevant when any new medicine is initiated – for further information, please click here***

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Management: Trigeminal Neuralgia

See NICE CKS for further guidance

- Trial of conventional analgesics – paracetamol / codeine with review within 2 weeks.

- If codeine ineffective consider tramadol for paroxysmal pain and review within 2 weeks

If no red flags – treat with Carbamazepine with view to reduce once in remission

- ***Prescribing Guidance***

If carbamazepine is contraindicated, ineffective, or not tolerated, seek specialist advice. Do not offer any other drug treatment unless advised to do so by a specialist.

- ***Link to escalation page***

Specialist initiated medications may include other anticonvulsant medications such as oxcarbazepine, lamotrigine, topiramate, gabapentin and pregabalin, or non-anticonvulsant medications such as baclofen.

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Escalation Routes

Neuropathic Pain that requires a referral to secondary care is predominantly managed by the Pain Specialist Team. A referral to neurology may be considered in the following cases:

- Known underlying neurological condition
- Or diagnosis of occipital or trigeminal neuralgia

If referral to Neurology is considered, please use A&G service if appropriate.

Please consider referrals to CBT/Mental Health Services or MSK/Physio if considered appropriate.

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Referral Criteria

Referral criteria:

- They have severe pain.
- Their pain significantly limits their participation in daily activities (including self care, general tasks and demands, interpersonal interactions and relationships, mobility, and sleeping).
- The underlying health condition that is causing neuropathic pain has deteriorated.

Please consider referrals to CBT/Mental Health Services or MSK/Physio if considered appropriate.