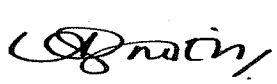
NHS Grampian

Neuropathic Pain In Adults: Guidance For The Diagnosis, Pharmacological Management And Review In Primary Care

Author:	Consultation Group:	Approver:
Medicines Management Lead Pharmacist	See Page 1	Medicines Guidelines and Polices Group

Signature:		Signature:
		

Identifier:	Review Date:	Date Approved:
MGPG/Guide/PC_NPain/1812	April 2029	April 2026 (Published June 2026)

Policy Statement:

It is the responsibility of all staff to ensure that they are working to the most up to date and relevant guideline, policies, protocols and procedures.

Version 1

Executive Sign-Off

This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: 

Replaces: New Document

Document application: NHS Grampian

Document:

Drafted:	March 2026
Completed:	April 2026
Approved:	April 2026
Amended and re-authorised	

Revision History:

Revision Date	Summary of Changes	Changes Made
	New Document.	

Consultative Group

Name:	Title:
Dr Adam Booth	GP, Aberdeen City HSCP and Medical Director Grampian LMC
Alistair Boyd-Orr	HSCP Lead Pharmacist, Primary Care, Moray
Dr Callum Duncan	Consultant Neurologist, NHS Grampian
Dr Saravana Kanakarajan	Consultant in Anaesthesia and Pain Medicine, NHS Grampian
Dr Colin Patterson	Consultant Anaesthetist, NHS Grampian
Dr Hannah Robertson	Consultant in Diabetes and General Medicine, NHS Grampian
Liz Robertson	HSCP Lead Pharmacist, Aberdeen City
Lyn Robertson	Medicines Management and Controlled Drugs Pharmacist, NHS Grampian

Neuropathic Pain In Adults: Guidance For The Diagnosis, Pharmacological Management And Review In Primary Care

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Neuropathic Pain in Adults: Guidance For The Primary Care Diagnosis, Pharmacological Management, Monitoring And Review

1. Aims

To provide clinicians with the information, resources and guidance required to diagnose, assess, manage and monitor adult patients with neuropathic pain.

To provide information to support timely and appropriate referral of patients with neuropathic pain who require specialist input (specialist pain service or condition specific specialist service).

2. Scope

Pharmacological management of neuropathic pain including: diabetic peripheral neuropathy, post-herpetic neuralgia, trigeminal neuralgia, chronic post-surgical neuropathic pain and idiopathic neuropathic pain.

3. Out With Scope

- Acute management of severe neuropathic pain.
- Management of biopsychosocial impacts of pain.
- Non-pharmacological management of neuropathic pain (Grampian Pain Management).
- Patients with chronic conditions or cancer under the management of a specialist service, e.g. multiple sclerosis (MS).
- Patients managed by the Substance Use Service (SUS) due to prescribing of respiratory depressants.
- Pregnant patients.
- Patients under the age of 18.

4. Pain Definitions (Including Types Of Neuropathic Pain)

Nociceptive pain	Pain that arises from actual or threatened damage to non-neural tissue and is due to the activation of nociceptors.
Neuropathic pain	Pain caused by a lesion or disease of the somatosensory nervous system.
Nociplastic pain	Pain that arises from altered nociception despite no clear evidence of actual or threatened tissue damage.

Source: Terminology | International Association for the Study of Pain (iasp-pain.org)

Neuropathic pain can have many different aetiologies and symptoms which can make diagnosis and management of neuropathic pain challenging.

Common neuropathic pain conditions include:

- diabetic peripheral neuropathy
- post-herpetic neuralgia
- trigeminal neuralgia
- chronic postsurgical neuropathic pain
- stroke and multiple sclerosis

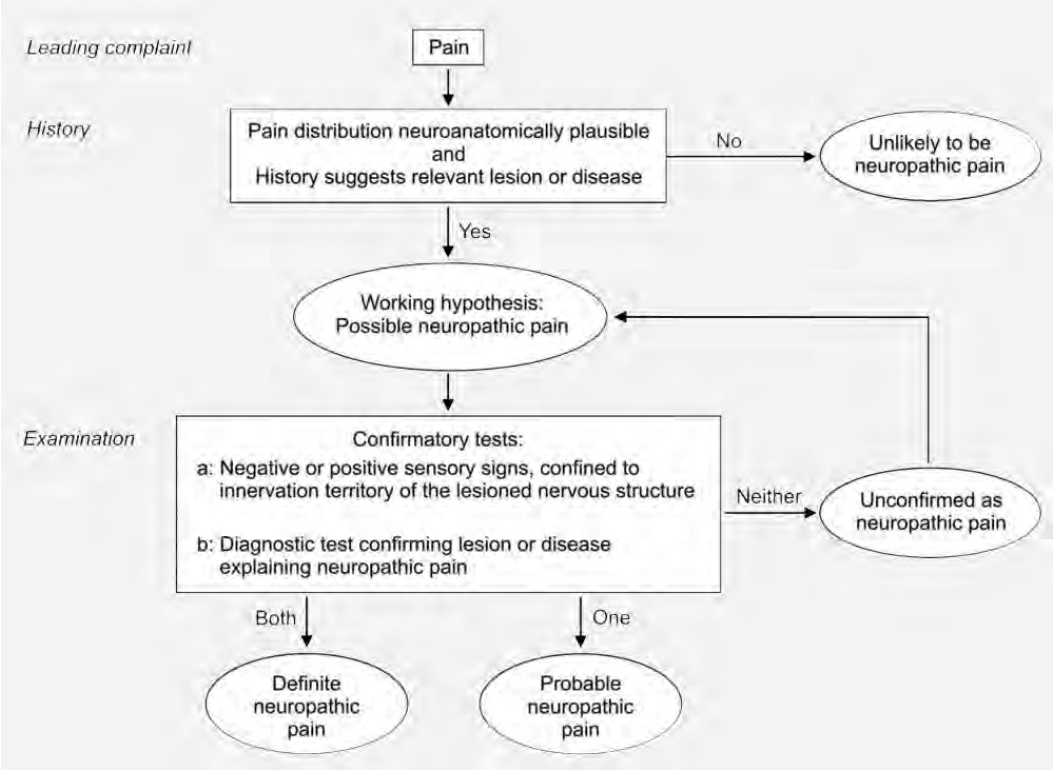
5. Diagnosis And Assessment

The management of neuropathic pain is dependent on the diagnosis made, thus it is imperative that the aetiology of neuropathic pain is fully explored to ensure the complaint is classified correctly.

Pain should have been present for greater than 12 weeks before a diagnosis of neuropathic pain could be made. Red flag symptoms suggestive of an underlying condition (e.g. unexplained weight loss, sweating, fever, chills) should be investigated and excluded while initiating management of neuropathic pain.

Diagnosis should involve both taking history and physical examination. Diagnosis of neuropathic pain can be defined as possible, probable and definitive.

Medication(s) should only be prescribed where a probable or definite diagnosis of neuropathic pain has been made.



Source: [Neuropathic pain: redefinition and a grading system for clinical and research purposes - PubMed (nih.gov)]

There are several tools which can support in the assessment of pain to determine if neuropathic pain should be considered as a diagnosis:

- Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) (Appendix 1) (Score of 12 or more indicates neuropathic pain. Repeated assessments can be used to assess treatment efficacy, pain changes/exacerbations or medication de-escalation impacts).
- Douleur Neuropathique 4 Questionnaire (DN4) (Appendix 2) (score of 4 or more indicates neuropathic pain).
- painDETECT (Appendix 3) questionnaire for use in patients with lower back pain/leg pain.

Where one of the above questionnaires indicate the possibility of neuropathic pain, examination can assist in further confirming diagnosis.

The examination findings should include either increased or decreased perception of touch, pinprick or thermal sensations in the nerve territory corresponding to pain, e.g. post-herpetic neuralgia in the affected dermatome, diabetic peripheral neuropathy in the hands and feet, lumbosacral radiculopathy in the appropriate root distribution in the legs, post-surgical neuropathic pain around scar.

6. Pharmacological Management

6.1. General Prescribing Points

Pharmacological management of neuropathic pain will be dependent on diagnosis, see information in sections below and appendices relating to specific conditions and medications.

Any pharmacological management should be prescribed in partnership with non-pharmacological/self-management measures to support pain management and living well with pain. Further information relating to the non-pharmacological management of pain can be found on the Grampian Pain Management website

The aim of pharmacological management of all types of neuropathic pain is for medications to reduce pain to an acceptable (mild to moderate) level. NHS Scotland's Quality Prescribing for Chronic Pain 2026-2029 document states that "In chronic pain efficacy is considered as a 30 to 50% reduction in pain intensity".

The risk: benefit of any medicine should be thoroughly explored and explained to the patient prior to prescribing. Prescribers should be alert to the possibility of misuse, dependence, drug seeking behaviours and diversion when prescribing medications (particularly gabapentinoids) for neuropathic pain.

Details of medications commonly used in neuropathic pain can be found in Appendix 4. Individual medication SmPC's should be consulted for full medication details. Medication titration details can be found in Appendix 5 and a pharmacological management algorithm can be found in Appendix 7.

Compliance with formulary is recommended when prescribing for neuropathic pain. Medications recommended for use within NHS Grampian can be checked via the Grampian Area Formulary.

Medications for neuropathic pain should have doses titrated up to the target dose/maximum tolerated dose and trialled for a sufficient period of time before benefit can be assessed.

- Where an agent is deemed not effective after appropriate length of trial at optimal dose (see Appendix 4 for details relating to duration of time to assess individual medicine efficacy) this should be reduced and stopped prior to initiating the trial of an alternative medication.
- Where an agent has been partially effective, but has not provided a sufficient level of pain relief or higher doses cannot be tolerated it may be appropriate to continue prescribing the first agent at the tolerated dose and consider the addition of a second agent.

Due to lack of evidence relating to their efficacy non-steroidal anti-inflammatory (NSAID) medications and nefopam should not be prescribed for neuropathic pain.

Prescribing of lidocaine medicated plasters for post-herpetic neuropathic pain (licensed indication) are included in this guidance. Primary care prescribing of lidocaine plasters for other, off-label indications, is not supported within NHS Grampian in line with NHS Scotland's guidance Achieving Value and Sustainability in Prescribing where lidocaine plasters are noted as a medicine with limited clinical value.

6.2. Prescribing For Neuropathic Pain (Excluding Trigeminal Neuralgia And Diabetic Peripheral Neuropathy)

Amitriptyline, duloxetine, gabapentin and pregabalin are the first line oral agents (NICE, 2020). Choice of agent to trial first will be dependent on individual patient, diagnosis and medication factors.

Patients with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments could trial capsaicin 0.075% cream (NICE, 2020).

Prescribers should be alert to the potential misuse of gabapentinoids as per MHRA Drug Safety Update.

Duloxetine use in conditions other than diabetic peripheral neuropathy would be off-label however its use is supported in NICE Clinical Guideline 173: Neuropathic pain in adults: pharmacological management in non-specialist settings.

Nortriptyline (off-label indication) can be considered as an alternative to amitriptyline, use is restricted to patients who have not achieved adequate pain relief from, or have not tolerated, conventional first, second and third-line treatments (i.e. amitriptyline, gabapentinoid and duloxetine trial). Nortriptyline may also be considered for patients who experience morning or persistent sedation with amitriptyline or for whom sedation should be avoided.

6.3. Prescribing For Trigeminal Neuralgia

Carbamazepine is the first line medication in trigeminal neuralgia.

Oxcarbazepine (off-label indication) can be considered as an alternative to carbamazepine for patients unable to tolerate carbamazepine.

If carbamazepine/oxcarbazepine is contra-indicated, not tolerated or an adequate response is not achieved, lamotrigine (off-label indication) or a gabapentinoid (see Section 6.2 above) can be considered.

Where carbamazepine/oxcarbazepine has **not been effective** it should be de-escalated whilst adding in another medication.

Where carbamazepine/oxcarbazepine has had **partial benefit** or higher doses are not tolerated, then another medication can be added after discussing potential interactions and side effects. This would usually be after specialist guidance.

6.4. Prescribing For Diabetic Peripheral Neuropathy

Duloxetine is the medication of choice in the management of diabetic peripheral neuropathy. (Please note, not all strengths of duloxetine are licensed for diabetic peripheral neuropathy but may be used during titration and de-escalation).

Treatment should be discontinued if there is inadequate response after two months.

If duloxetine is contra-indicated, not tolerated or an adequate response is not achieved, standard neuropathic pain treatments can be trialled, i.e. amitriptyline or a gabapentinoid (see Section 6.2 above).

For further information relating to prescribing for diabetic peripheral neuropathy please see Grampian Guidance: Peripheral Neuropathy in Diabetes.

6.5. Prescribing For Post-Herpetic Neuropathic Pain

Systemic agents should be used first line for post-herpetic neuropathic pain (see Section 6.2 above).

Lidocaine 5% medicated plasters may be trialled for patients who don't respond or are intolerant of first and second line systemic therapies for neuropathic pain (licensed indication).

6.6. Combination Prescribing

Where suitable agents have been individually trialled and have not achieved a suitable level of functionality, a combination of neuropathic pain medications can be considered to support patients (see Appendix 7).

Prescribing combinations should be undertaken with caution and consideration given to the benefit versus potential synergistic adverse effects of various combinations.

Medications being initiated should be started at a low dose and titrated upwards to maximum dose/maximum tolerated dose. Regular review of efficacy and side effects would be required.

Where a combination is deemed clinically appropriate to trial the decision on which medications to use would be based on the patient's previous response to medication. Where the currently prescribed medication is tolerated by the patient, addition of a second medication alongside this should be considered as the first-line combination.

Addition of weak opioids alongside other neuropathic analgesics should only be used in carefully selected and screened patients (SIGN 136) giving consideration to other prescribed medications, risk of respiratory depression, total opiate load and contraindications prior to prescribing taking place. Further guidance relating to this can be found in SIGN Guideline 136 and NICE Guideline 173

7. Monitoring And Review Of Patients With Neuropathic Pain

During initial management and dose titrations/medication trials patients should be reviewed a minimum of every four weeks. More frequent reviews may be required to assess ongoing medication titration/efficacy/tolerability, etc.

Patients who are well maintained on neuropathic pain medication (for a minimum of 6 months) may wish to consider de-escalating treatment (see Section 9 for further information) to assess ongoing benefit – with a view that patients should be taking the lowest possible dose of any medication for the shortest period of time. This should be discussed with stabilised patients at each review. Once stabilised on an effective dose of neuropathic pain medication without unacceptable side effects, it is recommended to continue for at least six months to prevent flare up. Patients should be reviewed at least annually. When de-escalation is attempted, it should be undertaken gradually with a clear and comprehensive plan in place for treatment of any exacerbation of symptoms.

8. Counselling For Patients With Neuropathic Pain

Details of condition being treated and understanding of neuropathic pain patient information leaflet accessible at Neuropathic Pain (Grampian Pain Management)

Treatment expectations:

- While treatment with pharmacological agents can support with the management of neuropathic pain, they will not eliminate it.
- Doses will need to be titrated so immediate benefits may not be felt. Once a maximum dose has been achieved, a number of weeks may still be required before benefits/optimal benefits achieved (4 to 6 weeks).
- Side effects of medications (will also be covered in patient information leaflets).

Self-management/non-pharmacological approaches are important in the management of pain and should be considered and encouraged alongside any pharmacological management (Grampian Pain Management). Engagement with non-pharmacological options, alongside pain medication may result in better achievement of pain reduction goals.

Regular reviews of pain and medication will be part of ongoing management, and there is potential in future to consider a trial of de-escalating medications to assess underlying pain and ongoing benefits of medication.

9. De-escalation Of Neuropathic Pain Medications

Regular reviews of neuropathic pain and medication may allow for the opportunity to consider a trial de-escalation of neuropathic pain medication(s) to assess ongoing benefit. Any decision to de-escalate medications should be made in partnership with the patient and planned in advance. There should be a clear understanding that de-escalation may not mean a cessation of pain medications, but a reduction in dose required.

As with the initiation of neuropathic pain medications, de-escalation should be done in a stepwise manner, with doses being tapered down allowing time to assess response and withdrawal at each stage.

See Appendix 6 for suggested de-escalation protocols for neuropathic pain medications.

10. Referral To Specialist Services

10.1. Specialist Pain Services

While it is expected and reasonable that neuropathic pain would be managed in a non-specialist Primary Care setting, below provides a number of circumstances where it would be appropriate to refer a patient to either the specialist pain service or appropriate medical speciality:

- Pain of unknown aetiology, or
- Severe pain (as per SIGN 136, pain that significantly limits lifestyle or participation in daily activities including sleep disturbance), or
- Worsening pain despite treatment (medications trialled at adequate dose for reasonable duration to assess benefit), or
- Conventional therapies, including combination treatments have provided sub-optimal symptom management (after reasonable trial period at therapeutic/tolerated dose) or
- Psychological distress, or
- Cancer pain, or
- Potential central neuropathic pain.

10.2. Specialist Neurology Services

With the exception of controlled classical trigeminal neuralgia all adult patients should be referred to neurology specialist services. All young patients should be referred.

11. References

- International Association for the Study of Pain (IASP) (2023) Terminology | International Association for the Study of Pain.
- painDETECT: a new screening questionnaire to identify neuropathic components in patients with back pain - PubMed (nih.gov)
- National Institute of Clinical Excellence [NICE] (2020) "Neuropathic pain in adults: Pharmacological management in non-specialist settings,"
- sign136_2019.pdf
- Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (nice.org.uk)
- International Association for the Study of Pain | IASP (iasp-pain.org)
- LANSS Scale for Neuropathic Pain Questionnaire Calculator
- Neuropathic pain: a pathway for care developed by the British Pain Society - British Journal of Anaesthesia (bjanaesthesia.org)
- Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0
- Trigeminal neuralgia: a practical guide (bmj.com)
- RCS: Guidelines for the management of trigeminal neuralgia 2021
- Quality Prescribing for Chronic Pain 2026-2029
- Achieving Value and Sustainability in Prescribing

12. Patient Information

- PAT136_2019 (sign.ac.uk)
- Grampian Pain Management Website
- Neuropathic Pain Leaflet
- Gabapentinoid Reduction – Patient Information Leaflet
- Pain Association Scotland
- NHS Inform: Chronic Pain

Appendix 1: S-LANSS Pain Score

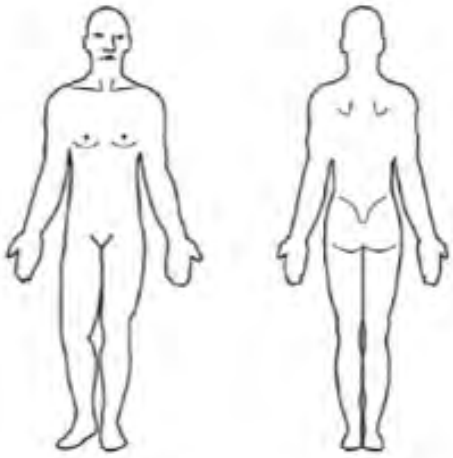
Also available online via [Right Decisions Service]

The S-LANSS Pain Score

Leeds Assessment of Neuropathic Symptoms and Signs (self-complete)

Name_____ **Date**_____

- This questionnaire can tell us about the type of pain that you may be experiencing. This can help in deciding how best to treat it.
- Please draw on the diagram below where you feel your pain. If you have pain in more than one area, **only shade in the one main area where your worst pain is.**



- On the scale below, please indicate how bad your pain (that you have shown on the above diagram) has been in the last week where:
  '0' means no pain and '10' means pain as severe as it could be.

NONE 0 1 2 3 4 5 6 7 8 9 10 **SEVERE PAIN**

- On the other side of the page are 7 questions about your pain (the one in the diagram).
- Think about how your pain that you showed in the diagram has felt **over the last week.** Please circle the descriptions that best match your pain. These descriptions may, or may not, match your pain no matter how severe it feels.
- Only circle the responses that describe your pain. **Please turn over.**

S-LANSS

1. **In the area where you have pain, do you also have 'pins and needles', tingling or prickling sensations?**

a)	NO – I don't get these sensations	(0)
b)	YES – I get these sensations often	(5)

2. **Does the painful area change colour (perhaps looks mottled or more red) when the pain is particularly bad?**

a)	NO – The pain does not affect the colour of my skin	(0)
b)	YES – I have noticed that the pain does make my skin look different from normal	(5)

3. **Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this**

a)	NO – The pain does not make my skin that area abnormally sensitive to touch	(0)
b)	YES – My skin in that area is particularly sensitive to touch	(3)

4. **Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like 'electric shocks', jumping and bursting might describe this.**

a)	NO – My pain doesn't really feel like this	(0)
b)	YES – I get these sensations often	(2)

5. **In the area where you have pain, does your skin feel unusually hot like a burning pain?**

a)	NO – I don't have burning pain	(0)
b)	YES – I get burning pain often	(1)

6. **Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area?**

a)	The painful area feels no different from the non-painful area	(0)
b)	I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area	(5)

7. **Gently press on the painful area with your finger tip then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?**

a)	The painful area does not different from the non-painful area	(0)
b)	I feel numbness or tenderness in the painful area that is different from the non-painful area	(3)

Scoring: a score of 12 or more suggests pain of predominantly neuropathic origin

Source: [Strategy-Chronic-Pain-Resources-SLANNS-tool.docx (live.com)]

Appendix 2: Douleur Neuropathique 4 Questions (DN4)

Answer the four questions below with yes or no for each item. Yes = 1, No = 0

Scores of 4 or greater indicate neuropathic pain

Patient Interview	
Does your pain present one or more of the following characteristics:	
Pain feels like burning	Yes/No
Sensation of painful cold	Yes/No
Pain feels like electric shocks	Yes/No
In the same area, is your pain associated with one or more of the following symptoms:	
Tingling	Yes/No
Pins and needles	Yes/No
Numbness	Yes/No
Itching	Yes/No
Patient Examination	
Is the pain located in an area where the exam unveils:	
Hypoesthesia to touch	Yes/No
Hypoesthesia to pin prick	Yes/No
Is the pain provoked or increased by	
Brushing	Yes/No

Count of 'Yes'	

Scores of 4 or greater indicate neuropathic pain

Appendix 3: painDETECT questionnaire

Table 1. painDETECT questionnaire

Item	Score
*Gradation of pain**	
• Do you suffer from a burning sensation (e.g. stinging nettles) in the marked areas?	0–5
• Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)?	0–5
• Is light touching (clothing, a blanket) in this area painful?	0–5
• Do you have sudden pain attacks in the area of your pain, like electric shocks?	0–5
• Is cold or heat (bath water) in this area occasionally painful?	0–5
• Do you suffer from a sensation of numbness in the areas that you marked?	0–5
• Does slight pressure in this area, e.g. with a finger, trigger pain?	0–5
Pain course pattern	
Please select the picture that best describes the course of your pain:	
 Persistent pain with slight fluctuations	0
 Persistent pain with pain attacks	–1
 Pain attacks without pain between them	+1
 Pain attacks with pain between them	+1
Radiating pain	
Does your pain radiate to other regions of your body? Yes/No	+2/0

*For each question: never, 0; hardly noticed, 1; slightly, 2; moderately, 3; strongly, 4; very strongly, 5
Questions used to document pain, but which were not used in the scoring, are not shown

Source: [painDETECT: a new screening questionnaire to identify neuropathic components in patients with back pain (tandfonline.com)]

Appendix 4: Neuropathic Pain Medications

See Appendix 5 for suggested dose titration schedules.

**Total Daily Target Doses stated below may not be appropriate for all patients. Maximum tolerated doses may be lower than Total Daily Target Doses due to individual patient, condition and medication factors.

Medication	**License** (Related to neuropathic pain, other indications not listed)	**Dose/frequency**	**Total Daily Target Dose****	**Time to assess efficacy**
Amitriptyline	Neuropathic pain in adults.	Taken once daily at night.	50mg daily	4 to 6 weeks
Capsaicin cream (0.075% strength only)	1. For the symptomatic relief of neuralgia associated with and following Herpes Zoster infections (post-herpetic neuralgia) after open skin lesions have healed. 2. For the symptomatic management of painful diabetic peripheral polyneuropathy.	Apply to the affected area 3 or 4 times daily.	Apply only a small amount of cream (pea size) to the affected area 3 or 4 times daily.	6 weeks
Carbamazepine	The paroxysmal pain of trigeminal neuralgia.	Taken twice daily.	1200mg daily	4 to 6 weeks
Duloxetine	Treatment of diabetic peripheral neuropathic pain. Off-label use in other neuropathic pain.	Taken once daily.	120mg daily	2 weeks
Gabapentin	Peripheral neuropathic pain.	Taken three times daily (once titrated)	1800mg daily	4 to 6 weeks
Lamotrigine	Off-label use in trigeminal neuralgia.	Taken twice daily	200mg daily	4 to 6 weeks

Medication	**License** (Related to neuropathic pain, other indications not listed)	**Dose/frequency**	**Total Daily Target Dose****	**Time to assess efficacy**
Lidocaine Medicated Plasters	Symptomatic relief of neuropathic pain associated with previous herpes zoster infection (post-herpetic neuralgia, PHN) in adults.	The painful area should be covered with the plaster once daily for up to 12 hours within a 24 hours period.	Only the number of plasters that are needed for an effective treatment should be used. When needed, the plasters may be cut into smaller sizes	2 to 4 weeks
Nortriptyline	Off-label use in neuropathic pain.	Taken once daily at night.	50mg daily	4 to 6 weeks
Oxcarbazepine	Off-label use in neuropathic pain.	Taken twice daily	1800mg daily	4 to 6 weeks
Pregabalin	Peripheral and central neuropathic pain in adults.	Taken twice daily.	300mg daily	4 to 6 weeks

Appendix 5: Dose Titration Information

The information below should be used as a guide only as titration of doses will vary depending on the patient, and titration may be done a stepwise manner to assess benefits and tolerability. Not all patients will require the maximum dose.

Full information pertaining to medications can be found using the BNF and EMC.

Aim: lowest effective dose to relieve pain and ensure tolerability for the shortest period of time.

Amitriptyline

Doses can be increased in 10mg increments every 7 days dependant on tolerability.

Dose can be increased to a maximum of 1mg/kg dependant on tolerability.

Dose	Duration
10mg at night	Minimum 1 week
20mg at night	
30mg at night	
40mg at night	
50mg at night	

Carbamazepine

Slow initial titration until freedom of pain is achieved. In the majority of patients a dosage of 800mg daily (in divided doses) is sufficient to maintain a pain free state.

Higher doses should be under supervision of specialist service.

Doses may need to be reduced in the elderly.

Dose titration below is suggested for twice daily dosing. Depending on individual patient factors there may be a requirement to split the total daily dose into three or four daily doses.

Dose	Total daily dose	Duration
100mg twice daily	200mg	Minimum one week
200mg twice daily	400mg	
300mg twice daily	600mg	
400mg twice daily	800mg	
500mg twice daily	1000mg	
600mg twice daily	1200mg	Maximum recommended dose

Duloxetine

Dose	Duration
Starting dose: 30mg daily	Minimum 2 weeks
60mg daily	
30mg morning and 60mg at night	
60mg twice daily	Maximum recommended dose

Gabapentin

Dose increments of 100mg three times daily, weekly, with a target dose of 600mg three times daily. Titration can be faster or slower depending on tolerability and patient specific factors.

Dose could be increased to 900mg three times daily dependant on need and tolerability.

Dose	Duration
Week one	Minimum 1 week
100mg three times daily	
Week two	
200mg three times daily	
Week 3	
300mg three times daily	
Week 4	
400mg three times daily	
Week 5	
500mg three times daily	
Week 6	
600mg three times daily	

Lamotrigine

Use should be under specialist guidance only.

Titration schedules should be adhered to due to risk of hypersensitivity syndrome/Steven Johnstone syndrome.

Dose	Duration
25mg daily	Minimum two weeks
50mg daily	
25mg morning and 50mg at night	
50mg twice daily	
50mg morning and 100mg at night	
100mg twice daily	

Oxcarbazepine

Slower titration of 150mg twice daily increments can be used depending on tolerability and patient specific factors.

Dose	Duration
300mg twice daily	Minimum two weeks
600mg twice daily	
900mg twice daily	

Pregabalin

Dose increments of 25mg twice daily, every 1 to 2 weeks, with a target dose of 150mg twice daily. Titration can be faster or slower depending on tolerability and patient specific factors.

Dose could be increased to 300mg twice daily dependant on need and tolerability

Dose	Duration
Week one	Minimum 1 to 2 weeks
25mg twice daily	
Week two	
50mg twice daily	
Week 3	
75mg twice daily	
Week 4	
100mg twice daily	
Week 5	
125mg twice daily	
Week 6	
150mg twice daily	

Appendix 6: Medication Reduction Regimens

Amitriptyline reduction

From BNF: The risk of withdrawal symptoms is increased if the antidepressant is stopped suddenly after regular administration for 8 weeks or more.

The dose should preferably be reduced gradually reducing in 10mg increments weekly, or longer if withdrawal symptoms emerge.

If possible tricyclic and related antidepressants should be withdrawn slowly.

Carbamazepine reduction

From BNF: Reduce the dose gradually over a period of at least 4 weeks.

Duloxetine reduction

From BNF: Dose should be reduced over at least 1 to 2 weeks.

Gabapentinoid reduction regimens

Taken from Effective Prescribing and Therapeutics Chronic Pain Prescribing Strategy**:** Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0

Gabapentin

Suggested Gabapentin Reduction Regime from 1200mg Three Times Per Day

Gabapentin	Morning	Afternoon	Night	No. 300mg capsules required per week
Week 1	1200mg (i.e. 4 x 300mg)	900mg (i.e. 3 x 300mg)	1200mg (i.e. 4 x 300mg)	77
Week 2	900mg	900mg	1200mg	70
Week 3	900mg	900mg	900mg	63
Week 4	900mg	600mg	900mg	56
Week 5	600mg	600mg	900mg	49
Week 6	600mg	600mg	600mg	42
Week 7	600mg	300mg	600mg	35
Week 8	300mg	300mg	600mg	28
Week 9	300mg	300mg	300mg	21
Week 10	300mg	-	300mg	14
Week 11	-	-	300mg	7

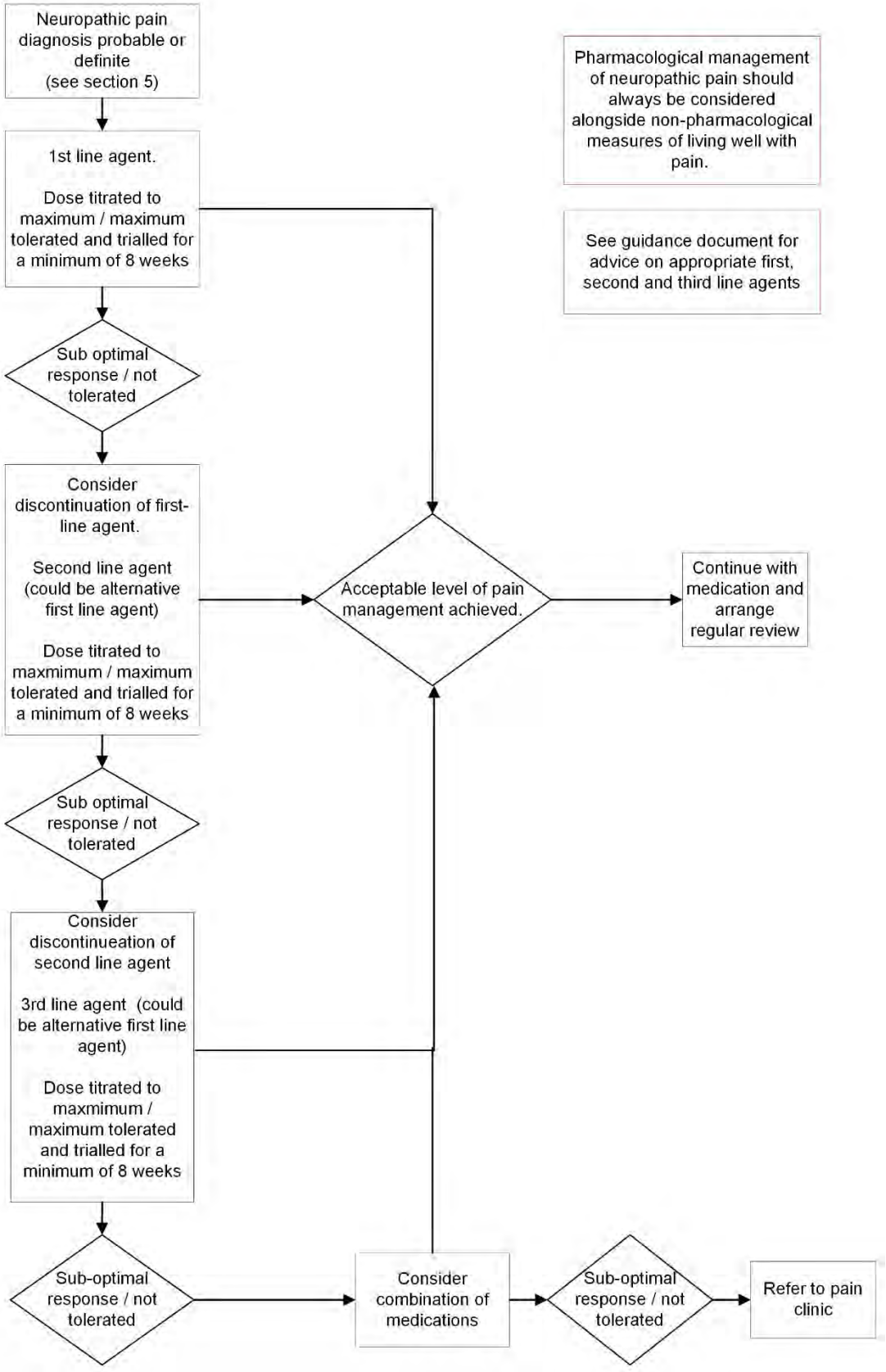
Pregabalin

Suggested Pregabalin Reduction From 300mg Twice Daily

Pregabalin	Morning	Afternoon
Week 1	250mg	300mg
Week 2	250mg	250mg
Week 3	200mg	250mg
Week 4	200mg	200mg
Week 5	150mg	200mg
Week 6	150mg	150mg
Week 7	100mg	150mg
Week 8	100mg	100mg
Week 9	50mg	100mg
Week 10	50mg	50mg
Week 11	25mg	25mg
Week 12	-	25mg

In practice, reducing regime may be adjusted depending on individual response and degree of associated risk.

Appendix 7: Neuropathic Pain (NP) Primary Care Pharmacological Management Flowchart



Appendix 8: Neuropathic Pain Medication Choices