Management of neuropathic pain (non-malignant)

Medicines Initiation Protocol

Introduction

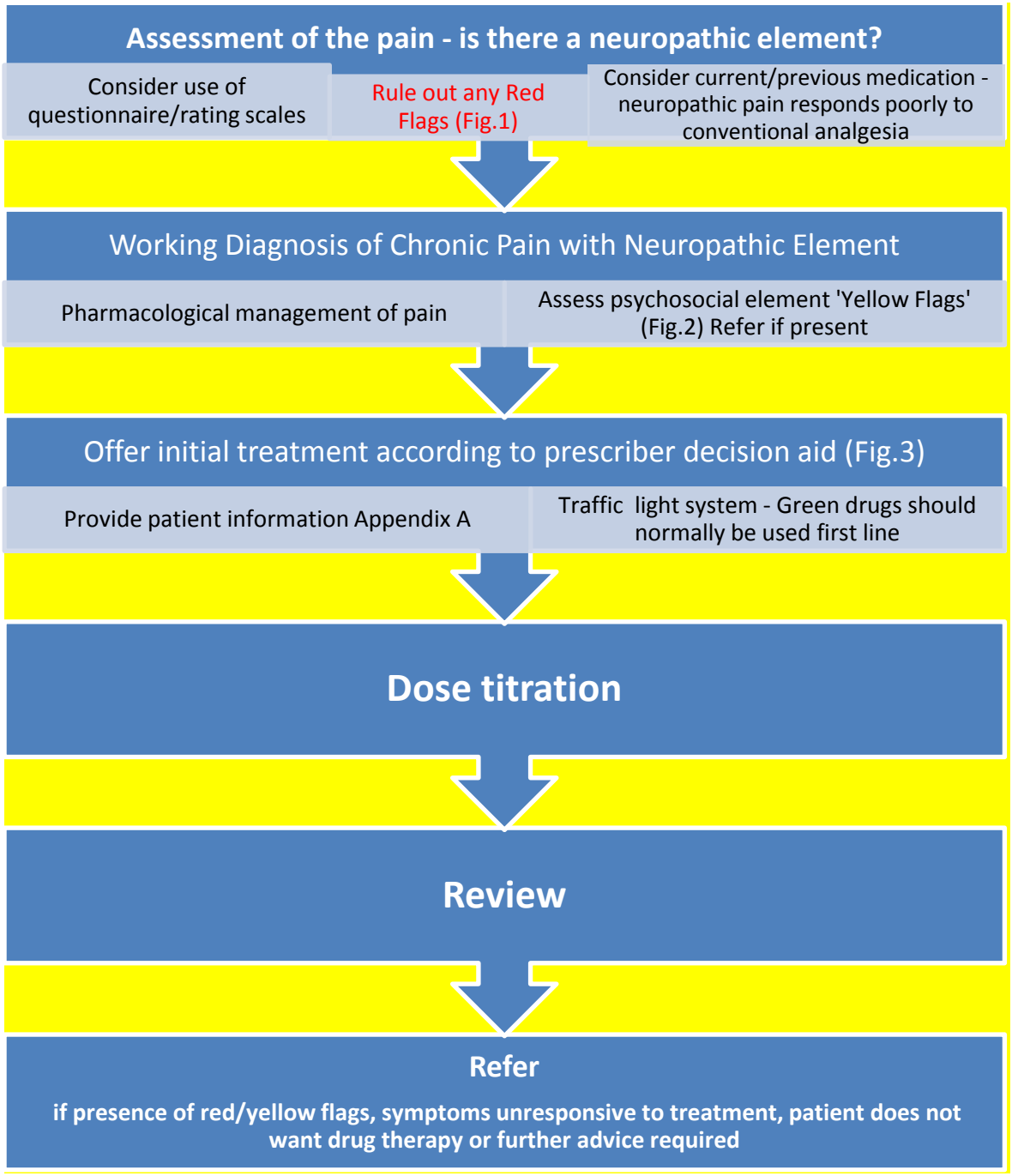
- Pain is one of the most common reasons that patients present to Primary Care
- It is known that there are widespread changes within the nervous system that give rise to persistent pain.
- According to the British Pain Society, one in seven people is thought to suffer from persistent pain and twenty percent of those report suffering for more than 20 years. People with pain consult their doctor up to five times more frequently than others, resulting in nearly 5 million GP appointments each year.
- Poorly managed chronic pain can affect quality of life for sufferers and their carers, leading to helplessness, isolation, depression and family breakdown.

Recommendations

- This guidance is intended to guide management and recommendations are based on established practice throughout the UK and relevant NICE guidance.
- Chronic pain is a bio-psychosocial problem. Chronicity of pain may cause complexity, both neuropathic and psychosocial.
- **It should be emphasised that medicines play only a minor part in managing persistent pain (30-50% reduction at best).** Patient expectation should be managed at the outset of treatment. Any medication is offered on a trial basis, it will be withdrawn unless there is a good reason to continue due to the long term risks of dependency, memory problems, unsteadiness and weight gain.
- Sleep is important in helping patient to manage their pain.
- Maintaining fitness, pacing activities and a generally healthy lifestyle are important. Non-pharmacological methods of pain relief such as TENS, acupuncture, physical methods for the reduction of muscle spasm are equally important.
- All patients with chronic pain should have psychosocial issues considered earlier rather than later 'Yellow Flags'
- All patients should be screened for common mental health problems that may result from experiencing difficult to control pain.

The following process diagram summarises the pathway to be followed when suspecting a pain problem with a neuropathic element.

Further detail on each step in the pathway can be found later in the document.



Assessment of the problem

Neuropathic pain is very challenging to manage because of the heterogeneity of its aetiologies, symptoms and underlying mechanisms. There are many possible causes of neuropathic pain. Most common causes of neuropathic pain are **diabetes, herpes zoster, trigeminal neuralgia and surgery** e.g. post hernia repair. Intensive treatment of Diabetes Mellitus (including lipids, blood pressure and glycaemic control) may reduce the development and progression of diabetic painful peripheral neuropathy and should be considered as part of a multidisciplinary holistic approach to patient care.

However, because many pain types can have a component of neuropathic (nerve) pain it is important to think about whether this is the case when assessing patients' pain. There are a

number of clues that can help with this, many of which depend on how the pain is felt and what character it has.

There is often uncertainty regarding the nature and exact location of a lesion or health condition associated with neuropathic pain, particularly in non-specialist settings. Neuropathic pain can be intermittent or constant, and spontaneous or provoked. Typical descriptions of the pain include terms such as shooting, stabbing, like an electric shock, burning, tingling, tight, numb, prickling, itching and a sensation of pins and needles. Some of these symptoms and descriptors are drawn together in questionnaires that can be useful in assessing pain, such as the **McGill Pain Questionnaire** or a simpler questionnaire derived from it called the **Short-Form McGill Pain Questionnaire**.

There are also several useful rating scales which can be helpful in making this assessment. In particular, the **PainDETECT** scale, **DN4** (Douleur Neuropathique 4) and **Leeds Assessment of Neuropathic Symptoms Scales** (LANSS or s-LANSS).

It is also very important to make an assessment of the effect the pain is having on the person's **lifestyle, daily activities (including sleep disturbance) and participation.**

Consider **medication** the patient is currently taking or has been tried already. Neuropathic pain often responds poorly to conventional analgesia.

Rule out any red flags. Red flags are clinical indicators of possible serious underlying conditions requiring further medical intervention. Red flags were designed for use in acute low back pain, but the underlying concept can be applied more broadly in the search for serious underlying pathology in any pain presentation.

Differential diagnosis	Red Flags from patient history	Red Flags from examination
Possible fracture	• Major trauma • Minor trauma in elderly or osteoporotic	• Evidence of neurological deficit (in legs or perineum in the case of low back pain) • Screening with blood tests and other investigations
Possible tumour, infection or inflammation	• Age < 20 or > 50 years old • History of cancer • Constitutional symptoms (fever, chills, weight loss) • Recent bacterial infection • Intravenous drug use • Immunosuppression • Pain worsening at night or when supine • Undiagnosed chronic inflammatory cause	
Possible significant neurological deficit	• Severe or progressive sensory alteration or weakness • Bladder or bowel dysfunction	

Figure 1. **Red flags** - clinical indicators of possible serious underlying conditions requiring further medical intervention

Assessment of psychosocial element

Once a working diagnosis of chronic pain with neuropathic element has been established, assess the effect the pain is having on the person's lifestyle, daily activities (including sleep disturbance) and participation (if not already undertaken) and screen for yellow flags (Figure 2.). **Yellow Flags** are psychosocial factors associated with unfavourable clinical outcomes and the transition to persistent pain and disability. They also flag other factors relating to perceptions about the relationship between work and health, which are associated with reduced ability to work and prolonged absence.

If yellow flags are identified, consider discussing options with pain management services. Early intervention is associated with better outcomes and patients should be strongly encouraged to engage with support programmes (including pain rehabilitation).

There is a lot of information and self-help resources that patients can access to support them to live with chronic pain http://www.nhs.uk/Livewell/Pain/Pages/Painhome.aspx http://chronicpainscotland.org/patients-area/living-well-with-chronic-pain/
These resources include information on Exercise and Activity, Dealing with Stress and relaxation, and Workplace issues/advice

Coping strategies for pain management can also be found on this site www.paintoolkit.org

Signposting to support services for patients with financial difficulties may also be helpful http://www.adviceguide.org.uk/england/debt_e.htm https://www.moneyadviceservice.org.uk/en/tools/debt-advice-locator

Attitudes and Beliefs	• Pain is harmful or severely disabling • Expectation that passive treatment rather than active treatment may help • Feeling that 'no-one believes the pain is real' –may relate to previous encounters with healthcare professionals
Emotions and Behaviour	• Fear-avoidance behaviour (avoiding activity due to fear of pain) • Low mood and social withdrawal • Lack of job satisfaction
Other psychosocial factors	• Poor family relationships or history of abusive relationships • Financial concerns particularly related to ill-health or ongoing pain • Poor social support from colleagues • Company policy on sick leave • Threats to financial security (e.g. benefit changes) • Ongoing litigation related to persistent pain problem • Lack of contact with work

Figure 2. **Yellow flags** – indicators of a psychosocial element

Offer pharmacological treatment

Neuropathic pain not responding to simple analgesia and with symptoms such as sleep disturbances, depression and interference with normal daily activities should be treated according to the prescriber decision aid below (Figure 3).

Offer a choice of amitriptyline, duloxetine or gabapentin as initial treatment. Treatment should be chosen based on individual patient factors and acquisition cost of the medicine (see Table 1 below). Pregabalin should usually be reserved for prescribing following discussion of options with a specialist. A prescribing decision aid has been devised to support this process (Figure 3).

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 (patient information leaflets available in Appendix A)
- 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).

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. When introducing a new treatment, take into account any overlap with the old treatments to avoid deterioration in pain control. Taper the dose of the drug to be withdrawn to prevent discontinuation symptoms. Clinical Knowledge Summaries has Prescribing information for additional information on starting and withdrawing drug treatments. Specific information for pregabalin withdrawal can be found in the East Sussex Pregabalin Review Protocol.

mitriptyline 1st line	Gabapentin 1st line	Capsaicin cream 0.075% 1st line	Duloxetine 2nd line	Pregabalin Specialist recommendation
Helpful if patient has problems with sleep	**Helpful where pain described as burning, shooting, stabbing, pricking**	**Helpful for localised pain**	**Helpful if patient also requires antidepressant**	**Helpful where pain described as burning, shooting, stabbing, pricking**
Best taken in the evening to reduce 'hangover effect' e.g. 6-8pm	Median effective dose is 600mg three times daily	Patients who do not wish to take oral medicine	Very low risk of diversion/abuse, therefore useful in patients with history of substance misuse	Median effective dose is 150mg twice daily
Consider nortriptyline if excess sedation occurs	Reduce dose in renal impairment	Patients who cannot tolerate oral medicines	No dose titration necessary	Reduce dose in renal impairment
Analgesic effect is separate from antidepressant effect	Avoid in patients with memory problems		Nausea common on initiation	Avoid in patients with memory problems
Median effective dose is 25-50mg daily	Some indications unlicensed		Some indications unlicensed	Some indications unlicensed
Unlicensed indication*	Consider risk of falls in elderly patients			Consider risk of falls in elderly patients
Consider risk of falls in elderly patients	Avoid in patients with active history of substance misuse			Avoid in patients with active history of substance misuse
	**Risk of suicidal ideation			**Risk of suicidal ideation

Figure3. Prescriber Decision Aid

***NICE guidance re off label use.** 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. 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.

****Risk of suicidal ideation.** Treatment with any anticonvulsant drug increases the risk of suicidal ideation and behaviour in all patient groups, regardless of prescribed indication, as early as one week after starting treatment. All patients should be monitored for signs of depression and/or suicidal ideation throughout treatment and particular care should be taken when prescribing these drugs in those with a history of mental health disorder and/or suicidal behaviour.

Dose titration regimens

It is necessary to titrate up to the median effective dose in order to reduce the incidence of side effects. Please provide written information for the patient to support this process (Appendix A)

Amitriptyline/Nortriptyline

Week 1	Week 2	Week 3	Week 4	Week 5
10mg	20mg	30mg	40mg	50mg

- Slowly titrate to reduce side-effects but ensure titration occurs even if dose is later reduced.
- Median effective dose is 25-50mg daily.
- Normal maximum dose is 50mg daily but up to 75mg can be used if patient is deriving benefit with limited side-effects

Gabapentin – Standard Titration

	Day 1	Day 4	Day 7	Day 10	Day 13	Day 16
Morning		100mg	100mg	100mg	300mg	300mg
Midday			100mg	100mg	100mg	300mg
Night	100mg	100mg	100mg	300mg	300mg	300mg

Gabapentin – Rapid Titration

	Day 1	Day 4	Day 7	Day 10	Day 13	Day 16
Morning		300mg	300mg	300mg	600mg	600mg
Midday			300mg	300mg	300mg	600mg
Night	300mg	300mg	300mg	600mg	600mg	600mg

- A longer titration starting at initial lower dose may be required depending on the patient's general health.
- Dosage will need to be reduced in patients with renal impairment. Access Prescribing information (Clinical Knowledge Summaries) for additional information.
- Median effective dose is 600mg three times daily
- Continue increasing as above to maximum 1200mg three times a day – determined by efficacy and side-effects (especially unsteadiness, drowsiness).
- May need to wait up to 2 weeks to experience maximum benefit, a therapeutic trial of 8 weeks at median effective dose is required before assessment of efficacy can be undertaken

Pregabalin – Standard Titration

	Day 1	Day 4	Day 7	Day 10	Day 13	Day 16
Morning		25mg	25mg	50mg	50mg	75mg
Night	25mg	25mg	50mg	50mg	75mg	75mg
	Day 19	**Day 22**	**Day 25**	**Day 28**	**Day 31**	**Maintenance**
Morning	75mg	100mg	100mg	125mg	125mg	150mg
Night	100mg	100mg	125mg	125mg	150mg	150mg

Pregabalin – Rapid Titration

	Day 1	Day 4	Day 7	Day 10
Morning		75mg	75mg	150mg
Night	75mg	75mg	150mg	150mg

- Pregabalin should only be used if gabapentin gives good effect but side-effects cannot be tolerated. Pregabalin should normally be considered following discussion of options with a specialist.
- Consider the potential for misuse before prescribing pregabalin. There are published reports of both pregabalin and gabapentin abuse, particularly in the substance misuse population. Also consider the potential for illicit diversion either by choice or through coercion.
- A longer titration starting at initial lower dose may be required depending on the patient's general health and previous susceptibility to side effects
- Dosage will need to be reduced in patients with renal impairment. Access Prescribing information (Clinical Knowledge Summaries) for additional information.
- Median effective dose is 150mg twice daily
- Continue increasing as above to maximum 300mg twice a day – determined by efficacy and side-effects (especially unsteadiness, drowsiness).
- May need to wait up to 2 weeks to experience maximum benefit, a therapeutic trial of 8 weeks at median effective dose is required before assessment of efficacy can be undertaken
- Ensure the dose is optimised to TWICE a day (BD) dosing, rather than THREE times a day (TDS), as this is more cost effective. It also limits the amount of medication available for illicit diversion.
- Avoid double dosing e.g. 2 twice daily as this increases costs due to the flat pricing structure of pregabalin

Combination therapy

Combination therapy is commonly prescribed for neuropathic pain. It may also be a helpful option as a stepwise approach if initially used drugs are insufficient at reducing pain. Combination therapy may also result in better tolerability because smaller doses of individual drugs are often used when combined with other drugs. However, there is a lack of trial evidence comparing the clinical and cost effectiveness and tolerability of different drug combinations.

Review

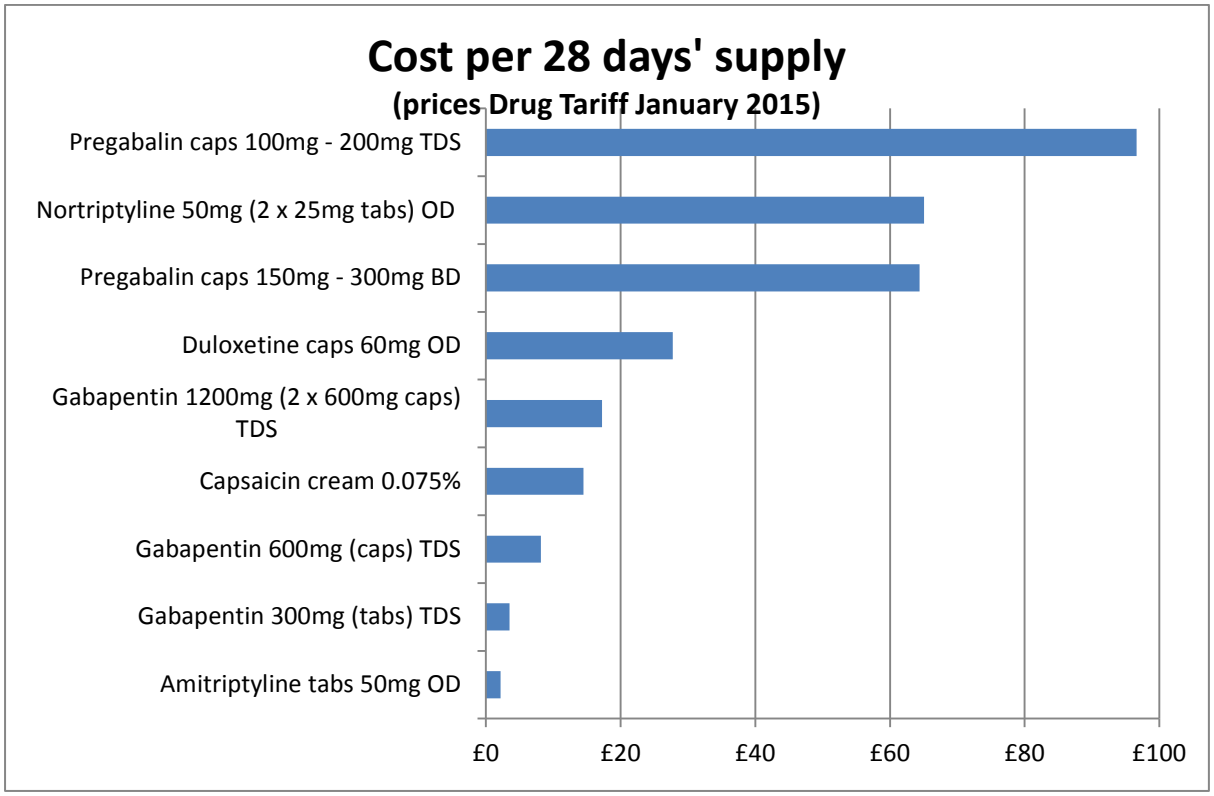
All patients should have regular clinical reviews, and have early reviews following medication changes. Once satisfactory pain control is achieved with any medication, treatment should then be continued. If improvement is sustained consideration may be given to reducing the dose gradually over time following consultation with the patient.

- Improve safety by undertaking regular review initially.
- Eight weeks is accepted as being an appropriate time to trial neuromodulatory medication, however, it should be 8 weeks ON the median effective dose, i.e. gabapentin 600mg tds; or pregabalin 150mg bd, or amitriptyline 25mg-50mg.
- If the drug is effective, continue for 6 months then wean to assess whether it is still required.
- Following this the drug should be reviewed at least annually.

Additional support

Consider contacting a specialist for discussion of options (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 or
- Red/Yellow Flags
- Patient's symptoms are unresponsive to treatment
- Patient does not want drug therapy
- Further advice required for particular clinical symptom set



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Amitriptyline

Amitriptyline is a medicine that was originally developed for treatment of depression, and consequently found to be effective in pain relief. You may find that the medication leaflet supplied with your amitriptyline only gives information about the use of this drug in depression.

It works by altering the way in which nerves send messages to the brain; this is often useful in chronic pain which can be aggravated by changes in the nervous system. This results in pain signals being sent to the brain when no actual damage is occurring in the painful area; this is known as neuropathic pain.

You should notice that your pain starts to improve after one to two weeks on amitriptyline. Because every patient is different, it is difficult to prescribe the ideal dose, therefore you have to start at a low dose and carefully increase the dose as explained below until you achieve 30-50% pain relief with least side effects.

How do I take Amitriptyline and how do I titrate up to my ideal dose?

Amitriptyline tablets come in different strengths, and are usually taken **at night**. We initially prescribe 10mg tablets and you should take the tablets 1-2 hours before sleep time. Take the dose regularly every day.

Your dose of amitriptyline may be slowly increased to between 50-75mg a day depending on how helpful it is for your pain. Most people need between 25-50mg to help them with their pain.

Amitriptyline/Nortriptyline

Week 1	Week 2	Week 3	Week 4	Week 5
10mg	20mg	30mg	40mg	50mg

Once you reach a dose that gives you pain relief without troublesome side effects then this is your ideal dose and your GP can put this on your repeat prescription.

What do I do if I get side effects?

All drugs have side effects, but they do not happen in all the people who take them. The most common side effects of amitriptyline are:

- Drowsiness
- Unsteadiness (risk of falls)
- Dry mouth
- Constipation
- Tiredness

Some people develop blurred vision or problems passing urine.

Most of these side effects usually reduce or disappear after taking the same dose for a few days, so it is worth trying to carry on with the amitriptyline.

How to manage side effects:

- Dry mouth – Drink more non-alcoholic drinks; chewing also increases saliva in the mouth
- Constipation - Drink more non-alcoholic drinks and eat plenty of fibre containing foods and fruit and vegetables

A common side effect of amitriptyline is drowsiness. If you are drowsy you should not drive or operate machinery.

Drinking alcohol may make you more drowsy, restrict alcohol intake to 1-2 units per day (1 unit=1/2 pint beer or lager, small glass wine or measure of spirit)

Can I stop Amitriptyline suddenly?
You can stop taking this medicine if you wish, however stopping abruptly may make you unwell, especially if you have been on it for a while, or are on a large dose. We recommend that you slowly reduce the dose over several weeks; should you feel unwell, consult your doctor.

How long will I have to take Amitriptyline for?
If the amitriptyline is helpful, you will be asked to continue with it for up to six months. Your treatment will be reviewed by either the pain clinic or your GP. Amitriptyline will be prescribed on a trial basis. Unless there is good reason to continue, treatment will be stopped after this time due to the risks associated with long term use of this medicine. There is no possibility of you becoming addicted to it. It is also important that you continue to take your other regular painkillers, unless you have been advised to stop taking these by your doctor.

Is it safe for me to take other medicines whilst I'm receiving treatment with amitriptyline?
Before you take or buy any new medicines, including herbal remedies, tell your doctor or pharmacist that you are taking amitriptyline and ask their advice.

What should I do if I forget to take a dose?
If you forget to take your dose that night, skip the missed dose and take your medication as normal. Do not take your amitriptyline in the daytime or try to 'double up' to make up for your missed dose.

Can I drink alcohol whilst taking Amitriptyline?
Drinking alcohol may make you more drowsy, restrict alcohol intake to 1-2 units per day (1 unit=1/2 pint beer or lager, small glass wine or measure of spirit). Consider avoiding alcohol if drowsiness is a particular issue for you.

Is it safe for me to drive whilst I'm taking Amitriptyline?
A common side effect of amitriptyline is drowsiness. If you are drowsy you should not drive or operate machinery.

Remember:

Never give your prescribed tablets to other people as they may not be safe for them to take. Any leftover tablets should be taken to your local pharmacy for safe disposal.

Gabapentin

Gabapentin is a licensed painkiller that was originally developed for treatment of epilepsy, and consequently found to be effective in pain relief. It works by altering the way in which nerves send messages to the brain (similar to rubbing your self after an injury); this is often useful in chronic pain which can be aggravated by changes in the nervous system. This results in pain signals being sent to the brain when no actual damage is occurring in the painful area; this is known as neuropathic pain.

You should notice that your pain starts to improve after one to two weeks on Gabapentin. Because every patient is different, it is difficult to prescribe the ideal dose, therefore you have to start at a low dose and carefully increase the dose as explained below until you achieve 30-50% pain relief with least side effects.

How do I take Gabapentin and how do I titrate up to my ideal dose?

Gabapentin capsules come in various strengths, and are usually taken **three times a day**. We initially prescribe 100mg or 300mg capsules and you should take: (as shown in the table below).

- Days one, two and three; take one capsule in the evening.
- Days four, five and six; take one capsule in the morning and one in the evening.
- Days seven, eight and nine; take one capsule in the morning, one at lunchtime, and one in the evening.

Gabapentin – Standard Titration

	Day 1-3	Day 4-6	Day 7-9	Day 10-12	Day 13-15	Day 16-18
Morning		100mg	100mg	100mg	300mg	300mg
Midday			100mg	100mg	100mg	300mg
Night	100mg	100mg	100mg	300mg	300mg	300mg

Gabapentin – Rapid Titration

	Day 1-3	Day 4-6	Day 7-9	Day 10-12	Day 13-15	Day 16-18
Morning		300mg	300mg	300mg	600mg	600mg
Midday			300mg	300mg	300mg	600mg
Night	300mg	300mg	300mg	600mg	600mg	600mg

Once you reach a dose that gives you pain relief without troublesome side effects then this is your ideal dose and your GP can put this on your repeat prescription.

Do not exceed 1800mg a day without consulting your Doctor.

What do I do if I get side effects?
All drugs have side effects, but they do not happen in all the people who take them. The most common side effects of Gabapentin are:

- Drowsiness
- Unsteadiness (risk of falls)
- Dizziness
- Weakness
- Tiredness
- Forgetfulness
- Increased appetite, weight gain

Side effects from Gabapentin usually reduce or disappear after taking the same dose for a few days, therefore should you experience these side effects then either:

• Stop increasing the dose;
• Or reduce the amount of Gabapentin you are taking.

If you don't have 30-50% pain relief, and the side effects have settled, you can then start increasing the dose again.

Rarer side effects include: stomach upset, altered bowel habit, increase in pain, generalised sensitivity and hair loss. Other possible side effects are detailed in the drug information sheet supplied with the capsules.

If you have any other troublesome side effects from Gabapentin, speak to your doctor straight away, and consider stopping this medicine.

Can I stop Gabapentin suddenly?
You should not stop taking this medicine suddenly, especially if you have been on it for a while, or are on a large dose. We recommend that you consult your doctor and slowly reduce the dose.

How long will I have to take Gabapentin for?
If the Gabapentin is helpful, you will be asked to continue with it for up to six months. Your treatment will be reviewed by either the pain clinic or your GP. Gabapentin will be prescribed on a trial basis. Unless there is good reason to continue, treatment will be stopped after this time due to the risks associated with long term use of this medicine. There is no possibility of you becoming addicted to it. It is also important that you continue to take your other regular painkillers, unless you have been advised to stop taking these by your doctor.

Is it safe for me to take other medicines whilst I'm receiving treatment with Gabapentin?
Before you take or buy any new medicines, including herbal remedies, tell your doctor or pharmacist that you are taking Gabapentin and ask their advice.

If you are taking any indigestion remedies, avoid taking them **two hours before** and **up to two hours after** your Gabapentin dose.

What should I do if I forget to take a dose?
You should take a missed dose as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your medication as normal. Do not try to 'double up' to make up for your missed dose.

Can I drink alcohol whilst taking Gabapentin?
If the Gabapentin makes you feel tired or gives you other side effects, then drinking alcohol may increase these side effects. Because of this, we advise you to avoid drinking alcohol if these side effects are troublesome.

Is it safe for me to drive whilst I'm taking Gabapentin?
Gabapentin may cause drowsiness. If you feel affected by this, we advise that you should not drive until the effects have worn off.

Remember:
Never give your prescribed tablets to other people as they may not be safe for them to take. Any leftover tablets should be taken to your local pharmacy for safe disposal.

Keep all medicines out of reach of children

Duloxetine

Duloxetine is a medicine that was originally developed for treatment of depression, and consequently found to have a beneficial effect on some types of pain. It is thought to work by increasing the activity of serotonin and noradrenaline, naturally occurring substances in the brain. Increasing the activity of these substances can calm down pain sensations, particularly when these are from nerve-related causes. (similar to rubbing yourself after an injury).

Duloxetine is also used to treat depression, generalised anxiety disorder and female stress urinary incontinence.

What are the benefits of taking duloxetine?
The benefits of taking duloxetine to manage pain are that it may:

- Ease long term nerve pain such as burning, tingling, shooting, pins and needles and 'strange' sensations
- Improve your sleep
- Improve your mood

How do I take Duloxetine?
Most people are prescribed duloxetine 60mg per day (1 capsule). It is best to take it at night and swallow it whole – do not open, break or chew the capsule. Duloxetine may be taken with or without food, but some people find that taking it with food can help to reduce any initial nausea (sickness) that may occur.
If you forget to take a dose one evening, do not worry, skip the missed dose and continue with your normal daily dose as usual.

What do I do if I get side effects?
All drugs have side effects, but they do not happen in all the people who take them. The most common side effects of duloxetine are:

- Nausea (feeling sick) – this tends to settle with time and can be improved by taking the medicine with food
- Drowsiness – if you experience drowsiness, take your medicine at night to improve your sleep
- Dizziness
- Dry mouth– if you experience this, try chewing sugar free gum or sucking sugar free sweets, drink more non-alcoholic drinks
- Headache

A common side effect of duloxetine is drowsiness. If you are drowsy you should not drive or operate machinery.

Drinking alcohol may make you more drowsy, restrict alcohol intake to 1-2 units per day (1 unit=1/2 pint beer or lager, small glass wine or measure of spirit)

Can I stop duloxetine suddenly? You can stop taking this medicine if you wish, however stopping abruptly may make you unwell. We recommend that you slowly reduce the dose over 1-2 weeks; should you feel unwell, consult your doctor.

How long will I have to take duloxetine for?
If the duloxetine is helpful, you will be asked to continue with it for up to six months. Your treatment will be reviewed by either the pain clinic or your GP. Duloxetine will be prescribed on a trial basis. Unless there is good reason to continue, treatment will be stopped after this time due to the risks associated with long term use of this medicine. There is no possibility of you becoming addicted to it. It is also important that you continue to take your other regular painkillers, unless you have been advised to stop taking these by your doctor.

Is it safe for me to take other medicines whilst I'm receiving treatment with duloxetine?
Before you take or buy any new medicines, including herbal remedies, tell your doctor or pharmacist that you are taking duloxetine and ask their advice.

Can I drink alcohol whilst taking duloxetine?
Drinking alcohol may make you more drowsy, restrict alcohol intake to 1-2 units per day (1 unit=1/2 pint beer or lager, small glass wine or measure of spirit). Consider avoiding alcohol if drowsiness is a particular issue for you.

Is it safe for me to drive whilst I'm taking duloxetine?
A common side effect of duloxetine is drowsiness. If you are drowsy you should not drive or operate machinery.

Remember:
Never give your prescribed tablets to other people as they may not be safe for them to take. Any leftover tablets should be taken to your local pharmacy for safe disposal.

Keep all medicines out of reach of children

Pregabalin

Pregabalin is a licensed painkiller that was originally developed for treatment of epilepsy, and consequently found to be effective in pain relief. It works by altering the way in which nerves send messages to the brain (similar to rubbing yourself after an injury); this is often useful in chronic pain which can be aggravated by changes in the nervous system. This results in pain signals being sent to the brain when no actual damage is occurring in the painful area; this is known as neuropathic pain.

You should notice that your pain starts to improve after one to two weeks on pregabalin. Because every patient is different, it is difficult to prescribe the ideal dose, therefore you have to start at a low dose and carefully increase the dose as explained below until you achieve 30-50% pain relief with least side effects.

How do I take Pregabalin and how do I titrate up to my ideal dose?

Pregabalin capsules come in various strengths, and are usually taken **twice a day**.

Pregabalin – Standard Titration

	Day 1-3	**Day 4-6**	**Day 7-9**	**Day 10-12**	**Day 13-15**	**Day 16-18**
Morning		25mg	25mg	50mg	50mg	75mg
Night	25mg	25mg	50mg	50mg	75mg	75mg
	Day 19-21	**Day 22-24**	**Day 25-27**	**Day 28-30**	**Day 31-33**	**Maintenance**
Morning	75mg	100mg	100mg	125mg	125mg	150mg
Night	100mg	100mg	125mg	125mg	150mg	150mg

Pregabalin – Rapid Titration

	Day 1-3	Day 4-6	Day 7-9	Day 10
Morning		75mg	75mg	150mg
Night	75mg	75mg	150mg	150mg

Once you reach a dose that gives you pain relief without troublesome side effects then this is your ideal dose and your GP can put this on your repeat prescription.

Do not exceed 600mg a day.

What do I do if I get side effects?

All drugs have side effects, but they do not happen in all the people who take them. The most common side effects of Pregabalin are:

- Drowsiness
- Unsteadiness (risk of falls)
- Dizziness
- Weakness
- Tiredness
- Forgetfulness
- Increased appetite, weight gain

Side effects from Pregabalin usually reduce or disappear after taking the same dose

for a few days, therefore should you experience these side effects then either:
• Stop increasing the dose **Or** reduce the amount of pregabalin you are taking.
If you don't have 30-50% pain relief, and the side effects have settled, you can then start increasing the dose again.

Rarer side effects include: stomach upset, altered bowel habit, increase in pain, generalised sensitivity and hair loss. Other possible side effects are detailed in the drug information sheet supplied with the capsules.

If you have any other troublesome side effects from pregabalin, speak to your doctor straight away, and consider stopping this medicine.

Can I stop pregabalin suddenly?
You should not stop taking this medicine suddenly, especially if you have been on it for a while, or are on a large dose. We recommend that you consult your doctor and slowly reduce the dose.

How long will I have to take pregabalin for?
If the pregabalin is helpful, you will be asked to continue with it for up to six months. Your treatment will be reviewed by either the pain clinic or your GP. Pregabalin will be prescribed on a trial basis. Unless there is good reason to continue, treatment will be stopped after this time due to the risks associated with long term use of this medicine. There is no possibility of you becoming addicted to it. It is also important that you continue to take your other regular painkillers, unless you have been advised to stop taking these by your doctor.

Is it safe for me to take other medicines whilst I'm receiving treatment with pregabalin?
Before you take or buy any new medicines, including herbal remedies, tell your doctor or pharmacist that you are taking pregabalin and ask their advice.

What should I do if I forget to take a dose?
You should take a missed dose as soon as you remember. However, if it is almost time for your next dose, skip the missed dose and take your medication as normal. Do not try to 'double up' to make up for your missed dose.

Can I drink alcohol whilst taking pregabalin?
If the pregabalin makes you feel tired or gives you other side effects, then drinking alcohol may increase these side effects. Because of this, we advise you to avoid drinking alcohol if these side effects are troublesome.

Is it safe for me to drive whilst I'm taking pregabalin?
Pregabalin may cause drowsiness. If you feel affected by this, we advise that you should not drive until the effects have worn off.

Remember:
Never give your prescribed tablets to other people as they may not be safe for them to take. Any leftover tablets should be taken to your local pharmacy for safe disposal.

Keep all medicines out of reach of children

Eastbourne, Hailsham and Seaford CCG
Kirstie Ingram

Hastings and Rother CCG
January 2015