

Letters to the Editor

Neuropathic pain – definition and drug therapy

Aust Prescr 2018;41:178–9

<https://doi.org/10.18773/austprescr.2018.069>

I thank Dr Murnion for her timely update regarding the definition and treatment of neuropathic pain.¹

Despite the rewording, the new definition by the International Association for the Study of Pain (IASP) may still be over-inclusive by attempting to encompass a heterogenous constellation of syndromes and conditions with poorly understood pathophysiology.² This has significant ramifications and causes confusion over the pharmaceutical management of neuropathic pain. For example, while gabapentinoids can be beneficial for postherpetic neuralgia and diabetic neuropathy, they do not appear to be better than placebo in sciatica,^{3,4} yet all these conditions are called neuropathic pain under IASP terminology.

The IASP recommended duloxetine, tricyclic antidepressants, pregabalin and gabapentin as first-line drugs.⁵ However, Australian guidelines still recommend amitriptyline first-line, pregabalin and gabapentin second-line, and duloxetine as a second- or third-line consideration.⁶

These differences are important in clinical practice. Amitriptyline and duloxetine are not subsidised by the Pharmaceutical Benefits Scheme (PBS) for neuropathic indications. Pregabalin and gabapentin are only PBS-subsidised when prescribed for refractory neuropathic pain unable to be controlled by other drugs. It is unclear what the 'other drugs' are, although for pregabalin, the Pharmaceutical Benefits Advisory Committee (PBAC) approval documents for neuropathic pain suggest these drugs may include amitriptyline and gabapentin.⁷ Nevertheless, PBS subsidy for both gabapentinoids is not for first-line drug therapy. The fact that these two drugs are the only PBS-subsidised drugs for neuropathic pain with poorly defined criteria may inadvertently result in a lower threshold for prescribing them.

After PBS listing there was greater than expected use of pregabalin for neuropathic pain and a higher than expected discontinuation rate after the first prescription. A subcommittee of PBAC concluded:

'Prescribing of pregabalin in clinical practice may not be optimal. A large number of patients do not have the dose of pregabalin up-titrated and persistence to therapy is poor.'⁸

Some of this prescribing could be related to attempts to use pregabalin for treating sciatica as neuropathic pain.

There are increasing concerns gabapentinoids are being misused.^{9,10} The UK has restricted them as Class C controlled drugs effective from April 2019.¹¹ Pregabalin appears to be highly lucrative in the Australian market leading to attempts at an early application for PBS listing before patent expiry (and associated legal proceedings).¹² Given the lack of efficacy of gabapentinoids in certain conditions still classified as neuropathic pain, I urge a review of prescribing indications and careful rewording of PBS-authority requirements.

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Bridin Murnion, the author of the article, comments:



The definition of neuropathic pain used in the article is the current internationally agreed definition.¹ This is refined from previous definitions, and, with the planned reclassification of chronic pain for ICD-11, there will likely be further refinement.²

The most recent meta-analysis identifies that the aetiology of neuropathic pain does not predict the response to drug treatments.³ Clearly, as new, robust evidence emerges, it must be included in the debate and incorporated into clinical practice.

Amitriptyline is on the general schedule of the Pharmaceutical Benefits Scheme (PBS), although neuropathic pain is 'off-label' use. The processes recommended for off-label prescribing, including patient discussion and agreement, provide a framework for its use.⁴

Duloxetine is PBS-subsidised for major depression. If a patient with neuropathic pain does not have concomitant depression, consider the processes for off-label use, including a discussion of cost.⁴

There is increasing concern about gabapentinoid misuse.⁵ It is timely, therefore, to consider how to improve prescribing, including scheduling changes and improved diagnosis of neuropathic pain and substance use disorder. As many patients do not respond,³ deprescribing pregabalin and gabapentin when they are not effective is critical. Non-pharmacological strategies must also be a major component of any pain management plan.⁶

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