key points

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Neuropathic pain is defined as 'pain that is caused by a lesion or disease of the somatosensory nervous system.' Common peripheral causes of neuropathic pain are diabetic neuropathy, trigeminal neuralgia, postherpetic neuralgia, radicular pain, chemotherapy-induced neuropathy, neuropathy secondary to tumour infiltration, and injury to nerves from trauma, surgery or electric shock. Conditions affecting the CNS such as stroke, spinal cord injury and multiple sclerosis may cause central neuropathic pain. It is important to have a low threshold of suspicion in patients with conditions associated with neuropathic pain such as diabetes and shingles.

When assessing patients it is important to determine not only whether there is a neuropathic element to the pain but also whether this is alone or in combination with a nociceptive component. Neuropathic pain may be constant or intermittent, spontaneous or provoked and is typically described as shooting, stabbing, like an electric shock, burning, tingling, tight, numb, prickling or itching. The International Association for the Study of Pain (IASP) pain grading system is a simple way of determining the likelihood of a neuropathic component. If the history suggests a relevant neurological lesion or disease and the patient describes pain in an anatomically plausible distribution of a nerve, neuropathic pain is 'possible'; it is 'probable' if there are corresponding examination findings in that same distribution and 'definite' if there is a confirmatory diagnostic test.

Neuropathic pain is persistent in many cases. As it is not always possible to cure the underlying disease or lesion causing the neuropathic pain completely, the aim of treatment is management rather than cure. Multidisciplinary team assessment and management in a specialist pain clinic may be required in order to achieve optimal analgesic response and rehabilitation. NICE recommends referral to a pain management specialist if the pain is severe, if it has a significant impact on function or sleep, or if the underlying health condition has deteriorated.

First-line medications include amitriptyline, gabapentin, pregabalin and duloxetine. If there is no improvement in pain or function it is important not to continue treatment. However, compliance should always be checked before making changes to treatment. If treatment fails with first-line therapy, NICE advises careful discontinuation and a trial of one of the other three drugs. In trigeminal neuralgia, carbamazepine is the first-line treatment with specialist referral if this fails. Tramadol should only be used as a short-term rescue medication. Capsaicin cream can be used for patients with localised neuropathic pain as an additional therapy, starting with the 0.075% formulation.