

key points

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Neuropathic pain can be considered to be a clinical

syndrome with multiple causes ranging from damage to peripheral nerve pathways at the level of peripheral nociceptors to abnormalities in the cortical neurones in the brain. It is defined as pain that is caused by a lesion or disease of the somatosensory nervous system and is estimated to affect 6-8% of the general population. Neuropathic pain leads to significant distress and disability for many patients making it a significant healthcare burden.

A low threshold of suspicion in conditions associated

with neuropathic pain can aid diagnosis. Data from the past decade suggest that it is found in 16-26% of patients with diabetes, 8% of patients suffering from shingles in the past three months (increasing to 40% and 75% in patients aged over 50 and 75 respectively), and 10-50% of patients following surgery. Typical neuropathic descriptors include burning, shooting, electric shock pain with numbness, pins and needles or itching.

After a general and neurological examination the

focus should turn to the affected pain area using an unaffected body part as a control. Sensory response to cotton wool, pinprick, temperature and vibration should all be assessed. This will identify the positive and negative signs found in neuropathic pain. Tinel's sign and Phalen's sign, although classically taught, have such poor sensitivity and specificity that GPs are no longer encouraged to rely on them, and they should not be advocated.

Neuropathic pain is often poorly responsive to

conventional analgesia with the mainstay of treatment being anticonvulsant and antidepressant medication. Multidisciplinary assessment and management in the specialist setting of the pain clinic is often required.

First-line medications for neuropathic pain include

amitriptyline, gabapentin, pregabalin and duloxetine (except in the case of trigeminal neuralgia). If treatment fails with first-line therapy, NICE advises careful discontinuation and a trial of one of the other three drugs. Combination therapy with an antidepressant and anticonvulsant is also advocated. In the case of trigeminal neuralgia, carbamazepine is used first line with specialist referral if this fails.

The use of opioids for non-malignant pain remains

controversial as neuroendocrine and immune modulatory side effects are increasingly being recognised alongside the characteristic side effects of tolerance, addiction and dependence. Guidance for their safe prescription is available from the British Pain Society. In the context of neuropathic pain, NICE advocates reserving tramadol for short-term rescue therapy only. Capsaicin cream can be considered for those with localised neuropathic pain as an additional therapy, starting with the 0.025% formulation.