

key points

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Diabetic neuropathy is thought to affect 1.9% of the world's population and 50% of patients with a diagnosis of diabetes mellitus which would equate to 2.25 million people in the UK. The term diabetic neuropathy includes multiple distinct clinical entities that have been classified under the broad headings of focal and multifocal neuropathies and symmetrical neuropathies.

Peripheral diabetic neuropathy, a chronic distal symmetrical predominantly sensory neuropathy, is the most common form of diabetic neuropathy. Most patients describe moderate to severe pain, using neuropathic descriptors such as burning, shooting or electric shocks. The common presentation is of painful symptoms originating in the feet, that then spread to the knees before involving the distal portion of the upper limbs in a 'glove and stocking' distribution.

There are a number of specific neuropathic pain assessment tools that can be readily used in a non-specialist setting in the community, such as the Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) questionnaire. This combines five simple questions and two examination findings to give a dimensionless score for the pain out of 24, with a score ≥ 12 suggesting a neuropathic component is likely.

Tight glycaemic control should be advocated as it has been implicated in reducing the intensity of pain and preventing further deterioration in symptoms. First-line medications that can be tried for neuropathic pain are amitriptyline, gabapentin, pregabalin and duloxetine. Dose titration should be carried out slowly to improve tolerability. If treatment fails with first-line therapy, NICE advises careful discontinuation before trying one of the three alternative drugs.

In the specialist setting of the pain clinic, when monotherapy with different antineuropathic agents has failed or has not been tolerated at an effective dose, combination therapy will then be explored. For localised areas of pain, capsaicin 0.025% cream can be trialled.