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SA Palliative Care

Community Pharmacy Update

A joint initiative of SA Palliative Care Services and Ambulatory & Primary Health

This is the third of four Community Pharmacy Updates on the subject of pain.

Neuropathic Pain

Causes and Characteristics

Neuropathic pain is caused by damage, injury or dysfunction of nerves. Causes include; diabetic neuropathy, direct invasion by cancer and post-herpetic neuralgia.

It can be difficult to distinguish neuropathic pain from severe visceral pain (affecting the internal organs). In many cases, the two occur together. Patients may require management with multiple agents to treat both nociceptive and neuropathic pain.

Features of neuropathic pain can include:

- Shooting or stabbing sensation
- Pulsing and/or spontaneous flares of pain
- Feeling of pins and needles, numbness, crawling insects or pain within an area of numbness
- Pain induced by light touch
- Altered appearance of skin surrounding painful area
- Resistance to non-opioid and opioid therapy

Pharmacological Management of Pain

Patients with neuropathic pain should have a trial of non-opioids and opioids, as their pain may partially respond to these agents.

Treatment with adjuvant analgesics (also known as co-analgesics) should be considered early when neuropathic pain is suspected. Treatment delay can lead to permanent pain syndromes that are unresponsive to therapy.

Agents commonly used to treat neuropathic pain in palliative care patients include:

- *Anti-depressants* (e.g. tricyclic anti-depressants). Doses used are smaller than required for anti-depressant effect. Side-effects and delayed onset of effect mean that other agents are generally preferred in palliative care.
- *Anti-convulsants* (e.g. sodium valproate and carbamazepine). Pregabalin and gabapentin are now preferred. Pregabalin is available on authority under RPBS and is likely to be added under authority to the PBS early 2013.
- *Corticosteroids* (e.g. dexamethasone). Have a role to play with treating some specific neuropathic pains by their reducing inflammation and oedema associated with tumour deposits, and by a central effect. Effectiveness reduces over time and the adverse effect profile restricts their use to short-term only.
- *Other treatments*. Other agents that may be used by specialists in specific circumstances include: bisphosphonates (bone pain), benzodiazepines (anxiety component of pain), antibiotics (painful infections such as cellulitis) and short-term infusions of lignocaine. Ketamine has been used for refractory neuropathic pain, but a recent published Randomised Controlled Trial failed to show any effect.

Next update: Breakthrough and Incident pain

Useful resources

> Therapeutic Guidelines for Palliative Care V3 2010
> www.palliativedrugs.com
> http://www.nps.org.au/publications/health-professional/nps-radar/latest-issue/pregabalin

For more information

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This update is intended to provide practical up to date and factual information relating to pharmacy and medicines management in the setting of Palliative Care and is based on critical review of available evidence. Individual patient circumstances must be considered when applying this information. Please feel free to distribute this update further to interested colleagues.