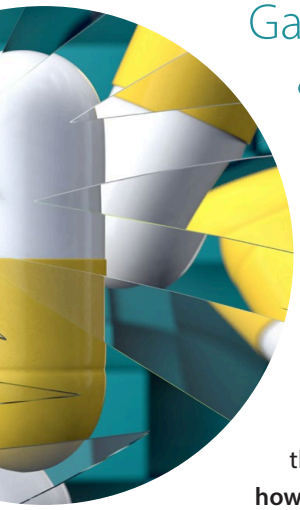

Gabapentinoids: when and how should they be prescribed?

The following questions can be used as discussion points for peer groups or self-reflection of practice.

It is strongly recommended that the following article is read before considering the questions. "**Gabapentinoids: when and how should they be prescribed?**"

Limited pharmacological treatment options to manage chronic non-neuropathic pain can lead to the inappropriate prescribing of gabapentin and pregabalin. Gabapentin and pregabalin, known as gabapentinoids, are funded in New Zealand for use in people with neuropathic pain and for seizure control in some people with epilepsy. The benefit of gabapentinoids, even for conditions they are indicated for, is variable; evidence of efficacy for other types of pain, e.g. cancer-related pain, episodic migraine, is very limited. Gabapentinoids should not be prescribed for people with chronic non-neuropathic pain, e.g. non-specific low back pain, and are no longer recommended for people with sciatica.

Since mid-2018, the funding for gabapentinoids in New Zealand has widened, which has resulted in increased use and growing safety issues. Gabapentinoids can interact with CNS depressants resulting in respiratory depression, accidental overdose and an impaired ability to perform tasks such as driving or operating machinery. There is also potential for misuse; gabapentinoids should generally be avoided or prescribed with caution in people with a history of substance misuse or dependence on prescription medicines. Consider prescribing lower doses in older people with frailty due to an increased risk of falls and respiratory depression.

If, following a trial of non-pharmacological interventions and other suitable analgesics, pain is still uncontrolled, a risk-benefit analysis should be performed to assess if a gabapentinoid is appropriate:

- Consider whether there is evidence that gabapentin or pregabalin is effective for managing the patients' specific type of neuropathic pain
- Check other medicines the patient is currently taking; assess for potential interactions, e.g. with CNS depressants
- Assess the risk of misuse, dependence or diversion*
- Consider and discuss potential adverse effects, e.g. problems with balance and sedation, weight gain and mood changes
- Ensure the patient understands the importance of adherence with their regimen, e.g. following instructions for dose titrations and not taking on an "as required" basis

* If there is clinical need to prescribe a gabapentinoid to a patient with a history of misuse, consider prescribing in short courses, i.e. every seven days rather than the standard 28 days, to monitor and minimise the risk of misuse

Once the decision has been made to initiate a gabapentinoid, a stepwise approach to pain management should be taken:

1. Start low and titrate the dose to achieve maximum benefit or to reach the maximum tolerated dose within dosing recommendations
2. Allow an adequate trial period of at least four weeks or after at least two weeks at the maximum tolerated dose
3. Assess response to treatment, e.g. a reduction in pain score and/or the ability to perform a task or participate in an activity they could not do before
4. If response is inadequate or adverse effects are intolerable, consider changing to the other gabapentinoid or a different class of medicine, e.g. TCAs, or trialling a combination of first-line neuropathic pain medicines
5. Regularly review and re-address lifestyle factors if the pain is inadequately managed or becomes progressively worse

People taking gabapentinoids require periodic review. Each review should include assessment of pain control, dose, the continued need for treatment, tolerability, adverse effects and assessment for misuse and/or dependence. For people taking a gabapentinoid long-term, an attempt should be made after six months of responding to treatment, to gradually reduce the dose or stop treatment, as appropriate, i.e. if pain has resolved. A gradual dose taper, e.g. over at least one week, is generally required when stopping a gabapentinoid completely.

Questions to consider:

1. Gabapentinoids are most effective for post-herpetic neuralgia and painful diabetic neuropathy. Before reading this article were you aware of the limited efficacy outside of neuropathic pain? Do you prescribe gabapentinoids for unapproved indications, and if so, what for and why?
2. A stepwise approach to pain management should be taken when initiating a gabapentinoid. What process do you follow when prescribing gabapentin or pregabalin? e.g. is it your first or last "port of call"? In your experience, how well do people respond to treatment, what do you usually consider an adequate response and how long after initiating treatment do you assess response? In your experience, how does the efficacy of gabapentinoids compare to amitriptyline or nortriptyline for neuropathic pain?
3. A risk benefit analysis should be performed before initiating a gabapentinoid. Thinking back to the last time you prescribed gabapentin or pregabalin, how did you assess the risks along with the potential benefits, and what made you comfortable prescribing?
4. People taking gabapentin or pregabalin commonly experience adverse effects and in some circumstances are at greater risk of harms, e.g. respiratory depression, sedation. After reading this article, has your view changed on the safety of gabapentinoids, and will this change the circumstances in which you prescribe them?
5. Ideally, all people taking a gabapentinoid should be reviewed periodically to assess pain control, dose, the continued need for treatment, tolerability, adverse effects and misuse and/or dependence. Do you actively recall patients or review at the next available opportunity? Do you stop gabapentinoids more often due to adverse effects, lack of clinical effect or concerns about misuse? How well do patients usually tolerate stopping a gabapentinoid?