Suffolk GP FEDERATION

NHS West Suffolk NHS Foundation Trust

Reducing the risks of prescribing with pregabalin, gabapentin and opioids

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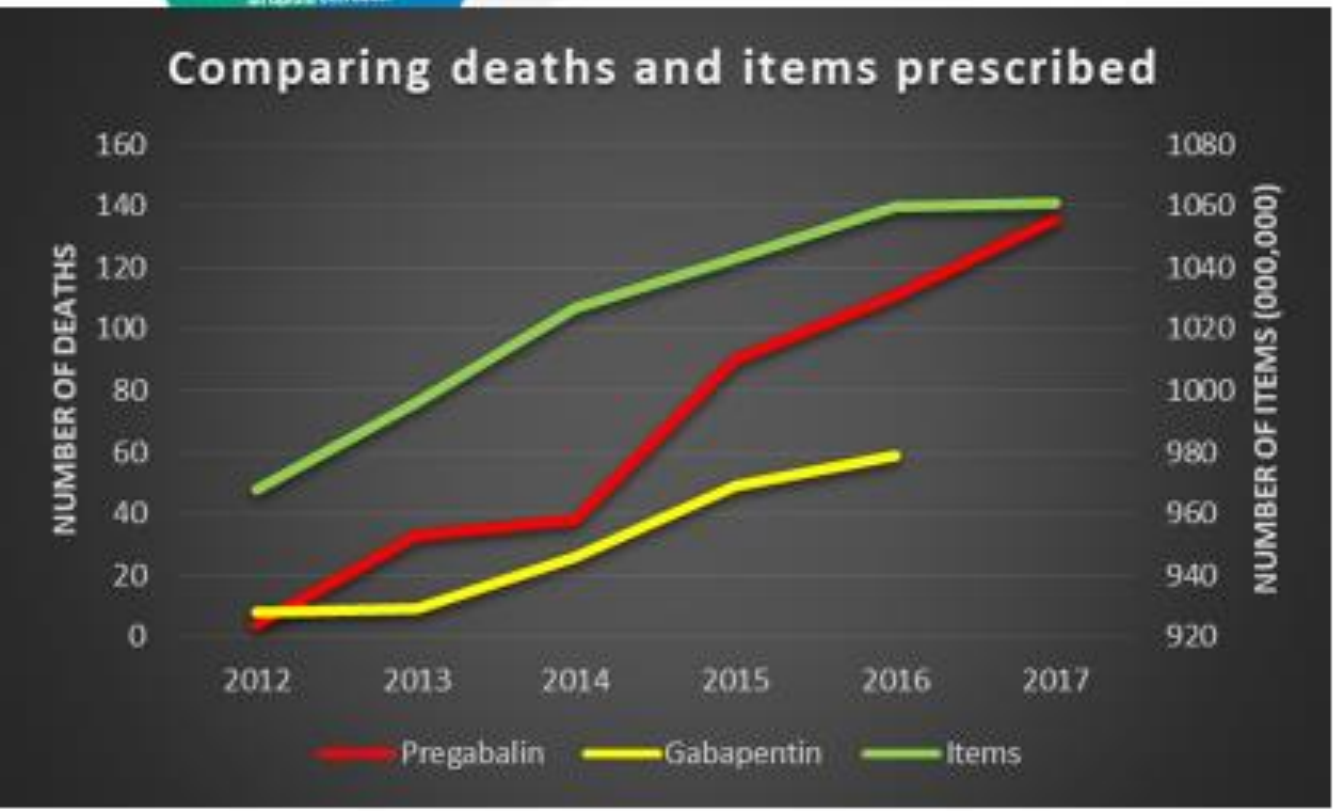
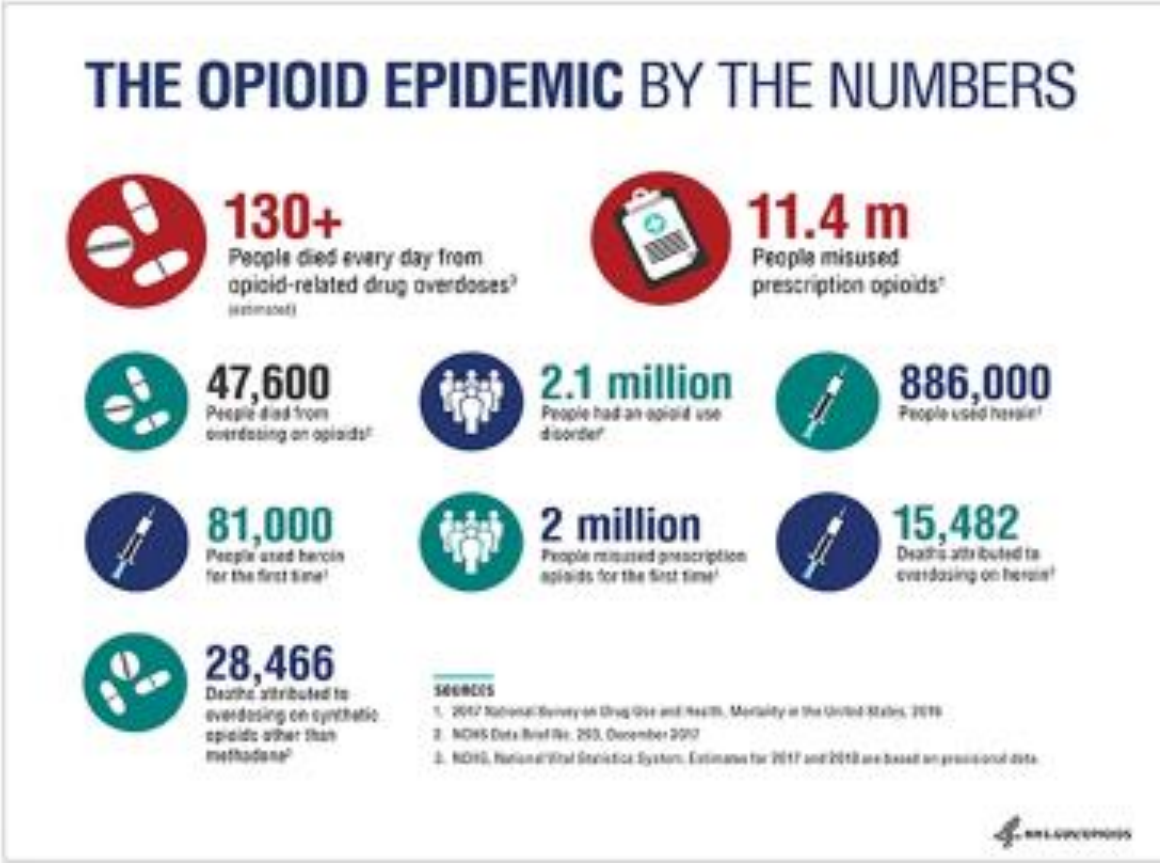
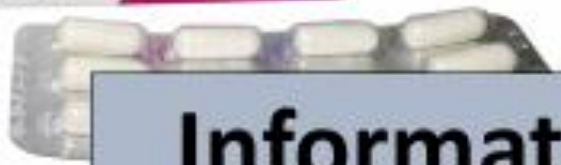
Prescribing of gabapentin and pregabalin in primary care triples in ten years
The Pharmaceutical Journal 29 NOV 2018
by Carolyn Wickwark
Gabapentinoids have been associated with a growing number of drug-related deaths, leading to their reclassification as Class C drugs in April 2019.







Information on deprescribing gabapentin and pregabalin

Prescribing for Chronic Pain in Primary Care

It is recommended that practitioners give careful consideration to the individual patient when prescribing pregabalin and gabapentin to minimise the risk of misuse, dependence, and diversion. Assessment of the balance of benefits and risks is essential.

Gabapentinoid prescribing for Chronic Pain in Primary Care: Resources for Clinicians and Boards, Version 1.2 – 11th December 2018

National Issues (1)

New controls over pregabalin and gabapentin from April 2019

Reason: concerns over misuse, illegal diversion, addiction and rising fatalities

Reclassified as Class C/ Schedule 3 controlled drugs under the Misuse of Drugs Act

Positive effects of pregabalin

- Euphoria
- Lifted mood
- Relaxation
- Increased motivation
- Low inhibition

N.B. May be used to enhance the effects of heroin and reduce the amount of heroin needed

Positive effects of gabapentin

- Relaxation
- Calmness
- Euphoria

N.B. Some users have reported that the ‘high’ from snorting gabapentin can be similar to taking a stimulant.

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Negative effects of pregabalin and gabapentin

- Drowsiness, sedation, respiratory depression and death may occur when used in combination with other central nervous system depressants including opioids, antidepressants, antihistamines, tranquillizers and alcohol.
- Physical dependencies, illegal diversion, misuse and death

Pregabalin can also have negative effects of chest pain, wheezing, swelling of extremities, weight gain, thirst, clumsiness, muddled thoughts, dizziness and drowsiness, sedation, vision changes and less commonly, hallucinations.

Licenced indications BNF

Gabapentin

- Adjunctive treatment of focal seizures with or without secondary generalisation
- Monotherapy for focal seizures with or without secondary generalisation
- Peripheral neuropathic pain
- Migraine prophylaxis
- Menopausal symptoms, particularly hot flushes, in women with breast cancer

https://bnf.nice.org.uk/drug/gabapentin.htm

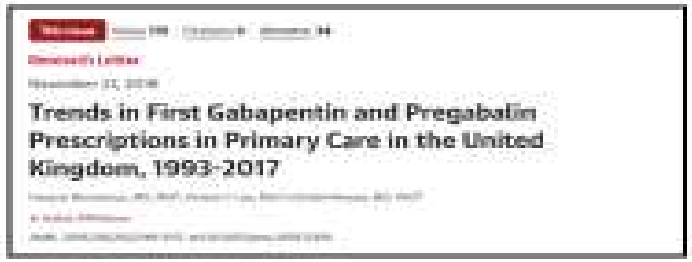
Licence indications BNF

Pregabalin

- Peripheral and central neuropathic pain
- Adjunctive therapy for focal seizures with or without secondary generalisation
- Generalised anxiety disorder

https://bnf.nice.org.uk/drug/gabapentin.htm

Gabapentinoids


Trends in First Gabapentin and Pregabalin Prescriptions in Primary Care in the United Kingdom, 1993-2017

- The rate of patients newly treated with gabapentinoids has tripled from 2007 to 2017 in primary care.

By 2017

- 50% of gabapentinoid prescriptions were for an off-label indication.
- 20% of gabapentinoid prescriptions had a co-prescription for opioids.

Public Health England

NHS England

Advice for prescribers on the risk of the misuse of pregabalin and gabapentin

PHE 2014

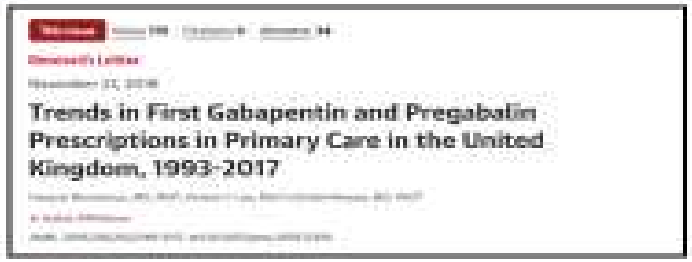
Suffolk

Advice for healthcare professionals:

- be aware of the risk of CNS depression, including severe respiratory depression, with gabapentin
- consider whether dose adjustments might be necessary in patients at higher risk of respiratory depression, including elderly people, patients with compromised respiratory function, respiratory or neurological disease, or renal impairment, and patients taking other CNS depressants
- report any suspected adverse reactions on a Yellow Card

MHRA 2017

Gabapentinoids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MHRA 2017

Gabapentinoid Prescribing for Chronic Pain in Primary Care - Resources for Clinicians and Boards v1.0

Quick Reference Guide (*full resource available at: https://www.therapeutics.scot.nhs.uk/pain/*)

Achieving the Correct Dosage

The following principles may be useful in the process of determining the correct dose for a patient:

- A titrated approach is recommended, accounting for patient characteristics, e.g elderly, renal impairment, breast feeding, etc.
    - Gabapentin – Start 300mg at night. Titrate upwards by 300mg per week. Evidence suggests a minimum of 1200mg is needed but doses may need to be increased to the maximum of 3600mg.
    - Pregabalin – Start 75mg twice daily. Titrate up to a maximum of 300mg twice daily. Manage according to side effects and clinical effectiveness.
- Regular review should be scheduled, particularly during the initiation phase, with first review within 4 weeks.
- A trial of dose reduction/cessation should be undertaken, following a period of stability
- Stepping up should be closely monitored. Dispense daily or weekly in high-risk patients
- Aim to maintain patients on the minimum dose which controls pain
- Where patients fail to engage with review, or there is no or insufficient effect in 2 months, consider gradual dose reduction and stopping

Pregabalin and Gabapentin: Withdrawal Summary Guidance for NON-CANCER pain in adults in primary care

Pharmacologic therapy should not be considered a long term management strategy

How often to review

- At least monthly, as an absolute priority, for patients with a history of misuse or if recently released from prison[1]
- 8 weeks after initiation[1]
- At least every 3 months if co-prescribed with opioids
- Every 3-6 months for all other patients[2]

Assess effectiveness, tolerability, adverse effects and adherence

Indications for trial withdrawal

- After two months of relative improvement in pain following stabilisation on treatment
- Every 6 months for patients on long term treatment
- If poor response to treatment
- Where gabapentinoids are being prescribed for **pain** outside their licensed indication, e.g. for non-neuropathic pain (unless recommended by the West Suffolk Integrated Pain Management Service)
- On request of patient
- If side effects are intolerable
- If there is evidence of diversion or non-adherence to treatment
- If patient is pregnant, breastfeeding or planning to conceive (unless the benefits to the mother outweigh the potential risk to the foetus or baby)

Drug	Reduction schedule
Gradual dose taper allows observation of emergent symptoms that may have been controlled by the drug.	
Gabapentin (total daily dose > 900 mg)	Reduce total daily dose by 300 mg every 10 days (range 7-14 days)[3]
Gabapentin (total daily dose ≤ 900 mg)	Reduce total daily dose by 100 mg every 10 days (range 7-14 days)
Pregabalin	Reduce total daily dose by 50-100 mg every 10 days (range 7-14 days)[3]
Warn patients of risk of overdose or death if a higher dose of pregabalin or gabapentin is taken following tapering as tolerance is reduced	

Unsuccessful withdrawal

- If complete withdrawal of treatment is not successful, continue on the last dose in the reduction regimen at which pain was tolerable and discuss long term goals and non-pharmacological management. Consider referral to West Suffolk Integrated Pain Management Service and/ or condition specific service. Re-attempt tapering in 3-6 months as dictated by patient and clinical factors.

Patient Support Available

- Patient Information Leaflet: Gabapentinoid Reduction
- Clinical advice via: West Suffolk Integrated Pain Management Service. Tel: 01284 712528 or 0845 241) 3313 (option 6)

References and resources:

1. PrescQIPP. 2016. Bulletin 119. Neuropathic pain. Pregabalin and gabapentin prescribing. January 2016
2. WSCCG. 2017. Pain ladder-chronic pain. Pain treatment pathway for non-cancer chronic pain ≥3 months duration in adults in primary care. 2017.
3. NHS England recommendations. 2014. Advice for prescribers on the risk of misuse of pregabalin and gabapentin. Dec 2014

CKS. 2018. Neuropathic pain – drug treatment. (Last revised November 2018)
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Quick reference guide.
NHS Scotland. 2018. Gabapentinoid prescribing for chronic pain in primary care. Resources for clinicians and boards. Scottish Government and NHS. 2018.
Quality prescribing for chronic pain. A guide for improvement 2018-2021.

Produced by: WSCCG Medicines Management Team in collaboration with West Suffolk Integrated Pain Management Service. Final version 1. January 2019. Review: January 2021.

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Gabapentin available doses

Tablets:

- 100mg
- 300mg
- 400mg

Oral solution:

- 50mg/ml

All doses available from multiple drug companies and costs vary

Pregabalin available doses

Capsules:

- 25mg
- 50mg
- 75mg
- 100mg
- 150mg
- 200mg
- 225mg
- 300mg

Liquid:

- 20mg/ml

All doses available from multiple drug companies and costs vary

Example of reduction of Gabapentin (total daily dose > 900mg 3 times daily)

Patient prescribed 900mg 3 times daily:

Total daily dose = 2700mg

Reduce total daily dose by 300mg every 10 days

e.g. 900mg in the morning
900mg in the afternoon
600mg at night

Establish when pain or discomfort may be at its worst during the day and taper down this dose last

Example of Gabapentin reduction (total daily dose ≤ 900mg)

Patient prescribed 200mg 3 times daily:

Total daily dose = 600mg

Reduce total daily dose by 100mg every 10 days

e.g. 100mg in the morning
200mg in the afternoon
200mg at night

Establish when pain or discomfort may be at its worst during the day and taper down this dose last

Example of reduction of Pregabalin

Patient prescribed 300mg twice daily:

Total daily dose = 600mg

Reduce total daily dose by 50 to 100mg every 10 days

e.g. 250mg in the morning
300mg at night

or 250mg in the morning
250mg at night

What should a patient do if pain increases during a reduction of gabapentinoids?

- Advise not to reduce gabapentinoids medication further
- Keep on the dose the patient has reduced to
- Increase frequency of non-pharmacological strategies for managing pain:

e.g.

- stretching
- pacing of activities
- relaxation
- distraction

Unsuccessful withdrawal

- If complete withdrawal of treatment is not successful continue on the last dose in the regimen at which pain was tolerable and discuss long term goals and non-pharmacological management.
- If increased pain does not settle patient should discuss with GP whether to increase dose slowly again to the lowest dose that reduces pain intensity.
- Consider referral to West Suffolk Hospital Integrated Pain Management Service and/or condition specific service.
- Re-attempt tapering in 3 to 6 months as dictated by patient and clinical factors.

References and resources:

- 1. PrescQIPP. 2016. Bulletin 119. Neuropathic pain. Pregabalin and gabapentin prescribing. January 2016
- 2. WSCCG. 2017. Pain ladder-chronic pain. Pain treatment pathway for non-cancer chronic pain ≥3 months duration in adults in primary care. 2017.
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