Orthopaedic Spinal Services

Analgesia guideline – neuropathic pain of spinal origin (eg lumbar radiculopathy)

Initial presentation

Follow up
2 days–4 weeks

Review
4–6 weeks

Medication recommendation

1 **Paracetamol**
and

2 **NSAIDs,** 5–7 days (if no contraindications)

3 **Low-dose antidepressant**
(antineuropathic agent)
> Nortriptylline 10-25mg in evening
> Amitriptylline 10-25mg in evening
> Duloxetine 30-60mg

4 **Continue regular paracetamol**
If the pain remains poorly controlled, consider the addition of:

5 **Option A: Tramadol**
or
Option B: Short-term opioid medication +/- tramadol

6 **A trial of low-dose gabapentinoid medication**
(if no benefit from antidepressant after 2–3 weeks)
> Pregabalin – starting dose 25 or 75mg nocte
> Progress to maximum of 300mg bd

7 If Pregabalin poorly tolerated or ineffective:
> Gabapentin – starting dose 100 or 300 mg nocte
> Progress in increments each 2-3 days
> Increase dose to 300mg (in elderly) or 1800mg
> Progress frequency to bd/tds

If severe symptoms persist after 4–5 weeks; review the patient's clinical presentation and re-consider the **triage and referral guideline** if required.

Clinical notes

Benzodiazepines: Do not prescribe benzodiazepines for low back pain or sciatica. Risks of abuse, addiction, tolerance, overdose and death are well documented: FPM Choosing Wisely Australia 2018.

Antidepressants:
> Doses should start at the lower end in older patients. Dose can be increased slowly (every 3-5 days) as tolerated to a maximum dose of 50mg (for nortriptyline and amitriptyline).
> Some patients may tolerate one better than another. May take 3–4 weeks to reach maximum effect.

Combination analgesics (eg Panadeine Forte) are not recommended for long-term use.

Tramadol:
> Consider contraindications including concurrent use of SSRIs.
> Dose can be incrementally increased to 400mg maximum (if minimal side effects); 300mg if >75 years. Best to avoid in patients with renal impairment.

Short-term opioid medication:
> Considered for severe pain (immediate-release only eg oxycodone) in age-related doses, whilst encouraging physical activity, avoidance of bed rest, and self-management promoting function: Low Back Pain Clinical Care Standard, ACSQHC 2022.
> The treating doctor must consider on an individual basis if an opioid analgesic is appropriate, monitor and evaluate its effective on recovery, function, and minimise harm as part of Analgesic Stewardship: ANZCA Position Statement on Acute Pain Management 2022.
> Slow-release opioids should be avoided in acute pain. They are less effective than immediate release opioids, lead to higher opioid doses, and increase the risks of respiratory depression and prolonged use: FPM Choosing Wisely Australia 2022 and Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard, ACSQHC 2022. They are also not recommended for chronic non-cancer pain as per the Therapeutic Guidelines, except in exceptional circumstances.
> Opioid analgesics for acute pain should not be taken for more than one week and at the lowest possible dose. Weaning and cessation should be planned with the patient such that the daily dose is progressively decreased as soon as possible: Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard, ACSQHC 2022.
Also see Information for patients given Oxycodone.

Gabapentinoids (antiepileptics):
> Pregabalin available on the PBS. Gabapentin is not on the PBS, however generic brand is similar to PBS price.
> This group of medications is generally effective within a few days.
> Older patients must be started on pregabalin at the lower dose of 25 mg doses due to risk of respiratory depression with opioids, and even without, opioids increased risk of sedation, dizziness and visual disturbance.
> These doses are based on people with good renal function, therefore adjust the maximum doses or avoid use in patients with renal impairment.

In cases of persistent symptoms it may be found that patients do better with:
> Regular paracetamol, +
> Other analgesics if appropriate,
> Low-dose antidepressant, +
> Low-dose antiepileptic (gabapentinoids).

Important: These guidelines are recommendations only and may not be appropriate for all patients. Be aware of the potential for interactions between these medications and other medications being taken by the patient, and co-morbidities that may increase the risk for adverse effects.

If further advice is required, please contact CALHN Pain Management Unit, The Queen Elizabeth Hospital, Tel: (08) 8222 7826 (weekdays).

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