SYICB Position Statement on the Prescribing of Gabapentinoids

SY ICB does not support the routine long-term (greater than 3 months) co-prescribing of opioids and gabapentinoids for neuropathic or chronic, non-cancer pain in adults.

This position statement relates to patients prescribed pregabalin or gabapentin to manage neuropathic pain. Use in other conditions like palliative care, epilepsy or Generalised Anxiety Disorder should be discussed with the relevant specialist service.

Pregabalin is licensed for managing neuropathic pain, Generalised Anxiety Disorder and Epilepsy. Gabapentin is licensed for managing neuropathic pain and epilepsy.

Unlicensed uses of gabapentin include treatment of oscillopsia and spasticity in patients with multiple sclerosis (NICE NG220).

Evidence for unlicensed use of gabapentinoids for pain outside of a neuropathic pain presentation is very limited and is not recommended.

- Do not initiate gabapentinoids to manage chronic primary pain (NICE NG193)
- Do not offer gabapentinoids for managing sciatica or low back pain (NICE NG59)

Gabapentinoids along with opioids, benzodiazepines, and antidepressants are commonly referred to as Dependence Forming Medicines (DFMs).

There have been several MHRA alerts relating to gabapentinoids:

- Both pregabalin and gabapentin were reclassified as Schedule 3 controlled drugs due to concerns of potential for abuse and dependence:
  MHRA/CHM advice: Pregabalin / Gabapentin and risk of abuse and dependence: new scheduling requirements from 1 April (April 2019)

- Gabapentin and pregabalin have been associated with a risk of severe respiratory depression even without concomitant opioid medicines. Clinicians are advised to consider any necessary adjustments in dose or dosing regimens in patients at higher risk of respiratory depression, especially those:
  - with impaired respiratory function, respiratory or neurological disease, or renal impairment
  - taking other CNS depressants (including opiates)
  - over 65 years.

  Special precautions to be taken for patients co-prescribed opioid and Pregabalin at doses exceeding 300mg a day.
  MHRA/CHM advice: Gabapentin: risk of severe respiratory depression (October 2017)
  MHRA/CHM advice: Pregabalin: reports of severe respiratory depression (February 2021)

- A new study has suggested pregabalin may slightly increase the risk of major congenital malformations if used in pregnancy. Patients should continue to use effective contraception during treatment and avoid use in pregnancy unless clearly necessary.
  MHRA/CHM advice: Pregabalin: findings of safety study on risks during pregnancy (April 2022) (PIL)

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National guidance on safe prescribing and withdrawal management of DFMs has been produced by:

- NICE Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults (NICE NG15)
- NHS England has developed guidance to support people who are taking medicines associated with dependence and withdrawal symptoms.

In view of these developments and the commitment of SYICB to ensure/improve patient safety, we recommend that:

- Patients should be kept aware of the likely efficacy of the drugs for management of their symptoms and also the risk of harm, including dependence and risk of withdrawal symptoms.

- Prescribing gabapentinoids for neuropathic pain should be accompanied by a plan (after a period of stability e.g. 2-3 months or at annual review) to attempt a gradual tapering to the minimum effective dose or stopping the treatment as appropriate. Ideally, this process should be incorporated into an annual structured medication review.

- Prescribing gabapentinoids for non-neuropathic chronic pain (including low back pain) and sciatica is not recommended due to limited evidence. Patients already taking gabapentinoids for these indications should be reviewed with a plan to taper and stop as able.

- For any new initiations of gabapentinoids, consider whether an adjustment in dose or dosing regimen is required to reduce risk of respiratory depression, particularly in patients:
    - aged 65 years and above
    - taking other CNS depressants (including opioids)
    - with impaired respiratory function, respiratory or neurological disease, or renal impairment

- Patients in the above risk categories (including those prescribed both opioids and gabapentinoids), should have a regular review of their medication dose and dose frequency (with a view to tapering as able). We recommend this annually (ideally as part of a structured medication review) and 2-3 months after changes in dose.

- Opioids and gabapentinoids should not routinely be co-prescribed for the same pain. Clinicians should routinely switch to the second drug, rather than adding it as an adjunct. Specialist advice to the contrary may be followed (and sought on a case-by-case basis, if clinically appropriate).

Tapering or stopping opioids requires careful planning and collaboration with the patient and all members of their healthcare team.

The RCoA's Faculty of Pain Medicine has produced advice on stopping opioids safely.

Sheffield Place has produced guidance for de-prescribing gabapentinoids.

Acknowledgement:

This has been adapted from the Doncaster Place Position Statement on the Prescribing of Gabapentinoids.

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