NPS MEDICINEWISE PROFESSIONAL

REVISITING TREATMENT OPTIONS
NEUROPATHIC PAIN

Practice Review: PBS data March 2018

Your PBS data are provided confidentially to you only and are intended for personal reflection on your practice. **Data are not used for any regulatory purposes.**

Additional **MedicineInsight** general practice cohort data are included to complement your PBS data.

⊢ 000001 000 DHS1
Dr Sam Sample
123 Sample Street
SAMPLETOWN ABC 1234

23 March 2018

Dear Dr Sample,

NPS MedicineWise supports clinicians in professional development and continuing quality improvement, with a focus on quality use of medicines and medical tests. The enclosed data focus on your prescribing of medicines for neuropathic pain.

Pregabalin is the most commonly prescribed medicine for neuropathic pain
Between 2013 and 2015, the total number of prescriptions for pregabalin steadily increased, while total prescriptions for other medicines[a] for neuropathic pain remained largely unchanged.[1] Several international studies have shown high rates of pregabalin prescribing without first diagnosing neuropathic pain.[2,3] Evidence for the efficacy of pregabalin in nociceptive pain is lacking[4] and the use of pregabalin in these conditions increases the risk of adverse effects[4] and potential misuse and abuse, particularly among opioid users.[5] The faculty of Pain Medicine (ANZCA), as part of Choosing Wisely Australia, advocates avoiding prescribing pregabalin and gabapentin for pain which does not fulfil the criteria for neuropathic pain. See: choosingwisely.org.au/recommendations

Accurate diagnosis of neuropathic pain is essential
While neuropathic pain may co-exist as a mixed presentation with nociceptive pain, a probable diagnosis can be determined by taking a targeted history and physical examination.[6,7] The use of pregabalin as a diagnostic tool is not helpful as treatment failure does not rule out neuropathic pain.[7]

Start neuropathic pain medicines at a low dose and titrate slowly to an effective dose
Amitriptyline and other TCAs, duloxetine and other SNRIs, gabapentin and pregabalin remain first-line medicines in the treatment of neuropathic pain.[8,9] Neuropathic pain is usually refractory to paracetamol and NSAIDs.[10] Opioids have a limited role due to their safety profile and potential for abuse.[10]

Reflect on your prescribing
The enclosed PBS data provide you with an opportunity to reflect on your practice and your prescribing patterns for medicines for neuropathic pain. To complement your individual PBS data, additional information from the **MedicineInsight** general practice database has been included. To help you interpret your data in the context of your own clinical practice, this information provides further insights into national prescribing patterns of neuropathic pain medicines. See: nps.org.au/medicine-insight

Our national program, Neuropathic Pain, provides a range of clinical resources as well as CPD activities for GPs. These can be found at nps.org.au/neuropathic-pain

- Educational visit – Neuropathic pain: touchpoints for effective diagnosis and management
- Clinical e-Audit – Neuropathic pain: a roadmap for diagnosis and management
- Patient resources – patient action plan and fact sheet on amitriptyline

Yours sincerely,

Lynn Weekes

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For more information about this Practice Review and how to interpret your data, see: nps.org.au/pbs-neuropathicpain

Independent, not-for-profit and evidence-based, NPS MedicineWise enables better decisions about medicines, medical tests and other health technologies.
This program is funded by the Australian Government Department of Health.

NPS MedicineWise ABN 61 082 034 393

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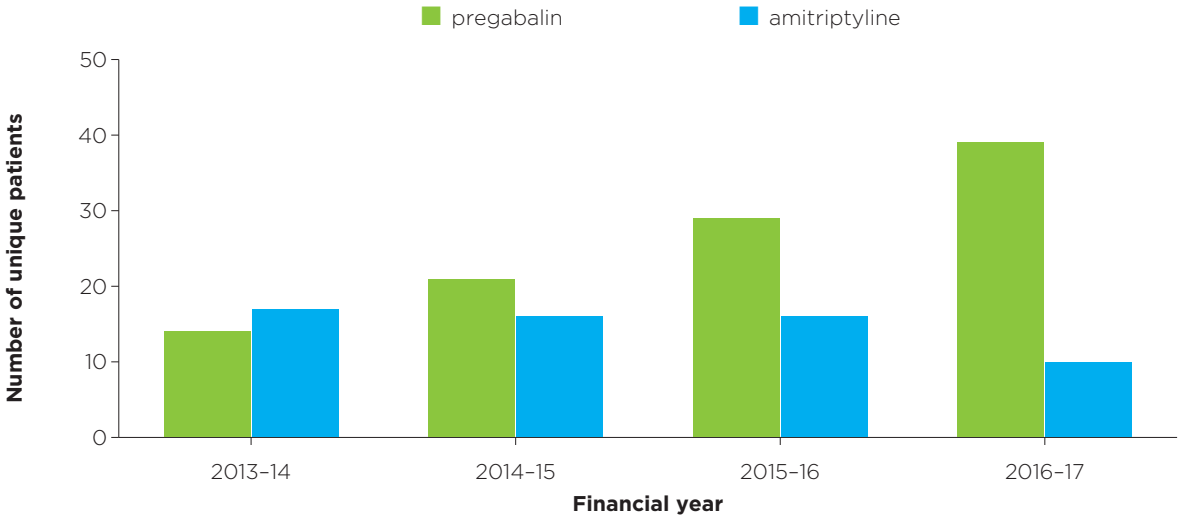
Your confidential prescribing data

NPS MedicineWise provides this information for your reflection only. The data are from the Department of Human Services and include all PBS prescriptions for pregabalin and amitriptyline that you prescribed and were dispensed. The indication for prescribing pregabalin is known to be for neuropathic pain[c] (based on PBS item codes). The indication for prescribing amitriptyline cannot be determined from the PBS data. Consider the data in relation to your patients and their indications for treatment.

How has your prescribing of amitriptyline and pregabalin changed over time?



Points for reflection

- Generally there is limited evidence for superior efficacy of a particular medicine in a specific neuropathic pain condition.[6]
- Individualise treatment choice by taking into consideration patient history, comorbidities and the risk vs benefit profile of the medicine.[10,11]
- Start neuropathic pain medicines at a low dose and titrate slowly based on effect and tolerability.[7,11]
- Low-dose amitriptyline remains a first-line medicine for the treatment of neuropathic pain in Australian and international guidelines.[6,10,12] Start amitriptyline at ≤ 25 mg a day.[10]
- Consider switching to another first-line medicine if there is no response to the initial medicine, or adding another first-line medicine if partial pain relief is achieved after an adequate trial.[11] Recognise that the use of combination medicines may increase the risk of adverse effects.

MedicineInsight data[d] show that 78% of patients using pregabalin have a recorded diagnosis of neuropathic pain.

How many of your patients using low-dose amitriptyline have neuropathic pain?

Total number of patients who had amitriptyline dispensed in financial year 2016-17	Number of patients who had only 10 mg strength tablets dispensed		Number of patients who had only 10 mg and/or 25 mg strength tablets dispensed	
10	1	10%	2	20%

Points for reflection

- Based on 20 years of clinical experience, amitriptyline has favourable efficacy and tolerability compared with other medicines for neuropathic pain.[6,13]
- Amitriptyline's analgesic effect is independent of its mood-altering effect and lower doses are required for neuropathic pain compared to depression.[10]
- Nortriptyline has comparable analgesic effect to amitriptyline[11] and is an effective TCA alternative for patients who cannot tolerate amitriptyline.[10]

MedicineInsight data[d] show that of all patients currently using amitriptyline for a recorded diagnosis of neuropathic pain, 64% were prescribed only 10mg strength tablets and 28% were prescribed only 25mg strength tablets.

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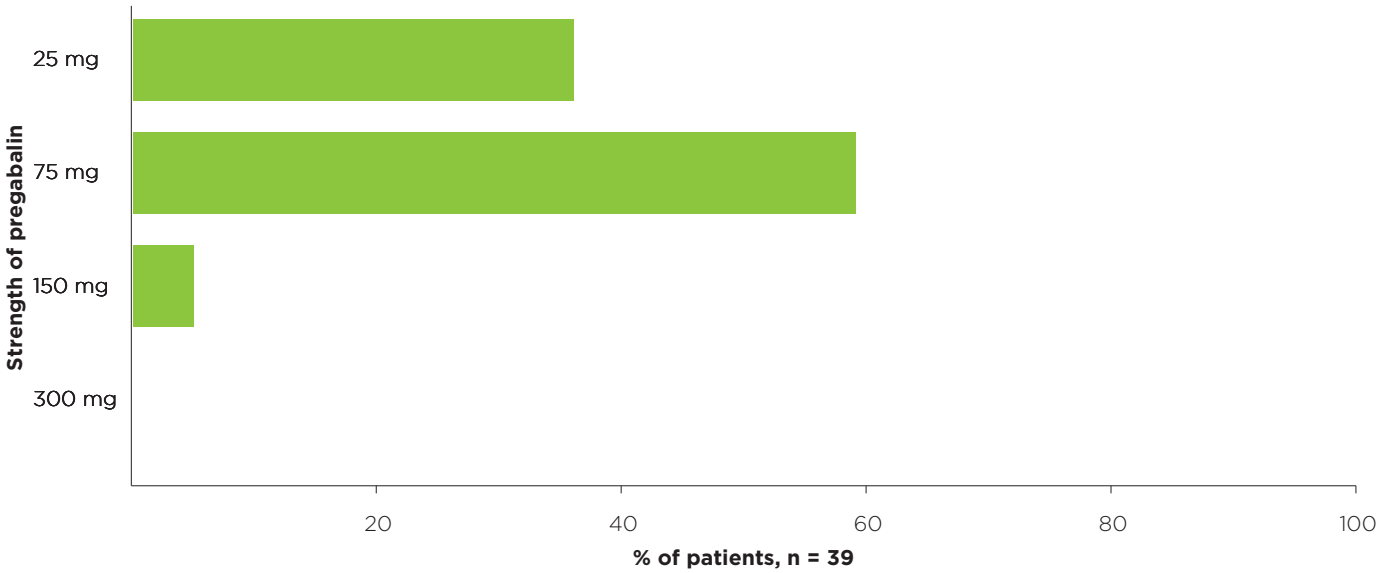
What strength of pregabalin do you prescribe for your patients?

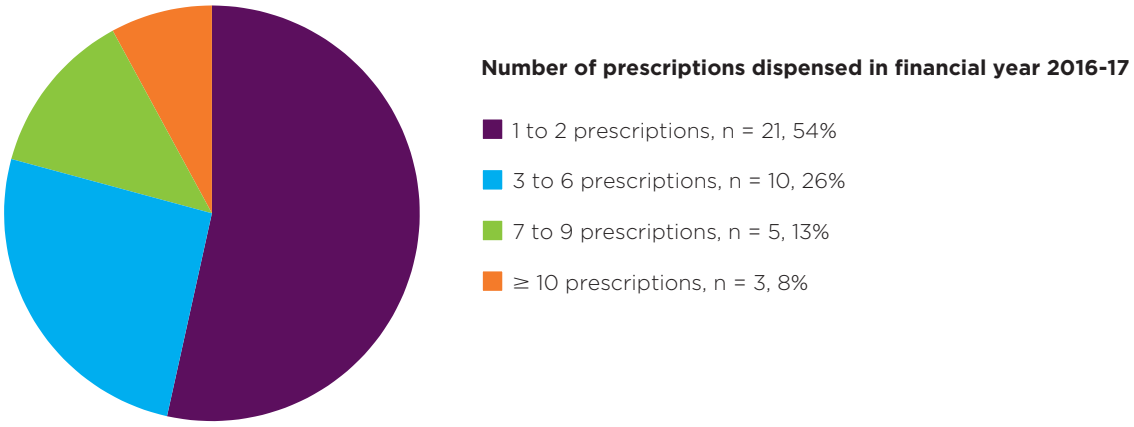


Note: Due to patients receiving multiple strengths of pregabalin on the same day, percentages may not total 100%, n = total number of patients. Data reflects prescriptions dispensed in financial year 2016–17.

Points for reflection

- Pregabalin is usually effective once up-titrated to 300-600 mg a day.[6] Use of subtherapeutic doses, including once-daily dosing,[14] may contribute to discontinuation of treatment due to inadequate pain relief.
- Start pregabalin treatment at a low dose (≤ 75 mg per day).[10] Consider lower initial doses and titrate the dose slowly to improve tolerability, especially in older and frail patients.[15]
- In 2016-17, **24 (62%)** of your patients started pregabalin treatment[e] with **13** of these patients starting treatment with 25 mg strength capsules and **11** of these patients starting with 75 mg strength capsules.
- It is estimated that only 9.4% of patients have their starting dose of pregabalin up-titrated.[1]

How adherent are your patients to pregabalin treatment?



Note: Based on twice-daily dosing, each pack of pregabalin should usually last 28 days; a patient would usually require 12 prescriptions per year. Due to rounding percentages may not total 100%.

Points for reflection

- Pregabalin usually requires an adequate trial of twice-daily administration for 4 weeks, with at least 2 weeks at the maximum tolerated dose,[11] as it may take several weeks to achieve effective pain relief.[15]
- An estimated 44% of patients stop pregabalin treatment after one prescription. High rates of pregabalin-related adverse effects could be a possible reason for discontinuation.[1]
- Starting pregabalin at a lower dose, splitting the dose and gradually up-titrating to the effective dose may minimise the risk of adverse effects.[15,16]
- Review each patient regularly and assess adherence and tolerance to medicines.
- Recognise that neuropathic pain medicines are only partially effective in managing pain.[6,10] Non-pharmacological strategies, such as exercise[17] and cognitive behavioural programs[18] may be useful in reducing and managing pain.

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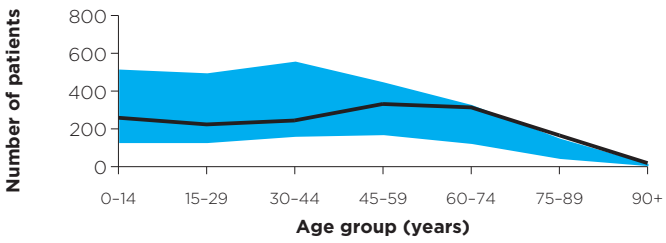
Practice profile

Age profile of your patients is provided to help you interpret your prescribing data.

Age profile of your patients

(1 July 2016 to 30 June 2017)



The black line represents the age profile of your patients. The shaded area lies between the 25th and 75th percentile for GPs in your RA[f].

Your RA[f] peer group is Major City

Your Medicare patients and concession card holders

(1 April 2017 to 30 June 2017)

Patients	You	Median of GPs in your RA[f]
Total Medicare	777	624
Concession card holders Includes those reaching Safety Net	315	167

Data from a 3-month period that represent patient mix have been provided. Department of Veterans' Affairs health card holders are not included.

Confidentiality

NPS MedicineWise has a contract with the Department of Human Services (DHS) for the supply of both MBS and PBS data which contains individual provider names and numbers, and aggregated patient data. This information is stored by NPS MedicineWise in Australia and is protected using multiple layers of accredited security controls, including best-practice encryption methods. This information is only accessed by NPS MedicineWise staff who have obtained an Australian Government security clearance.

Disclaimer

This information is derived from a critical analysis of a wide range of authoritative evidence and guidelines. Great care is taken to provide accurate information at the time of creation. This information is not a substitute for medical advice and should not be exclusively relied on to manage or diagnose a medical condition. NPS MedicineWise disclaims all liability (including for negligence) for any loss, damage or injury resulting from reliance on or use of this information.

Discrepancies may occur between the data provided and your own practice. This may be due to inaccurate recording of your provider number within the system or use of your provider number by someone else.

Contact

For queries about your data or any of this information, contact NPS MedicineWise:

02 8217 8700 @ info@nps.org.au

This mailout is sent to your preferred mailing address, as held at the Department of Human Services.

To update your preferred mailing address:

use Health Professional Online Services (HPOS) as a self-service option at https://www.humanservices.gov.au/health-professionals

@ send your full name, provider number and new preferred mailing address to provider.registration@humanservices.gov.au from a personal email address that clearly identifies you, or is the email address stored on the Medicare Provider Directory.

References

References available online at: nps.org.au/pbs-neuropathicpain

Notes

a. Other medicines are: amitriptyline, carbamazepine, duloxetine and gabapentin.
b. Data shown are an aggregate of all your provider locations.
c. Fibromyalgia is no longer defined as a neuropathic pain condition.[19,20]
d. MedicineInsight data as at 1 January 2018.
e. 'Started pregabalin treatment' is defined as the patient had their first prescription for pregabalin in this time period (financial year 2016-17) and did not have a prescription for pregabalin in the previous 12 months.
f. The comparator group 'RA' includes all general practitioners currently located in a similar geographical location (ie, major city, inner regional, outer regional, remote, very remote).

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