Gabapentinoid suggested tapering regimes

This document is to be used in conjunction with the following guidance document:

Analgesic Tapering Guidelines for adult patients with persistent pain patients taking strong opioids and/or gabapentinoids.

At best, no more than 25% of patients of patients with certain long term pain conditions (including painful diabetic neuropathy, pain following stroke and post herpetic neuralgia) receive *any* benefit from gabapentinoids.[1,2,3] A 50% reduction in pain is experienced by even fewer.[1,2,3]

Prescribing of gabapentinoids for neuropathic pain should be reviewed in line with the criteria set out in NICE[4] and should be gradually discontinued if ineffective. Even people who think they might obtain benefit from the use of a pregabalin or gabapentin should undertake a trial dose reduction periodically, to ensure they are benefiting / to see if they get the same benefit on a lower dose. Gabapentinoids are licenced for neuropathic pain and are very unlikely to be of benefit when prescribed for non-neuropathic pain.[5]

Side effects of gabapentinoids include sedation, weight gain, suicidal ideation, mood changes, hallucinations, muscle and joint pain, sexual dysfunction, and impaired immune response.

Co-prescribing of opioids and gabapentinoids ***should be avoided if possible,*** *due to the increased risk of respiratory depression, accidental overdose, and death.* The MHRA and manufacturers advise that when prescribing gabapentin in patients who require concomitant treatment with opioid medicines, patients should be carefully observed for signs of CNS depression, such as somnolence, sedation, and respiratory depression, and the dose of either gabapentin or the opioid should be reduced appropriately.[6,7]

Dose changes should be individualised to the person. The aim is not necessarily to stop the gabapentinoid medication, but there should be efforts made to reduce risk. Withdrawal effects are more likely where someone is on high dose gabapentinoid or has been taken for more than 6 weeks. Where a gabapentinoid has to be discontinued due to medical reasons it is recommended this should be done gradually over a minimum of 1 week independent of the indication[3]. If there is a planned reduction of gabapentinoid, this can be done as recommended on pages 2 and 3.

Before starting:

- Where possible, ensure any reduction is discussed and agreed with the patient.
- Agree the speed of dose reduction with the patient.
- Typically, one change per week is recommended. Some patients will need space to acclimatise to the new dose so the dose changes may be every one to two weeks. Inform the patient that reduction can be slowed but not reversed.

Gabapentin

A suggested regime for a patient who is already taking gabapentin 1200mg three times daily is included below. If the patient is taking a lower dose than 1200mg TDS then start the process further down the table and follow the suggested tapering guidance.

Dose changes should be individualised to the person, and made not more frequently than weekly.

Agreed dose reduction interval: weekly, fortnightly, monthly
Enter the table at the appropriate dose level
Gabapentin is available in the following formulations 100mg, 300mg,400mg capsules and 600mg and 800mg tablets

Change (e.g. weekly / fortnightly / monthly)	**Morning gabapentin dose**	**Midday gabapentin dose**	**Evening gabapentin dose**
1	900mg	1200mg	1200mg
2	900mg	900mg	1200mg
3	900mg	900mg	900mg
4	600mg	900mg	900mg
5	600mg	600mg	900mg
6	600mg	600mg	600mg
7	300mg	600mg	600mg
8	300mg	300mg	600mg
9	300mg	300mg	300mg
10	STOP	300mg	300mg
11	STOP	STOP	300mg
12	STOP	STOP	STOP

NB

- An alternative regime is to take the same dose reduction across the day. If the start dose is 1200mg three times a day, then the first reduction is 1100mg three times a day, and the second reduction is 1000mg three times a day etc. This may be more difficult in terms of the available formulations.
- Avoid using the liquid as levels of propylene glycol, acesulfame K and saccharin sodium may exceed the recommended WHO daily intake limits in low weight adults leading to electrolyte changes.[8]

Pregabalin

A suggested regime for a patient who is already taking pregabalin 300mg twice daily is included below. If the patient is taking a lower dose than 300mg BD then start the process further down the table and follow the suggested tapering guidance.

Dose changes should be individualised to the person, and made not more frequently than weekly.

Agreed dose reduction interval: weekly, fortnightly, monthly
Enter the table at the appropriate dose level
Pregabalin is available in the following formulations: 25mg, 50mg, 75mg, 100mg, 150mg, 200mg, 225mg and 300mg capsules and tablets.

Change (e.g. weekly / fortnightly / monthly)	Morning pregabalin dose	Evening pregabalin dose
1	250mg	300mg
2	250mg	250mg
3	200mg	250mg
4	200mg	200mg
5	150mg	200mg
6	150mg	150mg
7	100mg	150mg
8	100mg	100mg
9	50mg	100mg
10	50mg	50mg
11	STOP	50mg
12	STOP	STOP

Notes

- An alternative regime is to take the same dose reduction (25mg per dose) across the day. If the start dose is 300mg two times a day, then the first reduction is to 275mg twice a day, and the second reduction is 250mg twice a day etc.
- Avoid using the liquid which is comparatively a very high cost formulation.
- Pregabalin capsules are usually slightly lower cost than tablets for the NHS.

References

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