NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

CLINICAL GUIDELINE EQUALITY IMPACT ASSESSMENT - RECOMMENDATIONS

Clinical guideline: Neuropathic pain – pharmacological management: the pharmacological management of neuropathic pain in adults in non-specialist settings

As outlined in The guidelines manual (2012), NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. The purpose of this form is to document the consideration of equality issues in each stage of the guideline production process. This equality impact assessment is designed to support compliance with NICE's obligations under the Equality Act 2010 and Human Rights Act 1998.

Table 1 below lists the protected characteristics and other equality factors NICE needs to consider, i.e. not just population groups sharing the 'protected characteristics' defined in the Equality Act but also those affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. The table does not attempt to provide further interpretation of the protected characteristics.

This form should be drafted before first submission of the guideline, revised before the second submission (after consultation) and finalised before the third submission (after the quality assurance teleconference) by the guideline developer. It will be signed off by NICE at the same time as the guideline, and published on the NICE website with the final guideline. The form is used to:

- record any equality issues raised in connection with the guideline by anybody involved **since scoping**, including NICE, the National Collaborating Centre, GDG members, any peer reviewers and stakeholders
- demonstrate that all equality issues, both old and new, have been given due consideration, by explaining what impact they have had on recommendations, or if there is no impact, why this is.
- highlight areas where the guideline should advance equality of opportunity or foster good relations

- ensure that the guideline will not discriminate against any of the equality groups

Table 1 NICE equality groups

Protected characteristics
• Age • Disability • Gender reassignment • Pregnancy and maternity • Race • Religion or belief • Sex • Sexual orientation • Marriage and civil partnership (protected only in respect of need to eliminate unlawful discrimination)
Additional characteristics to be considered
• Socio-economic status Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas, or inequalities or variations associated with other geographical distinctions (for example, the North–South divide; urban versus rural).
• Other Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status. Whether such groups can be identified depends on the guidance topic and the evidence. The following are examples of groups that may be covered in NICE guidance: • refugees and asylum seekers • migrant workers • looked-after children • homeless people.

1. Have the equality areas identified during scoping as needing attention been addressed in the guideline?

Please confirm whether:

- the evidence reviews addressed the areas that had been identified in the scope as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability

What issue was identified and what was done to address it?	Was there an impact on the recommendations? If so, what?
It was identified during scoping that it was not within the remit of this guideline to consider the management of neuropathic pain in specialist pain services.	Within the update, the guideline development group (GDG) has maintained recommendations on key principles of care, which the group felt were very important when providing recommendations on drug treatments for neuropathic pain. This is to ensure that pharmacological management of the condition in non-specialist settings is managed holistically and so that healthcare professionals are able to sufficiently judge when referral to specialist services is required. These principles were derived from the evidence from one very large evidence review which looked at most effective monotherapy and combination therapy for the pharmacological management of neuropathic pain, and GDG expertise.
It was identified during scoping that certain pharmacological interventions for neuropathic may vary by underlying condition and ethnic group.	Throughout the development of the guideline the GDG considered whether treatment was likely to vary by underlying condition and ethnic group. The GDG considered how healthcare professionals would begin to treat a person presenting with apparent neuropathic pain in a non-specialist setting. The GDG took the *a priori* decision to look at the evidence in the following groups; central pain, peripheral pain and trigeminal neuralgia. The evidence was presented to the GDG within these groups. Little good quality evidence emerged which would have allowed the GDG to consider variations by underlying condition or ethnic group. The GDG felt that grouping conditions within central pain and peripheral pain would make most sense clinically and it was expected that the mode of action by which pharmacological agents would work within these groups would be similar. Although the evidence was presented for

	central pain and peripheral pain to the GDG separately, the GDG did not feel in a position to recommend different treatments for these two groups. No evidence was found for trigeminal neuralgia but the GDG felt that it was important that treatment licensed for this indication was recommended for people with trigeminal neuralgia. The GDG agreed that it would be appropriate to make a consensus recommendation for this subgroup.
Other comments	

2. Have any equality areas been identified *after* scoping? If so, have they have been addressed in the guideline?

Please confirm whether:

- the evidence reviews addressed the areas that had been identified after scoping as needing specific attention with regard to equality issues (this also applies to consensus work within or outside the GDG)
- the GDG has considered these areas in their discussions.

Note: some issues of language may correlate with ethnicity; and some communication issues may correlate with disability

What issue was identified and what was done to address it?	Was there an impact on the recommendations? If so, what?
The GDG identified that a greater body of evidence existed for peripheral neuropathy and within certain drugs licensed for use in neuropathic pain, which may favour some interventions over others simply based on the quantity of evidence.	The GDG chose to make an off label recommendation for amitriptyline. Based on the limited evidence available and GDG expertise of clinical practice, the GDG felt that this should be among the initially recommended treatment options for people with neuropathic pain. The GDG also chose to make research recommendations for more good quality studies to be conducted to look at the effectiveness of pharmacological agents for neuropathic pain. In addition, they also formulated a recommendation on how the symptomatic treatment of neuropathic pain relates to the underlying cause.
Stakeholders during consultation as well as the GDG identified that prescribing of neuropathic pain pharmacological treatments may differ for people with current drug misuse issues or a history of drug misuse.	Based on the strength of views from stakeholders during guideline consultation, the GDG revisited this discussion at their final group meeting. The GDG felt there was little within the evidence to suggest that pharmacological treatment for neuropathic pain for people with dependency issues should be different but were clear that this would be something that clinicians will want to consider in discussion with the individual. The GDG thought it may actually be the case that some people with current drug misuse issues or a history of drug misuse may actually be under treated if this sub group was separated out in the recommendations. The GDG concluded that the key principles of care which mention the need for regular clinical review and monitoring would address any issues such as substance misuse and individual clinical judgement should be used in situations where dependency issues may be present.
Stakeholders during consultation identified concerns around prescribing in primary care for people with HIV, older people and people who may be on concomitant treatment.	The GDG considered stakeholder concerns about the risks of treating neuropathic pain amongst people with HIV, older people and people on concomitant medication. They recognised that this was a very important issue. The GDG felt that a specific recommendation

	about the risk of prescribing for people with HIV and older people would not be required as consideration of this by the clinician would be implicit in recommendation 1.1.1, when agreeing an individualised treatment plan. Bullet point 4 of this recommendation also explicitly refers to concurrent medications that an individual may be on and any physical or psychological problems experienced by the individual. The GDG felt that due to the ambiguity of the term older people, that this should not be added to the recommendations. There was strong opinion that this guidance should empower health care professionals in non-specialist settings and there was real concern the lack of clarity about who the term older people may refer to could lead to under-treatment.
Other comments	

3. Do any recommendations make it impossible or unreasonably difficult in practice for a specific group to access a test or intervention?

For example:

- does access to the intervention depend on membership of a specific group?
- does using a particular test discriminate unlawfully against a group?
- would people with disabilities find it impossible or unreasonably difficult to receive an intervention?

There are no recommendations which make it impossible or unreasonably difficult in practice for a specific group of people with neuropathic pain to access pharmacological treatment.

Only one 'do not' recommendation was made for starting treatment with the following pharmacological agents in non-specialist services unless advised by a specialist pain service. Treatments which came under this recommendation were cannabis sativa extract, capsaicin patch, lacosamide, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, venlafaxine and tramadol (where this is not being prescribed for short-term rescue use). This recommendation was based on clinical and health economic evidence which demonstrated a lack of efficacy for a number of these drugs, higher rates of adverse events and or high costs.

However, these treatments will still be open to people with neuropathic pain where there has been discussion and agreement around treatment between the individual and the clinician and advice has been sought from a specialist pain service.

4. Do the recommendations promote equality?

State if the recommendations are formulated so as to advance equality, for example by making access more likely for certain groups, or by tailoring the intervention to specific groups.

The only recommendations which are separated out by type of neuropathic pain are those for trigeminal neuralgia. No clinical evidence was found within this subgroup but the GDG felt it clinically and ethically important that people with trigeminal neuralgia have access to treatment whilst waiting to be or in the process of being referred for specialist assessment.

The other recommendations provide guidance for healthcare professionals and patientswho are managing peripheral and/or central neuropathic pain and will ensure access to appropriate treatment.

5. Do the recommendations foster good relations?

State if the recommendations are formulated so as to foster good relations, for example by improving understanding or tackling prejudice.

The recommendations are not separated by cause of underlying pain as the GDG felt that this approach may favour underlying conditions or pharmacological treatments where a much greater body of research has been undertaken. It was also felt that to split and look at the evidence by area of the pain was more pragmatic and clinically sensible as often clinicians working in non-specialist settings would not necessarily be able to diagnose or have access to information on the patient's underlying condition or existing neuropathic pain diagnosis.

After looking at the evidence for peripheral and central pain, the GDG found little difference in the effectiveness of treatments for these 2 subgroups and so one set of recommendations has been made for all people with neuropathic pain (except trigeminal neuralgia). As such the recommendations should hopefully stop treatment delay for those without an existing diagnosis and also emphasise the importance of referring to a Pain Specialist where pain is not controlled and/ or further assessment is required.