Standard Operating Procedure

Painful Distal Sensory polyneuropathy in Diabetes Mellitus

Special Region (1)

Union Of Myanmar

Version: 1.0

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Approved by: Internal Medicine Unit

1. Purpose

To provide a standardized approach for diagnosis and management of painful distal sensory polyneuropathy in diabetes mellitus.

2. Definition

Painful diabetic neuropathy is a distal sensory polyneuropathy causing burning, stabbing, or electric pain, usually in a stocking distribution.

3. Clinical Features

- Burning pain
- Tingling
- Allodynia
- Worse at night
- Reduced sensation
- Reduced ankle reflexes

4. Red Flags

- Rapid progression
- Motor weakness
- Asymmetry
- Sphincter involvement

5. Assessment

History:

- Diabetes duration
- Glycemic control
- Alcohol use
- Medication history

Examination:

- Foot inspection

- Monofilament test

- Vibration sense

- Reflexes

6. Investigations

- HbA1c

- Renal function

- Vitamin B12

- TSH

7. Management

7.1. Non-pharmacological:

- Foot care

- Proper footwear

- Glycemic control

7.2. Pharmacological treatment

Drug	Starting Dose	Titration Strategy	Usual / Maximum Dose	Dose Escalation Interval	Common Side Effects	Key Clinical Notes
Amitriptyline	10 mg nocte	Increase by 10–25 mg	25–75 mg nocte (max ~100 mg in selected	Evy **5–7 D days**	Sedation, dry mouth, constipation, urinary retention, blurred vision,	Best for **night pain + insomnia**; avoid in elderly (falls), cardiac disease, glaucoma, BPH

Drug	Starting Dose	Titration Strategy	Usual / Maximum Dose	Dose Escalation Interval	Common Side Effects	Key Clinical Notes
			cases)		orthostatic hypotension	
Duloxetine	30 mg daily	Increase to 60 mg	60 mg daily (max 120 mg, but usually no added benefit)	After **1–2 weeks**	Nausea, dizziness, insomnia, dry mouth, ↑BP (rare), hepatotoxicity (rare)	Preferred if **depression/anxiety present**; avoid in **liver disease**
Pregabalin	75 mg BD	Increase to 150 mg BD → 300 mg/day	150–300 mg/day (max 600 mg/day)	Every **3–7 days**	Dizziness, somnolence, edema, weight gain, blurred vision	Adjust dose in **CKD**; rapid onset; caution with sedation/falls
Gabapentin	100–300 mg nocte or BD	Gradually titrate upward	900–3600 mg/day in 3 divided doses	Every **3–7 days**	Dizziness, somnolence, ataxia, peripheral edema	Adjust in **CKD**; slower titration; useful if cost issue

Dose Escalation Principles

Start **low → go slow**

- Reassess after:
    - **2–4 weeks** (initial effect)
    - **6–8 weeks** (full effect)
- Stop or switch if:
    - <30% improvement
    - Intolerable side effects

When to Use Combination Therapy

Use combination therapy **ONLY when:**

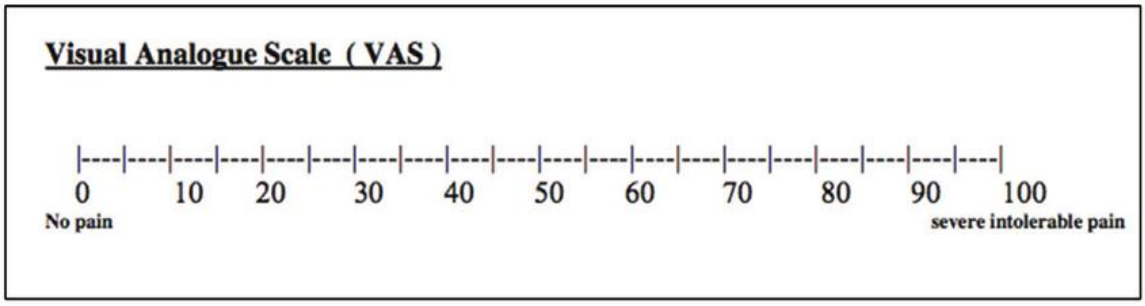
- Partial response (**<50% pain reduction**) after adequate trial of **one drug at optimal dose**
- Drug limited by **side effects before reaching effective dose**
- Severe neuropathic pain requiring multi-mechanism control

Preferred combination regimen

Combination	Rationale
Amitriptyline + Pregabalin	TCA + calcium channel modulation → synergistic
Duloxetine + Pregabalin	SNRI + central sensitization control
Gabapentin + Amitriptyline	Different mechanisms, commonly used

8. How to measure pain control?

Visual analogue scale is one of the favorite tools to assess the severity of neuropathic pain.



- 30 -50 % reduction in intensity of neuropathic pain is the favorable response while receiving treatment.

9. Avoid

- Routine opioid use

10. Follow-up

- 2–4 weeks initial review

- Then every 1–3 months

11. Referral

- Atypical features

- Refractory pain

- Foot ulcer

12. Foot Care Advice

- Daily inspection

- Avoid barefoot walking

13. References

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