Other Antidepressants
Duloxetine is a SNRI antidepressant licensed for use in depression, SUI and neuropathic pain. There is evidence of benefit in diabetic neuropathy and FM at a dose of 60 mg/day [439, 440]. Side-effects are common and may result in its discontinuation.

Anticonvulsants
Anticonvulsants are commonly used in the management of neuropathic pain. There are general studies and some looking more particularly at pelvic pain. Individual agents have been systematically reviewed. Their use is suggested in the NICE Neuropathic Pain Guidelines [437].

Carbamazepine has a long history of use in neuropathic pain. Evidence exists for its benefit [441]. Trials trend to be of short duration, showing only moderate benefit. There are side-effects; some of which may be serious. It is no longer a first choice agent. Other anticonvulsant agents are available with fewer serious side-effects.

Gabapentinoids
There is a growing awareness and evidence of the risk for dependence and misuse of gabapentinoids [442]. A formal assessment of efficacy against benefit and side-effects (both pain and QoL) is required with the patient in order to determine the lowest effective dose and if longer-term treatment is to be used.

Gabapentin is commonly used for neuropathic pain and has been systematically reviewed [443, 444]. This demonstrates good evidence for posterpatic neuralgia and diabeltic neuropathy but evidence for other neuropathies is limited. A double-blind RCT looking at CPPPS in women with no obvious pathology demonstrated no benefits but higher levels of side effect [444].

Pregabalin is a commonly used neuromodulator with good evidence of efficacy in some neuropathic conditions [445]. The dose for benefit is in the range of 300-600 mg/day. Evidence for central neuropathic pains is inadequate. Some patients do gain moderate to significant benefit but most will gain no benefit and then the drug should be discontinued. Other agents can be used in the management of neuropathic pain but they are best administered by specialists in the management of pain whom are familiar with their use. They tend to be considered after the standard options have been exhausted. As with all good pain management, they are used as part of a comprehensive multi-dimensional management plan.

Opioids
Over recent years opioids have been used extensively for managing chronic non-cancer pain. There is increasing evidence that their role is limited in this population but may be beneficial for a small number of patients at a low dose in a managed setting [446]. There is clear evidence of harm and significant professional, public and political interest. Their use is beneficial for both acute pain and for cancer pain management particularly towards the end of life.

Often patients will stop taking oral opioids due to side effects or insufficient analgesic effect [447]. There is clear evidence of harm including effects on the endocrine and immune systems as well as a growing understanding of opioid-induced hyperalgesia [448]. There is limited guidance on the best method for tapering the dose of opioids with the aim of stopping or finding the lowest effective dose [449].

Opioids should only be used in conjunction with a management plan with consultation between clinicians experienced in their use. It is suggested that a pain management unit should be involved along with the patient and their primary care physician. Ensure there are arrangements for formal monitoring, follow-up and review. If opioids are used and the pain remains, then they are not working and should be stopped even if there is no alternative [448].

The risk of harm increases substantially at doses above 120 mg/day morphine equivalence [448] and guidance suggests regular (at least annual) review for patients with over 50 mg/day morphine equivalence and pain specialist involvement above 90 mg/day morphine equivalence [450].

There are well-established guidelines for the use of opioids in pain management as well as considering the potential risks [448, 450]. Opioid reduction and optimisation should be undertaken where opioids are not providing clear measurable benefit. There is also information available online for patients [448]. Opioids Aware is a web-based resource for patients and healthcare professionals, jointly produced by the Faculty of Pain Medicine of Royal College of Anaesthetists and Public Health England, to support prescribing of opioid medicines for pain: https://fpm.ac.uk/opioids-aware.