Develop Strategy to Halt Overuse of Pain Meds

BY JANE SALODOF McNEIL

S COTTSDALE , A RIZ . — Withdraw- ing patients from overused headache medica- tions is long, hard work for them, but it can be accomplished with strong physi- cian support, Dr. Todd D. Rozen told clin- icians at a symposium sponsored by the American Headache Society.

Dr. Rozen, a neurologist at the Michi- gan Head-Pain and Neurological Institute in Ann Arbor, Mich., outlined a com- copia of maneuvers ranging from med- ication switches to acupuncture and biofeedback that can be used to accom- plish withdrawal.

Getting patients to adopt realistic ex- pectations is crucial to successful with- 
drawal, he said. Chronic daily headache patients must understand at the outset that the brain has to reset and takes time to heal after long-time overuse of medica- tions. Eventually they may have fewer headaches, he said, but they will not be headache free after withdrawal.

"The goal is to get away from daily headache," he said. "I tell my patients, hav- ing migraine is normal ... but daily pain is never normal." Whether you decide that inpatient treat- ment is necessary or that outpatient treat- ment is possible, quickly discontinue the overused medication, because tapering it does not work, Dr. Rozen advised.

Patients who overuse an over-the- counter remedy can usually withdraw with outpatient therapy, he said. Some pa- tients can even stop "cold turkey." In most cases, however, he recommended switching them to a longer-acting nonsteroidal anti-inflammatory drug such as naproxen sodium or indomethacin for 5-7 days per week and then tapering it down to 3-4 days per week.

Meanwhile, prepare the patient to deal with pain, he advised. "You have to have a treatment strategy for mild pain, mod- erate pain, and severe pain." He said the pain is the barrier to treat in some respects because the strategy is to pursue alternative therapies rather than medication, he said. These alternative considerations include hydration, relaxation tech- 

iques, biofeedback, and aerobic exer- cise, but not medication.

"If they can get over this step, they are going to get better," he said. "If they can’t, they will not." For moderate pain, Dr. Rozen suggest- ed indomethacin or naproxen sodium with or without a dopamine receptor an- tagonist. Start at 3-4 days per week, ta- pering down to 2 days per week. If the pa- tient has tension, add an anxiomer.

For severe pain, the medication choice can vary, but rescue therapy should be lim- ited to two times per week. "You need re- cure medication," he said. "It is helpful if patients are sedated. They have had this headache all day long. It helps if they sleep well," he said. Outpatient therapy usually works for patients who have overused triptans, but some need inpatient therapy. Triptan withdrawal is relatively fast and some patients can simply stop their medica- tion, he explained. But medication with- drawal also can mimic opioid withdraw- 

al with associated nausea, diarrheaa, and abdominal pain. Inpatients can be pre- pared to vary the dose.

Dr. Rozen said that he would clonazepam. Don’t try to taper patients off the drug as an inpatient.

Withdrawal seizures and needs to be weaned out of the drug as an inpatient. Dr. Rozen said. "They have to know that."

Pharmacists Have Misconceptions About Chronic Pain Management

BY FRAN LOWRY

O RLANDO — Pharmacists who dispense in the community tend to be skeptical about pa- tients who require chronic medication with controlled substances, according to a survey of pharmacists practicing in both urban and rur- al areas of Alabama.

The survey revealed that many pharmacists have serious misconceptions about chronic pain management and the way physicians prescribe medications to manage their pain, Karen F. Mar- 

lowe, Pharm.D., of the University of South Al- 

abama Medical Center, Mobile, said at the an- 

nual clinical meeting of the American Academy of Pain Management.

Dr. Marlowe sent a 40-question survey to 150 pharmacists who dispensed in two coun- 

ties between December 2003 and February 2006. Seventy-eight surveys were returned: slightly more than half of responders (53%) were female, and 25% worked in chain drug stores, 25% in independent pharmacies, 20% in hospitals, 16% in "big box" or supermarkets, and 14% in grocery stores.

For most of the respondents, pain medica- tion, including NSAIDs represented 25% of their daily prescription volume.

The pharmacists’ main concern was for their compliance with controlled substance regula- tions. Most considered their knowledge of pain medications and controlled substances good or excellent.

None felt they had received adequate ed- ucation about pain medications in pharmacy school. That response was something of a sur- prise to Dr. Marlowe. "I have looked at what is included in pharmacy school [curricula] in various parts of the country. Pharmacy schools on the West Coast have better pain [curricula] than do pharmacy schools on the East Coast. I graduated from Auburn University in 1995, and I got just 1 day ... out of 4 years to learn about choosing and monitoring pain therapy."

Two of the survey’s most interesting findings were that pharmacists perceive early refills of pain medication as a sign of addiction and that the majority of phar- macists felt uncomfortable dispensing opiates. "These are serious mis- 

understandings, and we need to target them as areas for further educa-

tion," she said.

The survey also found that female pharmacists were more likely to dis- pense emergency supplies of controlled sub- stances than male pharmacists (70% vs. 45%, respectively), while male pharmacists were more likely to agree with the statement that physicians overprescribe (males, 48%, vs. fe- 
males, 33%). Also, 50% of pharmacists in prac- tice longer than 15 years were more likely to contact a physician regarding pain medica- tions and seek an opinion on early refills.

Dr. Marlowe said that she plans to conduct similar surveys nationwide. "We need to determine which issues need to be addressed ... . We be- able to look at who specifically needs to be ed- ucated [and whether] misconceptions [are] re- cessional. And are they to taper off time out of school? Are they more prevalent in rural versus urban areas? In chain versus hospital pharma- 

cies? The results will be interesting to see."

Pharmacies and non-prescription stores, 25% in independent pharmacies, 20% in hospital stores, 25% in independent pharmacies, 20% in hospitals, 16% in "big box" or supermarkets, and 14% in grocery stores.

Factors Underlying Migraine

BY BRUCE K. DIXON

S COTTSDALE , A RIZ . — Mis- 

conceptions and other barriers to be- 

havioral therapy limit headache pa- 


tients’ access to potentially beneficial nonpharmacologic treatments. Don-

ald B. Penzien, Ph.D., said at a sym- 

posium sponsored by the American Headache Society.

Standard behavioral interventions include relaxation training, biofeed- 

back training, cognitive behavioral 

therapy, stress management, or 

some combination of these ap- 

proaches, said Dr. Penzien, profes- 

sor of psychiatry and director of the 

Head Pain Center at the University of 

Mississippi, Jackson.

Reimbursement and workforce is- 

sues limit the use of these non-

pharmacologic treatments, but an- 

other factor weighs heavily as well: the stigma of seeking care from a behavioral specialist, he said.

"The reality is that patients with migraine or tension headache don’t necessarily have emotional illness, yet research shows they still can benefit from behavioral therapy," he said in an interview.

Even the best pharmacologic agents have their limits because "migraine as a headache is a psychophysiological dis- 

order," Dr. Penzien explained.

Patients most suitable for behav- 

ioral therapy are those with poor tolerance of and medical contraindications for drug 

treatment or inadequate response to 

medications; those who prefer non-

drug interventions; pregnant and 

nursing women; and those with his- 


tory of frequent or excessive use of analgesic or other acute medications.

"Over 300 studies have evaluated behavioral therapy for the manage- 

ment of migraine. On average, these 

interventions have shown 35%-55% 

improvement pretreatment to post treat- 

ment," Dr. Penzien said.

Furthermore, he added, the ef- 

fects of behavioral treatments appear 

enduring; the literature shows effi- 


cacy up to 7 years post treatment.

Behavioral treatment typically en- 

tails 6-12 clinic sessions with a pro- 

fessional. Cost and time considera-


tions have given rise to the minimal 

therapist contact (MTC) approach, 

which requires fewer sessions. MTC 

interventions are started at the clinic and then patients are sent 

home with reading and audio ma-

aterials that guide their acquisition of 

new behavioral skills on their own time. "Minimal contact therapies are producing results in the range of 

what we can do with the more in-


tensive clinic-based therapies. The patients appreciate the convenience and lower cost," he said.

Dr. Penzien said that he would like to see more research. "Physicians and 

neurologists increase their focus on psychological and emotional fac- 

tors underlying migraine. "Rela- 


tively short-term behavioral inter-

ventions can be of great importance in 

assisting your patients to better manage their headaches."

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