Cancer Pain Needs Vary Among African Americans

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — African American cancer patients are heterogeneous in their need for pain medication, Salimah Meghani, Ph.D., said at a meeting sponsored by the Department of Health and Human Services and the Office of Minority Health.

Dr. Meghani interviewed 36 self-identified African American cancer patients from three outpatient oncology clinics in Philadelphia; all were over age 18 years and had solid tumors. All of the patients had self-reported pain at least 1 month in duration during the last 6 months; none had major surgery in the prior 3 months.

The patients filled out a 32-item self-report instrument assessing pain severity and its impact, and researchers conducted open-ended interviews lasting 50-70 minutes. To ensure reliability among coders, 15% of the transcripts were independently coded by Dr. Meghani and a consultant. They were 35-75 years old. Slightly more than half were male, two-thirds were single, and 89% were Christian, said Dr. Meghani, a postdoctoral fellow at the Center for Health Disparities Research at the University of Pennsylvania, Philadelphia. Almost all of the patients were insured; the median annual household income was in the $20,000-$30,000 range.

Only one-third of the patients said they preferred to take pain medication regularly. Overall, 25% said they were concerned about taking too much pain medication, and 36% said they had problems with side effects from pain medication. On the other hand, 19% of the patients said they needed more pain medication and 36% said they needed stronger medication.

Dr. Meghani separated 35 of the patients into three categories. (One patient did not participate in the interview and so could not be categorized.) The first category, which included four patients, was called “nonbelievers.” They didn’t want to take too much pain medication for fear that it would reoccurring disease.

The second, more middle-of-the-road category (“centralizers”), included 24 patients. They tended to take their pain medication despite their ambivalence about it. Dr. Meghani quoted one patient in this group: “I wish I could stop [taking the medication], but I know I can’t, so I have to deal with it.”

The third category, called “strong believers,” included seven patients. These patients were strongly in favor of taking pain medication, with one of them quoting as saying, “I don’t mind taking [pain medicine] because it relieves me and it keeps the pain down and it gives me a chance to get my rest.”

The study had several limitations, including a small sample size and lack of accounting for type or stage of illness, type or strength of the prescribed medication, and history of dependency. But the results showed that black patients cannot be put into a “one-size-fits-all” category regarding pain management, Dr. Meghani said.

Of the 36 patients, 25% said they were taking too much pain medication, 19% said they needed more, and 36% said they needed stronger medication.

Reasons for Failure of Chronic Daily Headache Tx Numerous

BY DAMIAN McNAMARA
Miami Bureau

SCOTTSDALE, ARIZ. — Consider a range of explanations when a chronic daily headache patient does not improve with new therapy, Dr. Joel R. Saper said at a meeting sponsored by the American Headache Society.

Some top reasons include medication overuse headache (formerly known as rebound headache), a wrong diagnosis, and psychobiologic or behavioral barriers to treatment, when a person with chronic daily headache fails to improve. Improperly selected or improperly dosed medication is other possible culprits, said Dr. Saper, founder and director of the Michi- gan Head Pain & Neurological Institute at the University of Michigan, Ann Arbor.

“My best two pieces of advice are to consider that individual as the first patient you’ve ever seen with chronic daily headache,” Dr. Saper said, “and it’s not daily chronic headache until you’ve ruled out everything else.” The differential dia-gnosis includes the other primary headache disorders and organic causes of intractable headache such as ophtalmic si-nusitis, an Arnold-Chiari malformation, and pseudotumor cerebri.

“How much you treat patients with chronic daily headache, the more you learn you did not get it right the first time,” Dr. Saper said.

Patients who take almost any headache medications 2 or 3 days a week for months are at higher risk for medication-overuse headache (Curr. Pain Headache Rep. 2005;9:430-5). This pro-gressive disorder is characterized by predictable and escalating headache frequency and medication use in patients with pre-existing headache.

“If you start a drug and are not there to deal with its consequences, you put all of us at risk,” Dr. Saper said. “You better be willing to monitor them” and change therapy when warranted.

Headache is a symptom of more than 300 illnesses, making diagnosis of a pri-mary disorder difficult. Causes of headache include cerebral venous occlusion, Lyme disease, infiltrative dis-ease, exposure to toxins, AIDS, and op-portunistic meningitis.

Psychiatric, behavioral, and drug mis-use barriers are more pervasive than per-haps appreciated, Dr. Saper said. Remember the basics, such as a thorough physical examination, comprehensive history, and getting differential informa-tion from relatives, he suggested.

“If we are dealing in some cases with challenging headaches or a challenging individual with headaches? It is important to ask when someone is not getting better,” Dr. Saper said.

Drug abuse and medication noncom-pliance are also possible when a patient is not improving, he said.

Interventional procedures are some-times necessary to treat intractable headaches. A neural blockade such as an epidural or C2-3 might help, or con-sider neural stimulation, Dr. Saper said.

Sometimes, hospitalization is required to reach a correct diagnosis. “An outpa-tient visit is a snapshot, a moment that you spend with that patient,” Dr. Saper said. “When trained staff is with a patient 24 hours for a day, you begin to learn something about that case you would not learn in an outpatient setting.” For example, how does a patient interact with their family? Does the patient speak down to the hospital cafeteria and eat something they are not supposed to?”

Improvements in Sleep Hygiene Benefit Chronic Migraine

BY DEBBIE LERMAN
Contributing Writer

PHILADELPHIA — Insomnia and poor sleep habits may be the cause of the transformation from episodic to chronic migraines, Dr. Anne H. Calhoun said in an interview with CONTEMPORARY PRACTICE IN HEADACHE.

This hypothesis turns on its head the former paradigm, which was that pain causes medication overuse. “I don’t think that that’s the case,” Dr. Calhoun said. “I think that it’s the case that the pain is a symptom and the greenhouse effect, the thermal or the low oxygen cause the blood vessels to dilate.”

In migraine headaches, the pain is a secondary symptom, Dr. Calhoun said. “The hypothesis is that there are other possible culprits, said Dr. Saper, founder and director of the Michigan Head Pain & Neurological Institute at the University of Michigan, Ann Arbor.

“I think if you look at the patients, you see that there’s a correlation between poor sleep and migraine. It’s not the case that people who have migraines have poor sleep; it’s the other way around.”

The American Migraine Foundation estimates that 20% of people with chronic daily headache have a sleep disorder.

Eliminate TV, reading, and music in bed. (60 minutes before bedtime). Reduce sleep-onset latency. (Use visualization technique, and allow no caffeine within 8 hours of bedtime).

Plan consistent and adequate time for nocturnal sleep period (8 hours for adults and 10 hours for adolescents).}

Sleep-Habit Modification For Patients

Avoid nootropics. (Allow 4 hours between dinner and bedtime, and minimize fluids before bed-time.)

Eliminate naps.