Teach Patients About Medication Overuse

**BY MICHELE G. SULLIVAN**
Mid-Atlantic Bureau

Henderson, Nev. — Treating medication overuse headache involves a three-pronged approach of patient education, teaching pain coping skills, and addressing psychological issues that put patients at risk, said Dr. Amy L. Lake III, Ph.D., said at a symposium sponsored by the American Headache Society.

Most patients don’t understand that excessive use of opioids can actually make them hyper-sensitive to pain, said Dr. Lake of the Michigan Head Pain and Neurological Institute, Ann Arbor. “They believe the pain is stronger than the medication, not that the medication is actually making them worse.” This thought process can be the root of ever-increasing medication use, as the patient experiences “pain anxiety” and attempts to forestall pain by pre-medicating.

The first step is to teach patients how medication overuse exacerbates headache pain, he said. Only when they have a clear understanding of this relationship will they be open to adhering to medication limits.

Sustained opioid use downregulates opioid receptors and upregulates excitatory receptors. This results in increased synthesis of excitatory neuropeptides. “Opioids are contraindicated in these patients, because ‘there is a risk that the patient will start to use them for the other pain problems, and then will have difficulty controlling the use. There’s also evidence that long term use of opioids actually may aggravate pain and make the patient less responsive to other treatment,’” he said.

Raynaud’s disease is also more common in migraine patients, as is a combination of Raynaud’s and noncardiac chest pain. Physicians should be wary of prescribing opioids or narcotics to headache patients who have these symp- toms, because “there is a risk that the patient will start to use them for the other pain problems, and then will have difficulty controlling the use. There’s also evidence that long term use of opioids actually may aggravate pain and make the patient less responsive to other treatment,” said Dr. Lake.

When asked about drug treatment options in headache patients, Dr. Lake said one important factor is to be very specific in your use of compounds that might contribute to headache pain. “I use as a teaching tool, also shows pa- tients that improvement isn’t happen- ing immediately. They need to stay the course. It takes time for the receptors to remodel, and how much time depends on how long they’ve been taking the medication and how much they’ve been on,” Dr. Lake said.

Simply taking away the analgesic isn’t the answer, he stressed. Patients need to understand that drugs are not the only way to alleviate headaches, and that they will probably have to tolerate some level of pain. “The evidence, clinically and em- pirically, shows that long term use of these patients to move to pain-free days. They have to find ways of dealing with headache that doesn’t involve drugs.”

Biofeedback, stress management, and antidepressants all may be effective tools in relancing responses to headache pain. A 2001 study concluded that a combination of stress management and antidepressants was more effective than was either treat- ment alone in reducing chronic tension-type headache (JAMA 2001;285:2208-15).

And a 2002 study of medication overuse relapse showed that 3 years after medica- tion withdrawal, patients on a combina- tion of propranolol and the triptan narco- dicain had experienced significantly fewer headaches per month and used less anal-gesic medication per month than did those on prophylaxis only (Headache 2002;42:483-90).

Treating any comorbid psychiatric dis- order is critical, Dr. Lake said. His own unpublished study of 267 consecutive pa- tients shows how common psychiatric disorders are in headache patients: All of the patients had at least one Axis I disor- der, including depression (70%) and anxi- ety (42%); 26% had an Axis II personality disorder. Of those with an Axis II disorder, 63% had medication overuse headache, compared with 42% of those without such a disorder. The presence of an Axis II disorder was significantly asso- ciated with a poor long-term outcome.

Hospitalization may be the best way to assess the presence of these additional problems. “This gives you an opportuni- ty to observe not only the patient’s be- havior, but family interactions and mari- tal problems that you might not see otherwise. As they come into your of- fice they may be able to pull it all togeth- er for a half an hour, but when you see them day in and day out, you have the op- portunity to get to know the patient and family. It’s all right there in front of you,” Dr. Lake said.

Comorbid Illnesses Are Common in Migraine

**BY MICHELE G. SULLIVAN**
Mid-Atlantic Bureau

Henderson, Nev. — The concom-itant and comorbid conditions associated with migraine and chronic daily headache offer both therapeutic challenges and op- portunities, Dr. Elizabeth W. Loder said at a symposium sponsored by the American Headache Society.

These problems may not be severe enough to warrant inpatient therapy on their own, but when combined with headache, they result in such a burden of symptoms that hospitalization might make sense, said Dr. Loder, director of the headache management program at Spaulding Rehabilitation Hospital in Boston.

“Sometimes it’s expeditious to do other things in the hospital, even though you’re not necessarily admitting them for that rea- son,” she said. “For example, I think it’s very useful to have polysomnography for oxygen levels done on all your headache patients admitted to the hospital. You’ll find a lot of sleep apnea that way. Treating that in isolation is important, but it may im- prove the headache situation as well.”

Some of the most frequent findings are other pain disorders. “It’s very uncommon to have a headache patient in the hospital who doesn’t also have some other pain disorder,” Dr. Loder said.

Among the most common pain disor- ders in this population are fibromyalgia, back and neck pain, musculoskeletal pain, irritable bowel syndrome, and noncar- diac pain. Physicians should be wary of prescribing opioids or narcotics to headache patients who have these symp- toms, because “there is a risk that the patient will start to use them for the other pain problems, and then will have difficulty controlling the use. There’s also evidence that long term use of opioids actually may aggravate pain and make the patient less responsive to other treatment,” she said.

Raynaud’s disease is also more com- mon in migraine patients, as is a combi- nation of Raynaud’s and noncardiac chest pain. The cluster of symptoms may stem from underlying microvascular disease. “This impos- ition of trigger points is of significant concern, but may some- how improve the Raynaud’s symptoms while acting as a migraine preventive.”

Microvascular disease may also be im- plicated in the connection of migraine with coronary heart disease, Dr. Loder said. Numerous studies have documented the association, including the National Health and Nutrition Examination Survey, which found a doubling of the risk of heart attack in migraineurs. Subsequent studies have not upheld that conclusion.

“The evidence is conflicting,” Dr. Loder said. “None of the studies were designed specifically to look at the association of migraine with heart disease, so you’re re- lying on previously diagnosed migraine” as the variable. Since most diagnosed mi- grane is usually severe, often with aura, the study populations are probably skewed. “What we are probably seeing is the incidence of cardiovascular disease in the patient population. But the defi- nitive statement on this awaits a prospec- tive study.”

She said, however, that primary heart disease, including uncontrolled hyperten- sion, dyslipidemia, and obesity, is a compo- nent of many migraine triptan options because triptans and dihydroergoto- matine are contraindicated in these pa- tients. “Controlled hypertension is not a contraindication for triptans, but pa- tients might have other risk factors, so you might feel more comfortable assessing them in the hospital,” Dr. Loder said.

Chronic Pelvic Pain Linked to Illness, Abuse

**BY JOHN R. BELL**
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Pelvic disease, psychological mor- bidity, and abuse are three of the factors most strongly associ- ated with chronic pelvic pain in women, according to a metaanalysis including data on more than 90,000 patients. Dr. Pallavi Lathie and colleagues at the University of Birmingham (Eng- land) evaluated 122 studies that exam- ined dysmenorrhea, dyspareunia, and noncyclic pelvic pain, including re- cent current pelvic pain. The reports in- cluded were published in six languages and were extracted from several large databases; a total of 69,927 women were assessed.

Studies were chosen based on inclusion of relevant clinical and statistical terms, as well as the quality of the research design (BMJ 2006;332:749-55).

Patient characteristics associated with dysmenorrhea were being at least 30 years of age, having a body mass in- dex of less than 20 kg/m², smoking, menarche before the age of 12, irreg- ular or heavy menstrual flow, pre- menstrual symptoms, clinically sus- pected pelvic inflammatory disease, sterilization, and history of being sex- ually assaulted.

The factors associated with de- creased risk were use of oral contra- ceptives, being married, having chil- dren, exercising, and including fish in the diet.

For dyspareunia, associated factors were having undergone female genital mutilation, having clinically suspected pelvic inflammatory disease, and being peri- or postmenopausal. Depression, anxiety, and history of sexual assault were more common in women with dyspareunia.

Those factors most strongly associat- ed with noncyclic pelvic pain were childhood or adult physical, sexual, or other abuse; miscarriage; longer menstrual flow; pre- menstrual symptoms, clinically sus- pected pelvic inflammatory disease, psychological morbidity, and sexual assault.

The investigators concluded that “strong and consistent associations” ex- isted “between chronic pelvic pain and presence of pelvic pathology, history of abuse, and coexistent psychological morbidity . . . [providing] potential tar- gets for new prevention and interven- tion strategies for treating women with this disabling con- dition, for which current treatment op- tions provide little relief.”