Develop Strategy to Halt Overuse of Pain Meds

BY JANE SALODOF MACNEIL
Southwest Bureau

SCOTTSDALE, ARIZ. — Withdrawing patients from overused headache medications is long, hard work for them, but it can be accomplished with strong physician support, Dr. Todd D. Rozen told clinicians at a symposium sponsored by the American Headache Society.

Dr. Rozen, a neurologist at the Michigan Head-Pain and Neurological Institute in Ann Arbor, Mich., outlined a cornucopia of maneuvers ranging from medication switches to acupuncture and biofeedback that can be used to accomplish withdrawal.

Getting patients to adopt realistic expectations is crucial to successful withdrawal, he said. Chronic daily headache patients must understand at the outset that the brain has to be reset and takes time to heal after long-time overuse of medications. 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, having migraine is normal …but daily pain is never normal."

Whether you decide that inpatient treatment is necessary or that outpatient treatment 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 patients 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, moderate pain, [and] severe pain."

Mild pain is the hardest to treat in some respects because the strategy is to pursue alternative therapies rather than medication, he said. These alternatives could include hydration, relaxation techniques, biofeedback, and aerobic exercise, 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 suggested indomethacin or naproxen sodium with or without a dopamine receptor antagonist. Start at 3-4 days per week, tapering down to 2 days per week. If the patient has nausea, add an antiemetic.

For severe pain, the medication choice can vary, but rescue therapy should be limited to two times per week. "You need rescue medication," he said. "It is helpful if patients are sedated. They have had this headache all day long. It helps if they sleep well."

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 medications, he explained. But triptan withdrawal also can mimic opioid withdrawal with associated nausea, diarrhea, and abdominal pain. Inpatients can be switched to intravenous DHE (dihydroergotamine mesylate) and outpatients can be given Migranal NS. A steroid taper is another option, but a longer-acting triptan is rarely the best option.

"Get them away from triptans. Switch them to something different," Dr. Rozen said, adding that overusers of triptans also benefit from the mild-moderate-severe approach to headache pain during withdrawal.

When weaning patients from butalbital, the first step is to determine their butalbital level, he continued. If it is above 10 mcg/mL, the patient is at risk of withdrawal seizures and needs to be weaned off the drug as an inpatient.

For patients with very low butalbital levels, he suggested outpatient care and prevention of withdrawal symptoms with clonazepam. Don't try to taper patients from butalbital because they are using it to treat anxiety and will not stop. Phenobarbital is another option, he added, but be prepared to vary the dose.

Patients who are abusing opioids almost always have to be hospitalized. "I tell them I will be there every step of the way, as long as [they] show the effort and do the hard work," Dr. Rozen said. "They have to know that." ■

Pharmacists Have Misconceptions About Chronic Pain Management

BY FRAN LOWRY
Orlando Bureau

ORLANDO — Pharmacists who dispense in the community tend to be skeptical about patients who require chronic medication with controlled substances, according to a survey of pharmacists practicing in both urban and rural areas of Alabama.

The survey revealed that many pharmacists have serious misconceptions about chronic pain patients and the way physicians prescribe medications to manage their pain, Karen F. Marlowe, Pharm.D., of the University of South Alabama Medical Center, Mobile, said at the annual clinical meeting of the American Academy of Pain Management.

Dr. Marlowe sent a 40-question survey to 150 pharmacists who dispensed in two counties between December 2005 and February 2006. Seventy-eight surveys were returned: slightly more than half of responders (53%) were female, and 25% worked in chain drugstores, 25% in independent pharmacies, 20% in hospitals, 16% in "big box" or superstores, and 14% in grocery stores.

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

The pharmacists' main concern was for their compliance with controlled substance regulations. Most considered their knowledge of pain management and controlled substances good or excellent.

None felt they had received inadequate education about pain medications in pharmacy school. That response was something of a surprise 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 pharmacists felt uncomfortable dispensing opiates. "These are serious misunderstandings, and we need to target them as areas for further education," she said.

Surveyed pharmacists perceived early refills of pain medication as a sign of addiction.

DR. MARLOWE

The survey also found that female pharmacists were more likely to dispense emergency supplies of controlled substances than male pharmacists (70% vs. 40%, respectively), while male pharmacists were more likely to agree with the statement that physicians overprescribe (males, 48%, vs. females, 35%). Also, 50% of pharmacists in practice longer than 15 years were more likely to contact a physician regarding pain medications and seek an opinion on early refills.

Dr. Marlowe said that she plans to conduct her survey nationwide. "We need to determine which issues need to be addressed. . . . We'll be able to look at who specifically needs to be educated [and whether] misconceptions [are] regional. Are they due to length of time out of school? Are they more prevalent in rural versus urban areas? In chain versus hospital pharmacies? The results will be interesting to see." ■

Behavioral Therapies Address Factors Underlying Migraine

BY BRUCE K. DIXON
Chicago Bureau

SCOTTSDALE, ARIZ. — Misconceptions and other barriers to behavioral therapy limit headache patients' access to potentially beneficial nonpharmacologic treatments, Donald B. Penzien, Ph.D., said at a symposium sponsored by the American Headache Society.

Standard behavioral interventions include relaxation training, biofeedback training, cognitive behavioral therapy, stress management, or some combination of these approaches, said Dr. Penzien, professor of psychiatry and director of the Head Pain Center at the University of Mississippi, Jackson.

Reimbursement and workforce issues limit the use of these nonpharmacologic treatments, but another 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 can still benefit from behavioral therapy," he said in an interview.

Even the best pharmacologic agents have their limits because headache is a psychophysiologic disorder, Dr. Penzien explained.

Patients most suitable for behavioral headache treatments include those with poor tolerance of and medical contraindications for drug treatment or inadequate response to medications; those who prefer nondrug interventions; pregnant and nursing women; and those with history of frequent or excessive use of analgesic or other acute medications.

"Over 300 studies have evaluated behavioral therapy for the management of migraine. On average, these interventions have shown 35%-55% improvement pretreatment to post treatment," Dr. Penzien said.

Furthermore, he added, the effects of behavioral treatments appear enduring; the literature shows efficacy up to 7 years post treatment.

Behavioral treatment typically entails 6-12 clinic sessions with a professional. Cost and time considerations 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 materials 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 intensive clinic-based therapies. The patients appreciate the convenience and lower cost," he said.

Dr. Penzien said that he would like to see primary care physicians and neurologists increase their focus on psychological and emotional factors underlying migraines. "Relatively short-term behavioral interventions can be of great importance in assisting your patients to better manage their headaches." ■