Psychiatric Disorders Common With Headache

BY SHARON WORCESTER
Southeast Bureau

MIAMI BEACH — Comorbid psychiatric conditions are common in patients with headache disorders, and can adversely affect the prognosis in patients with such disorders, Alvin E. Lake III, Ph.D., said at a symposium sponsored by the American Headache Society.

However, combined behavioral and drug therapy as well as patient education have been shown to improve outcomes, said Dr. Lake, director of the behavioral medicine division at the Michigan Headache and Neurological Institute, Ann Arbor.

Studies suggest that close to 50% of patients with chronic daily headache have an anxiety and/or mood disorder. In those with medication overuse headaches, the prevalence of mood and anxiety disorders appears to be even higher at 68%, according to one study.

Headache patients with psychiatric disorders also appear to have poorer long-term outcomes than do those with no psychiatric disorder. In one study, 57% of patients with multiple psychiatric disorders had worsening of their headaches over an 8-year period, compared with 7% of those with no psychiatric disorder. In addition, 29% of those with multiple psychiatric disorders experienced improvement, compared with 53% of those with no psychiatric disorder.

It appears that in most cases, the psychiatric disorders preceded the headache disorders. In a study of 41 patients with medication overuse headaches and comorbid psychiatric disorders, the psychiatric disorder preceded the headaches in 76% of those with a major depressive episode, 79% of those with panic disorder, 80% of those with generalized anxiety disorder, 89% of those with substance abuse disorder, and 100% of those with social phobia, Dr. Lake noted.

In addition to mood disorders, which have a genetic component, psychological factors, such as anticipatory fear of pain, and psychosocial factors, such as family and work pressures and a need to function, can drive excessive use of preemptive treatment, which in turn can lead to headache chronicity, he explained.

In one study of headache patients, the use of analgesics at initial assessment was associated with a relative risk of 19.6 for chronic daily headaches at 11-year follow-up, compared with a relative risk of 3.1 in those without analgesic overuse. Daily or weekly analgesic use also elevated the risk for chronic pain; in those who used analgesics more than 15 days per month, the relative risk of chronic migraine was 13.3 and the relative risk of nonmigraine headache was 6.2, compared with those without analgesic overuse.

Differential attention to the headache pain has been shown to modulate the subjective experience of pain, Dr. Lake said.

For example, attention to pain location increases responses in the somatosensory cortex, while attention to the unpleasantness of the pain increases responses in the limbic system.

Distraction, such as activities that divert attention away from the pain, can lower pain intensity and increase brain stem periaqueductal gray activation, which has been shown to predict changes in perceived pain intensity.

Thus, behavioral therapy is useful in this patient population. Several studies demonstrate improved outcomes with combined treatment.

For example, in one study of patients with chronic tension headaches, 64% of patients who received tricyclic antidepressants as well as stress management training had improvement at 8 months, compared with 29% of placebo patients, 38% of those on tricyclic antidepressants alone, and 35% who received stress management training alone.

In another study of patients with medication overuse headaches, headache days per month were reduced at 3 years' follow-up from 30 to 11 days in patients who received inpatient pharmacologic therapy and biofeedback-assisted relaxation training, compared with a reduction from 30 to 18 days in those who received only inpatient pharmacologic therapy.

Analgesic doses per month were reduced from 59 to 4 doses in the combination treatment group, compared with a reduction from 59 to 20 doses in those with preventive medication treatment alone. The relapse rate to medication overuse headaches was 13% in the combination treatment group, compared with 42% in the medication-only group.

Patient education has also been shown to be of benefit, Dr. Lake said.

A study published in May 2006 showed that patients who attended three 90-minute educational sessions taught by intensively trained lay migraineurs was useful for improving outcomes and reducing analgesic overuse (Headache 2006;46:726-31).

Of 100 consecutive migraine patients who received routine medical management and were randomly assigned to attend or not attend the classes—which offered information on migraine pathogenesis, management, and risks of rebound—those who attended had a significantly greater reduction in mean migraine disability assessment scores (reduction of 24 vs. 14 points) at 6 months.

They also had fewer headache days per month, less headache-related dysfunction, less abortive medication use, less analgesic overuse, and fewer headache-related phone calls and unscheduled visits to doctors, Dr. Lake said. ■

Antidepressants May Improve Multiple Outcomes After Stroke

BY HEIDI SPLETE
Senior Writer

WASHINGTON — Prompt, short-term treatment with antidepressants is associated with significantly improved physical, cognitive, and survival outcomes in stroke patients—regardless of whether they have symptoms of depression, Dr. Robert Robinson said at the annual meeting of the American Academy of Clinical Psychiatrists.

"Perhaps all patients who suffer a stroke should be evaluated by a psychiatrist and treated with antidepressants, because [these drugs] appear to improve their recovery," said Dr. Robinson, who serves on the speakers' bureau for Forest Laboratories Inc. He also serves as a consultant for Hamilton Pharmaceuticals Inc. and Avanir Pharmaceuticals.

Data from recent studies have shown that antidepressants have beneficial effects on physical and cognitive recovery (as well as on mortality) after a stroke and that these effects may last for several years, said Dr. Robinson, professor and head of the department of psychiatry at the University of Iowa, Iowa City.

Dr. Robinson shared data that he collected in collaboration with his colleague at the university, Dr. Kenji Narushima, on 34 stroke patients who were treated with nortriptyline, fluoxetine, or a placebo starting within a month of having a stroke (average of 19 days after the stroke) and 28 patients who began treatment more than a month after the stroke (J. Nerv. Ment. Dis. 2003;191:645-52).

The nortriptyline doses were 25 mg/day for the first week, which then was increased to 50 mg/day for weeks 2-3, 75 mg/day for weeks 4-6, and 100 mg/day for the final 6 weeks.

Antidepressants foster nerve growth, and growth of new nerves may protect against a future stroke.

DR. ROBINSON

The fluoxetine dosage started at 10 mg/day for the first 3 weeks, which then was increased to 20 mg/day for weeks 4-6, 30 mg/day for weeks 7-9, and 40 mg/day for the final 3 weeks, the investigators reported.

The patients who were treated early had a significantly better recovery in activities of daily living than did those who were treated later, even after a logistic regression analysis controlled for several factors, including existing depression, motor impairment, and psychiatric history. The finding suggests that patients who are given antidepressants—whether they are depressed or not—within the first month after a stroke recover better than if they are given antidepressants at a later date, Dr. Robinson said.

Similarly, a study of cognitive outcomes based on executive function tests showed that patients who were treated with antidepressants within a month of a stroke scored significantly higher at 21 months' follow-up, compared with patients who received a placebo.

The improvements were independent of any diagnosis of depression at the start of treatment.

Not all patients respond to antidepressant medication, but those who do seem to gain a cognitive effect that lasts, Dr. Robinson said.

Stroke patients who receive antidepressants also tend to live longer.

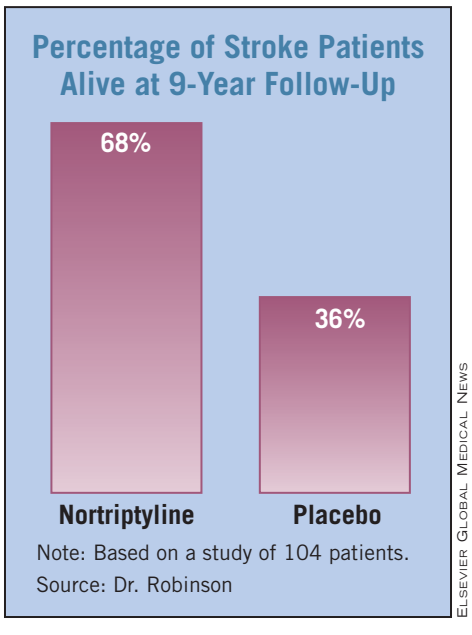
Dr. Robinson cited results from a randomized study of 104 stroke patients on which he was a coinvestigator. The patients received 12 weeks of either nortriptyline or a placebo, and 68% of the nortriptyline patients were alive after 9 years, compared with 36% of placebo patients.

Interestingly, the placebo patients were significantly more likely to have died of cardiovascular events, while the patients who took antidepressants were more likely to have died from other causes (Am. J. Psychiatry 2003;160:1823-9).

The long-term benefits from only 12 weeks of antidepressant therapy are remarkable, Dr. Robinson said, although the mechanism of action that drives the benefits remains uncertain.

One possible explanation for the long-term effect is that the antidepressants foster nerve growth, and the growth of new nerves may protect against a future stroke. "But where the neurogenesis is occurring is something that is a particularly intriguing question," Dr. Robinson said. Neurogenesis may be involved in a neurophysiologic mechanism that turns on or off for extended periods of time in response to antidepressants, but more research is needed, he said.

"A major goal of clinical psychiatry is to see how our treatments affect outcome," he added. ■



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