Early Treatment May Promote Medication-Overuse Headache

BY JANE SALODOF MACNEIL
Southwest Bureau

SCOTTSDALE, ARIZ. — Early treatment of migraine can contribute to development of medication-overuse headaches in pain-adverse patients, Dr. James R. Couch warned at a symposium sponsored by the American Headache Society.

These patients will take their pills every time they think they might be about to get a migraine, said Dr. Couch, a professor of neurology at the University of Oklahoma Health Sciences Center in Oklahoma City.

"The more they think they are getting a headache and take the medication early, the more likely that this may lead to developing an MOH [medication-overuse headache]–induced chronic daily headache," he said.

The conundrum for prescribing physicians, as presented by Dr. Couch, is that current and previous studies show patients really do have a better response if they take their medications at the first sign of a migraine. He recommended early treatment for the patient who has an occasional menstrual-induced migraine, but suggested a cautious approach for those with more frequent headaches.

"If a patient is having 10 or more headaches a month, do not get them into the early treatment or be careful about the early treatment," he said. Instead, make sure these patients know when they are starting a headache as opposed to thinking they might be getting one.

"I think this is one of the main problems," Dr. Couch said.

He added that patients who "get a buzz" from their medication also could be at greater risk of developing MOH. Some patients will use their headache medication like a dose of alcohol, he warned.

He recommended asking whether the patient feels a lot better immediately after taking a headache remedy. In his experience, some will say that it gives them energy in the afternoon, helping them to finish their work.

The pathophysiology of MOH is not clear, according to Dr. Couch, but genetic predisposition and psychological factors appear to be involved. Depression and bipolar disorder are common in MOH patients, he said. Typically, the MOH patient has an underlying headache, but sometimes social factors drive the medication overuse. "Is there something else going on there?" he urged physicians to explore in these patients.

Chronic daily headaches and MOH are a worldwide problem, according to Dr. Couch. He pointed to studies in the United States, Spain, China, and Ethiopia that show 4%-5% of the population have headaches 15 days or more each month.

In developed countries, he said about 1% of the population develops MOH. These patients account for 20% of the chronic daily headache population and may be increasing in number. In the 25- to 50-year-old age group where MOH is most prevalent, Dr. Couch said it is as common as epilepsy and more common than multiple sclerosis or stroke.

The best treatment is prevention, he said. Know what medications your patients are taking, keep track of refills, and discuss the possibility of MOH as soon as you recognize the patient is at risk, he urged. ■

Better Patient Interviews May Aid Migraine Treatment

BY BRUCE K. DIXON
Chicago Bureau

SCOTTSDALE, ARIZ. — Open-ended questions during patient interviews elicit the best information for guiding the management of patients with migraine headache, Dr. Richard B. Lipton said at a symposium sponsored by the American Headache Society.

Yet closed-end questions focusing on headache triggers, frequency, and symptoms comprised most of the dialogue between physicians and migraine headache patients, based on the American Migraine Communications Study (AMCS). And the patient and physician often differed in their assessments of headache frequency, disability, and impairment, said Dr. Lipton, who is professor of neurology at the Albert Einstein College of Medicine, New York.

Most 'physicians and patients were misaligned on migraine frequency post visit, which is amazing to me.'

DR. LIPTON

Patients and physicians really weren't hearing and understanding each other during the office visit, he said. As a result of these miscommunications, physicians underappreciated the need for preventive treatment and patients had incomplete knowledge about medication use and inappropriate expectations of their outcomes.

The AMCS findings were based on analyses of videotaped encounters with 60 patients (80% women, mean age 42 years) and a geographically representative sample of 14 primary care physicians and 8 neurologists. The average duration of migraines was 14 years with a frequency of five episodes per month.

Dr. Lipton and his coinvestigator Dr. Steven R. Hahn analyzed the structure of questions posed during the recorded physician-patient interviews. Closed-ended questions allowed patients to make selections, while open-ended questions encouraged more wide-ranging dialogue. A typical closed-end question, for example, was: "Are the headaches on one side of your head or bilateral?" An example of an open-ended question would be: "Tell me about your headaches."

Framing the interview with closed-ended questions gleans only limited information, said Dr. Hahn, professor of clinical medicine at Albert Einstein. "Open-ended questions are the foundation of patient-centered interviewing, and they allow patients to recount their symptoms in the narrative context, focusing on the things that are most important to them."

Based on assessments after the interviews, 35 of the 60 patients were not receiving any therapy for their disabling headaches. The other 25 had been prescribed an average of two drugs, primarily triptans, but many did not have an accurate understanding of how to use the drugs or what they could reasonably expect from drug therapy.

Overall, "55% of physicians and patients were misaligned on migraine frequency post visit, which is amazing to me. It seems to me that the question of how many headache days occur over a 3-month period would be something patients and physicians could agree on," Dr. Lipton said.

Dr. Lipton and Dr. Hahn recommend an "ask, tell, ask" approach. First, ask the patient about the number of headache days. Then repeat what you have heard. Finally, ask whether you have stated the situation correctly.

The "ask, tell, ask" technique improves communication and thus will improve treatment, Dr. Lipton concluded. ■

Personality Trait Can Worsen Rheumatoid Arthritis Symptoms

BY JANE SALODOF MACNEIL
Southwest Bureau

TUCSON, ARIZ. — A psychological trait associated with heightened awareness of bodily distress may help to explain why some rheumatoid arthritis patients suffer more from achiness, malaise, and fatigue than do others with similar disease severity, Dr. Ilana M. Braun reported at the annual meeting of the Academy of Psychosomatic Medicine.

The trait, somatic absorption, was closely associated with generalized symptoms of rheumatoid arthritis in 87 patients studied by Dr. Braun, a psychiatrist at Harvard Medical School and Massachusetts General Hospital in Boston. It had no relationship to specific symptoms, such as joint pain, swelling, stiffness, and deformity, or to disease severity.

The magnitude of effect was modest, accounting for just 4% of variability in nonspecific symptoms, but Dr. Braun noted that it was significant statistically—and possibly clinically. People who score high on measures of absorption have a capacity for deep involvement in sensory events, she said. They have a heightened sense of reality that makes them more sensitive not only to bodily distress, but also to hypnosis and to biofeedback.

"There might be a role for psychiatry in the treatment of rheumatoid arthritis," she said, questioning whether some patients might respond to these kinds of interventions for nonspecific symptoms.

"It is a personality style that you can target," Dr. Braun added in an interview. "This is not a disorder. These are perfectly healthy people [mentally]. They just have a certain way of responding to the world."

While calling for more research into the clinical utility of her finding, Dr. Braun suggested that ultimately it may present rheumatologists with an alternative to increasing medication when patients complain they feel poorly in the absence of specific symptoms. "What I am saying is, for the malaise and the fatigue don't double the dose," she said. "Send them to the hypnotist."

The study was supported by a Webb Fellowship from the academy. Dr. Braun enrolled patients from a larger, longitudinal study of rheumatoid arthritis. The largely female population had a median age of 55.5 years. A majority, 85%, had been to college, more than half were employed, and about half were married.

Patients completed the 14-item Rheumatoid Arthritis Symptoms Questionnaire. Dr. Braun and her coinvestigators also used erythrocyte sedimentation rate and a standard 28-joint physical examination by a rheumatologist to measure disease severity.

Assessment of somatic absorption was based on the 29-item Somatic Absorption Scale, a measure derived from the Tellegen Absorption Scale. Dr. Braun said the Somatic Absorption Scale focuses on "absorption as it pertains to somatic or visceral experience." For example, a subject might be asked whether she could imagine her arm being so heavy she could not move it, or if she notices how her clothes feel against her skin.

Dr. Braun reported somatic absorption was significantly more pronounced in younger subjects, people with more severe psychiatric symptoms, African Americans, and Hispanics. Rheumatoid arthritis symptoms with statistically significant ties to somatic absorption were pain in limbs, pain in back, fatigue, generalized aching, and "feeling sick all over."

In a discussion of the findings, Dr. Stephen J. Ferrando said he found himself looking up the literature on absorption, a personality construct developed in the 1970s to assess which patients might respond to hypnosis and biofeedback.

Dr. Ferrando, professor of clinical psychiatry and clinical public health at Cornell University in New York, called the findings very interesting and said he looks forward to an analysis of how the subjects fare in the longitudinal study from which the population was drawn. ■

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