

# Sumatriptan-Naproxen Combo Beats Either Alone

*Triptans, NSAIDs target different aspects of vascular, inflammatory processes underlying migraine.*

BY MARY ANN MOON  
Contributing Writer

A tablet combining sumatriptan and naproxen is more effective than either medication alone for treating acute migraine, reported Dr. Jan Lewis Brandes of the Nashville Neuroscience Group and her associates.

The combination medication also was found to be well tolerated in two clinical trials that “constitute the first placebo-controlled assessments of a triptan and an NSAID contained in a single fixed-dose tablet,” the researchers reported.

“These studies used more rigorous evaluation of efficacy than any approved acute migraine treatment to date,” they added.

Triptans and NSAIDs, two of the most frequently used antimigraine agents, target different aspects of the vascular and inflammatory processes that are believed to underlie migraine.

“It is hypothesized that migraine attacks arise from neurally induced cranial vasodilation that produces painful inflammation of the sur-

rounding nerves. Peripheral and central pain pathways appear to be sequentially recruited and sensitized as a migraine attack develops,” Dr. Brandes and associates explained.

Triptans are thought to address the initial peripheral sensitization in migraine, while NSAIDs are thought to address central sensitization. Therefore, the investigators assessed the safety and efficacy of a tablet specifically formulated for both clinical trials, which contained 85 mg sumatriptan and 500 mg naproxen.

The study subjects—1,441 in study 1 and 1,470 in study 2—were recruited from and treated at 118 sites across the country, including primary care practices, and neurology and headache clinics. Mean patient age was 40 years, and over 85% of the study population was female.

Patients were randomly assigned in nearly equal numbers to receive the combination therapy, sumatriptan alone, naproxen alone, or placebo.

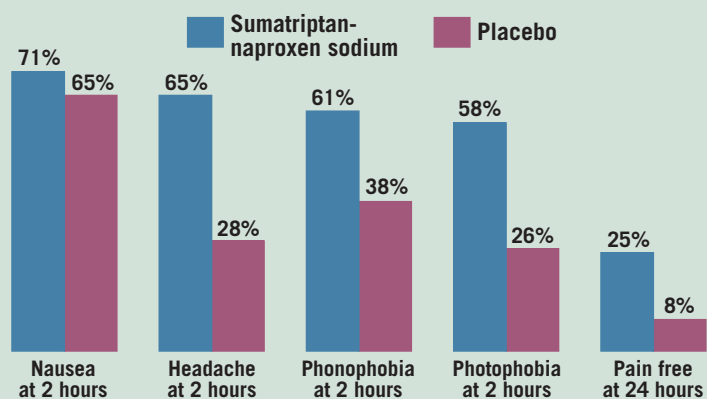
The combination medication was significantly more effective than placebo or either of the single-drug formulations in every outcome assessed: acute relief of headache pain, photophobia, phonophobia, nausea, and vomiting at 2 hours, as

well as sustained relief of these same symptoms at 24 hours, Dr. Brandes and associates reported (*JAMA* 2007;297:1443-54).

The only serious adverse event that occurred in both clinical trials involved a woman who experienced heart palpitations after taking sumatriptan alone. However, this subject had numerous CVD risk factors, as well as depression and anxiety, and she was taking medications for all of the disorders. The palpitations were deemed to be of no clinical significance.

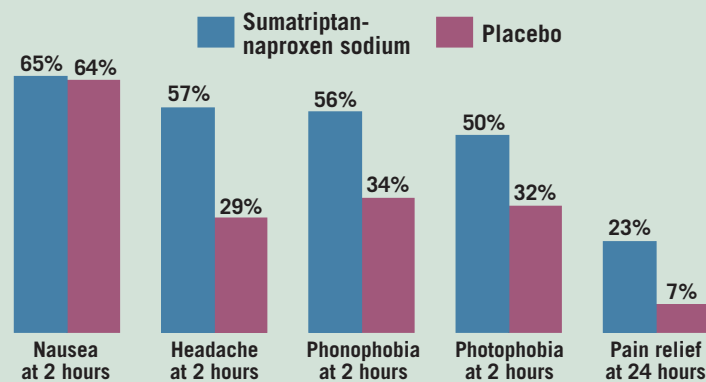
Future studies of the combined therapy should assess whether different combinations of doses might be more efficacious, the researchers noted. ■

## Migraine Symptom Relief—Study 1



Note: Based on a study of 1,441 migraine patients.  
Source: *Journal of the American Medical Association*

## Migraine Symptom Relief—Study 2



Note: Based on a study of 1,470 migraine patients.  
Source: *Journal of the American Medical Association*

# Opioid Regulations Often Misunderstood by Practitioners

BY BRUCE K. DIXON  
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SALT LAKE CITY — State laws governing the availability and use of opioid analgesics are becoming less onerous, but confusion persists among regulators and practitioners, David E. Joranson said at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association.

“There are some positive aspects of policies being developed over the last several years because [states] are recognizing how valuable opioids are in medical practice,” said Mr. Joranson, director of



**The Pennsylvania Uniform Control Substances Act's definition of addiction is confusing.**

MR. JORANSON

the University of Wisconsin Pain and Policy Studies Group in Madison. The group's mission is to “achieve more balanced international, national, and state policies so that patients' access to pain medications is not compromised by efforts to prevent diversion and drug abuse.”

Many physicians do not have a clear understanding of federal and state regulations governing pain management and overestimate state and federal restrictions on opioid use. This disconnect can contribute to unreasonable fear of regulatory scrutiny and unnecessary conservatism in prescribing, he said.

In an interview, Mr. Joranson urged the major organizations advocating for improved pain management in palliative care to focus their members' attention on better understanding how policies can improve patient care—and then work to change those that hinder treatment.

“If a physician knows the laws, he should be perfectly comfortable prescribing opioids for chronic pain. If he doesn't know the law, he might be concerned,” he added.

During a luncheon presentation, those who attended the meeting participated in an electronic survey that showed significant gaps in knowledge.

For example, more than half of the 300 survey participants, which included physicians and nurses, said that the Drug Enforcement Administration limits prescriptions for schedule II controlled substances such as morphine to a 30-day supply, when in fact the DEA permits an unlimited supply (though the agency is currently finalizing a 90-day supply limit).

Many survey participants also were un-

aware that several states recently adopted pain policies and eliminated restrictions on drug quantity, Mr. Joranson said. This same survey drew similar results at the recent annual meeting of the American Academy of Pain Medicine in New Orleans, he added.

The Wisconsin Pain and Policy Studies Group conducted a 6-year evaluation and analysis of each state's policies, culminating in a “report card” issued in 2006. The overall grade improved over the period in 19 states.

Mr. Joranson said that, unfortunately, 16 states confuse physical dependence and addiction, and at least one state contradicts itself. The Pennsylvania Uniform Controlled Substances Act defines a drug-dependent person as someone “who is using a drug, controlled substance, or alcohol, and who is in a state of psychic or physical dependence, or both. . . . This definition shall include those persons commonly known as ‘drug addicts.’ ”

Yet the Pennsylvania State Board of Medicine guideline says physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

“So if you have a physically dependent pain patient in Pennsylvania, depending on which definition you look at, that person either is an addict or is definitively not an addict,” Mr. Joranson said.

Other states that confuse the addiction issue are Arizona, Colorado, Georgia, Hawaii, Idaho, Indiana, Louisiana, Maryland, Missouri, Nevada, New Jersey, North Carolina, Oklahoma, Tennessee, and Wyoming.

A model policy is available from the Federation of State Medical Boards, summarized as follows:

- ▶ Controlled substances are necessary for public health.
- ▶ People should have access to appropriate and effective pain relief.
- ▶ Pain management is part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness.
- ▶ Physicians should not fear regulatory sanctions.
- ▶ Physical dependence is not synonymous with addiction.

This is an opportunity for physicians to come forward and explain to policy makers the importance of making those changes that are needed, Mr. Joranson said.

Mr. Joranson has received honoraria from A.L. Pharma Inc. and Abbott Laboratories, and he has received grant support from Purdue Pharma L.P. and Endo Pharmaceuticals. ■

For more information on state policies and guidelines on pain and links to other resources, go to [www.painpolicy.wisc.edu/index.htm](http://www.painpolicy.wisc.edu/index.htm).