Criteria Proposed for Refractory Migraine

American Headache Society plan could lead to major changes in classification system.

BY ALICIA AULT
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CHICAGO — A proposed definition and diagnostic criteria aim to help physicians deal with the growing number of patients presenting with refractory migraine, Dr. Elliott A. Schulman said at the annual meeting of the American Headache Society.

"[Refractory migraine] is out there, we just haven't defined it," said Dr. Schulman, noting that the incidence is probably 10%-50% of cases seen in practice. By setting a definition, he said, patients who need greater care can be identified early, a standard of care can be established, the epidemiology can be further studied and clarified, and candidates for novel treatment approaches can be identified for clinical trials.

To address the problem, the society's Refractory Headache Special Interest Section was formed in 2000. In April 2006, the section surveyed all AHS members on a proposed definition of refractory migraine, whether it should be added to the International Classification of Headache Disorders, and for information on some of the best practices used.

Two hundred-twenty members responded, for a response rate of 18%, said Dr. Schulman, a neurologist at Lankenau Hospital, Wynnewood, Pa. More than half the respondents believed that refractory migraine should be defined as occurring more than 15 days a month, that it should be associated with disability, and that a definition should include inadequate response to multiple abortive and preventive medications. Almost 60% said a refractory migraine definition should be added to the ICHD.

The criteria proposed for refractory migraine and refractory chronic migraine, which were unveiled at the AHS meeting, were based on the survey results, a literature review, and collaborative discussions, Dr. Schulman said.

The section proposed the following criteria:

► The primary diagnosis is ICHD-II migraine or chronic migraine.

► The headaches cause significant interference with function of quality of life despite modification of triggers, lifestyle factors, and adequate trials of acute and preventive medicines with established efficacy. This would include failed adequate trials of preventive medicines, alone or in combination, from two of four drug classes: β-blockers, anticonvulsants, tricyclic antidepressants, and calcium channel blockers, as well as failed adequate trials of abortive medicines, including both a triptan and an intranasal or injectable dihydroergotamine (DHE); and either nonsteroidal anti-inflammatory drugs or combination analgesics.

► An adequate trial is defined as an appropriate dose administered typically for at least 2 months or the maximum-tolerated dose.

► The following modifiers would be included: with or without medication overuse, as defined by ICHD-II; with significant disability, as defined by a Migraine Disability Assessment Questionnaire score of 11 or higher.

The criteria "are intended to stimulate discussion leading to a consensus on the definition of refractory migraine and refractory chronic migraine for research and clinical purposes," said Dr. Schulman.

Dr. Morris Levin of Dartmouth University, Hanover, N.H., discussed at least four different options for how refractory migraine could be added to the ICHD classification system: as a new diagnostic chapter; as a subdivision to each current headache chapter; as a modifier to the primary diagnosis, as is done with the DSM-IV used for psychiatric disorders; or as an "axis II" diagnosis, again, as is used in the DSM-IV.

In weighing the pros and cons, Dr. Levin noted that the first option would make for a huge new chapter, which might be impractical. Adding subsections to the primary headache diagnosis is logical but would create new language and many new diagnoses, he said.

The addition of a modifier would least affect the rest of the ICHD, but would add another layer to each patient's diagnosis, said Dr. Levin.

Finally, adding another axis would change the overall ICHD format.

Even so, he said, it is worth trying at least one approach and then field testing it, as that would help provide data and validity to the ICHD classification committee.

Dr. Schulman disclosed that he has received grants, honoraria, advisory board and consultation fees from Merck & Co. and Pfizer Inc., and his institution receives direct pharmaceutical industry support. Dr. Levin has received grants, honoraria, and other fees for consultation and advisory board participation from Elan Pharmaceuticals Inc., Allergan Inc., AstraZeneca, Merck, Pfizer, and Ortho-McNeil Inc. His institution also receives direct pharmaceutical industry support. ■

Frequent Callers to Headache Clinics Also Take More Opioids

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

CHICAGO — Patients who frequently call their headache specialty clinic are more likely to be taking multiple opioids in higher doses, potency, and quantity than those who do not call frequently, Karen Fisher, R.N., said at the annual meeting of the American Headache Society.

Ms. Fisher and her colleagues of the headache clinic at the University of North Carolina at Chapel Hill researched their database to identify common characteristics of patients who called frequently (at least 20 times in a calendar year) and those who did not (no calls within a calendar year). High-frequency (26) and low-frequency callers (18) were similar in age (about 42 years), marital status, ethnicity, and diagnosis. There was a nonsignificant trend for more females in the frequent-caller group. Migraine was the most frequent diagnosis in each group. All patients had been followed for at least 5 years.

Calls included requests for refills, complaints that medication was not working, and requests for different medications, among other topics.

The patients were similar in their use of triptans and botulinum toxin. But significantly more of the frequent callers were taking opioids (96% vs. 11%).

Frequent callers also were more likely to be taking multiple opioids of higher potency and dose. To further investigate the relationship of opioid strength to calling frequency, the researchers assigned morphine equivalency strength to each milligram of opioid prescribed. (See box.)

Frequent callers were taking significantly more daily morphine equivalents than nonfrequent callers were (154.4 mg vs. 1.4 mg).

"Further research is needed to explore the relative contributions of psychological characteristics, burden of illness, or other factors [that] might contribute to the excessive calling, which is associated with negative perceptions on the part of headache clinic staff and caregivers," Ms. Fisher said. ■

Morphine Equivalency of Opioid Prescriptions

Medication	Morphine Equivalent
1 mg meperidine	0.1 mg
1 mg Tylenol #3	0.5 mg
1 mg Darvocet	0.5 mg
1 mg hydrocodone	1 mg
1 mg morphine	1 mg
1 mg oxycodone	1 mg
1 mg hydromorphone	4 mg
1 mg fentanyl	400 mg

Source: Ms. Fisher

Promote Optimal Functioning in Families of Headache Patients

BY SHARON WORCESTER
Southeast Bureau

MIAMI BEACH — The impact of headache disorders extends beyond the patient and can have devastating effects on family life.

Attention to this potential problem can promote improved family functioning, Alvin E. Lake III, Ph.D., said at a symposium sponsored by the American Headache Society.

The problem can be a cyclical one: Family stressors and pressures, and the need to continue functioning in the family setting, can lead to analgesic overuse, which in turn increases the risk of chronic daily headaches; the headache disorder then becomes an issue that adversely affects family life and relationships.

Studies show that migraineurs often miss family social activities, avoid making social plans for fear of canceling, have difficulty accomplishing normal household tasks like housecleaning, and argue more with spouses and children.

In one study of 389 migraineurs who experienced more than five attacks per year, 85% said their migraines caused them to do less housework, 45% said the migraines caused them to miss social activities, and 50% said they were more likely to argue with family members. More than 70% said they also suffered other adverse consequences, said Dr. Lake, director of the psychology division at the Michigan Headache & Neurological Institute, Ann Arbor.

Of 100 spouses who participated in the study, 29% agreed that arguments were more common, and 60% said the migraines had other adverse effects on relationships.

Children are also affected. Another study showed that of 130 children under age 12 with a parent who suffered from migraines, 66% "kept quiet," 61% experienced canceled plans, 42% received "other child care," 25% were confused about their situation, and 17% had hostility. Of 88 children over age 12, 87% avoided loud activities, 61% avoided asking for help, 42% had plans canceled, 21% avoided school, and 12% had hostility.

Encourage families to modulate attention to the migraineur's pain. As with patients who have been shown to experience less pain intensity when their attention is diverted from the pain, families will also experience improved functioning if family life doesn't revolve around the pain, Dr. Lake said, and suggested that enabling behaviors should be discouraged.

Families and patients should be advised to set achievable goals for accomplishing tasks or participating in activities, and they should be encouraged to replace all-or-nothing thinking with a mind-set that "some is better than none." For example, they can agree to attend a social event for an hour rather than avoiding it altogether, he said.

Finally, family members should be encouraged to maintain their own lives. Compromise and balance are key factors in optimizing family functioning, Dr. Lake said. ■