

Cancer Pain Needs Vary Among African Americans

BY JOYCE FRIEDEN

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WASHINGTON — African American cancer patients are heterogeneous in their need for pain medication, Salimah Meghani, Ph.D., said at a meeting sponsored by the Department of Health and Human Services and the Office of Minority Health.

Dr. Meghani interviewed 36 self-identified African American cancer patients from three outpatient oncology clinics in Philadelphia; all were over age 18 years and had solid tumors. All of the patients had self-reported pain at least 1 month in duration during the last 6 months; none had had major surgery in the prior 3 months.

The patients filled out a 32-item self-report instrument assessing pain severity and its impact, and researchers conducted open-ended interviews lasting 50-70 minutes. To ensure reliability among coders, 15% of the transcripts were independently coded by Dr. Meghani and a consultant.

The patients were 33-75 years old. Slightly more than half were male, two-thirds were single, and 89% were Christian, said Dr. Meghani, a postdoctoral fellow at the Center for Health Disparities Research at the University of Pennsylvania, Philadelphia. Almost all of the patients were insured; the median annual household income was in the \$20,000-\$30,000 range.

Only one-third of the patients said they preferred to take pain medication regularly. Overall, 25% said they were concerned

about taking too much pain medication, and 36% said they had problems with side effects from pain medication. On the other hand, 19% of the patients said they needed more pain medication and 36% said they needed stronger medication.

Dr. Meghani separated 35 of the patients into three categories. (One patient did not participate in the interview and so could not be categorized.)

Of the 36 patients, 25% said they were taking too much pain medication, 19% said they needed more, and 36% said they needed stronger medication.

The first category, which included four patients, was called “nonbelievers.” They didn’t want to take too much pain medication for fear that it would hide recurring disease.

The second, more middle-of-the-road category (“centralists”) included 24 patients. They tended to take their pain medication despite their ambivalence about it. Dr. Meghani quoted one patient in this group: “I wish I could stop [taking the medication,] but I know I can’t, so I have to deal with it.”

The third category, called “strong believers,” included seven patients. These patients were strongly in favor of taking pain medication, with one of them quoted as saying, “I don’t mind taking [pain medicine] because it relaxes me and it keeps the pain down and it gives me a chance to get my rest.”

The study had several limitations, including a small sample size and lack of accounting for type or stage of illness, type or strength of the prescribed medication, and history of dependency. But the results showed that black patients cannot be put into a “one-size-fits-all” category regarding pain management, Dr. Meghani said. ■

Reasons for Failure of Chronic Daily Headache Tx Numerous

BY DAMIAN McNAMARA

Miami Bureau

SCOTTSDALE, ARIZ. — Consider a range of explanations when a chronic daily headache patient does not improve with standard therapy, Dr. Joel R. Saper suggested at a symposium sponsored by the American Headache Society.

Some top reasons include medication-overuse headache (formerly known as rebound headache), a wrong diagnosis, and psychobiologic or behavioral barriers to treatment, when a person with chronic daily headache fails to improve. Improperly selected or improperly dosed medication are other possible culprits, said Dr. Saper, founder and director of the Michigan Head Pain & Neurological Institute at the University of Michigan, Ann Arbor.

“My best two pieces of advice are to consider that individual as the first patient you’ve ever seen with chronic daily headache,” Dr. Saper said, “and it’s not daily chronic headache until you’ve ruled out everything else.” The differential diagnosis includes the other primary headache disorders and organic causes of intractable headache such as sphenoid sinusitis, an Arnold-Chiari malformation, and pseudotumor cerebri.

“The more you treat patients with chronic daily headache, the more you learn you did not get it right the first time,” Dr. Saper said.

Patients who take almost any headache medications 2 or 3 days a week for months are at higher risk for medication-overuse headache (Curr. Pain Headache Rep. 2005;9:430-5). This progressive disorder is characterized by predictable and escalating headache frequency and medication use in patients with pre-existing headache.

“If you start a drug and are not there to deal with its consequences, you put all of us at risk,” Dr. Saper said. “You better be willing to monitor them” and change therapy when warranted.

Headache is a symptom of more than 300 illnesses, making diagnosis of a primary disorder difficult. Causes of headache include cerebral venous occlusion, Lyme disease, infiltrative disease, exposure to toxins, AIDS, and opportunistic meningitis.

Psychiatric, behavioral, and drug misuse barriers are more pervasive than perhaps appreciated, Dr. Saper said. Remember the basics, such as a thorough physical examination, comprehensive history, and getting collateral information from relatives, he suggested.

“Are we dealing in some cases with challenging headaches or a challenging individual with headaches? It is important to ask when someone is not getting better,” Dr. Saper said.

Drug abuse and medication noncompliance are also possible when a patient is not improving, he said.

Interventional procedures are sometimes necessary to treat intractable headaches. A neural blockade such as an epidural or C2-C3 might help, or consider neural stimulation, Dr. Saper said.

Sometimes, hospitalization is required to reach a correct diagnosis. “An outpatient visit is a snapshot, a moment that you spend with that patient,” Dr. Saper said. “When trained staff is with a patient 24 hours a day, you begin to learn something about that case you would not learn in an outpatient setting.” For example, how does a patient interact with their family? Does the patient sneak down to the hospital cafeteria and eat something they are not supposed to? ■

Improvements in Sleep Hygiene Benefit Chronic Migraine

BY DEBBIE LERMAN

Contributing Writer

PHILADELPHIA — Insomnia and poor sleep habits may be the cause of the transformation from episodic to chronic migraine, Dr. Anne H. Calhoun said in a poster session at the annual meeting of the American Headache Society.

This hypothesis turns on its head the former paradigm, which was that pain causes medication overuse, which causes migraines to become chronic, which then leads to insomnia and sleep problems.

But insomnia and poor sleep habits may be the cause and not the result of migraine’s transformation to chronic.

Based on this assumption, Dr. Calhoun, a neurologist at the University of North Carolina in Chapel Hill, conducted a study

to see whether improving sleep habits might improve headaches in chronic migraine sufferers. “We found that when you improve sleep, headaches improve,” she said.

The study included 147 women with chronic migraine seen in an academic headache clinic. The women were given a comprehensive sleep interview and instructed in sleep habit modification. (See box.) They were given the interview and asked about adherence to each of five instructions on all subsequent visits. They recorded their headaches in standardized diaries, from which a headache index was calculated.

At baseline, the women averaged 23 headache days per 28-day recording period, with a mean headache index of 46.1. Of the 147 women, 72.8% met International Classification of Headache

Disorders (ICDH-2) criteria for medication overuse headache, and 85% reported awakening tired. The researchers looked at how improvement on each of the five sleep habits—as well as an aggregate of sleep habit improvements—affected headache frequency and severity.

They found that the more detrimental sleep habits women were able to improve, the less frequent and severe their headaches were. For example: for the 28 women who improved on all five detrimental sleep habits, headache frequency was 23.4 on average pre-sleep improvement vs. 10.4 on average post improvement, for an overall improvement of 58.7%. The headache index in the same group improved by 68.5%.

In contrast, for the nine women who managed to improve on only one or none of the detrimental

sleep habits, frequency improved by 23.9%, and headache index improved by 26.3%.

Of the 108 women who completed at least 2 visits, 60 women (56%) reverted to episodic migraine after a mean of 2.8 visits.

Further study is needed to see if sleep problems might be a primary factor in the etiology of chronic migraine, rather than a secondary symptom, Dr. Calhoun said in an interview with this newspaper.

“I’d like to see doctors addressing sleep issues as a primary factor in chronic migraine,” she said. “Questions about sleep should move up to the top of the list when we’re treating these patients. Then, if we find that patients have poor sleep habits, we can counsel them on how to improve their sleep which may, in turn, have a big impact on their migraines.” ■

Sleep-Habit Modification For Patients

- ▶ Plan consistent and adequate time for nocturnal sleep period (8 hours for adults and 10 hours for adolescents).
- ▶ Eliminate TV, reading, and music in bed.
- ▶ Decrease sleep-onset latency. (Use visualization technique, and allow no caffeine within 8 hours of bedtime).
- ▶ Avoid nocturia. (Allow 4 hours between dinner and bedtime, and minimize fluids before bedtime.)
- ▶ Eliminate naps.