Get It Right the First Time With High-Dose Triptan

In patients with acute migraine, the greater chance of improvement offsets the risk of adverse events.

BY DAMIAN McNAMARA
Miami Bureau

SCOTTSDALE, ARIZ. — When it comes to triptan use in treatment of acute migraine, consider the maxim: Go big or stay home.

A high dose of a given triptan may be associated with an elevated risk for side effects; however, it also is more likely to be effective. Patients who do not respond to a lower dose given in the hope of avoiding adverse events are not going to come back to give the drug a second chance at a higher dose, Dr. Lawrence C. Newman said at a symposium sponsored by the American Headache Society.

"Studies generally show that the higher dose ranges are more effective for the triptans. We want to get treatment right the first time," Dr. Newman said. Underdosing, he added, might cause a lack of efficacy and drive a patient to discontinue therapy or refuse another migraine-specific medication in the future.

A patient who experiences an adverse event, which is more likely at a high dose, will never take a triptan again, a meeting attendee observed. "I respect your opinion, but you are blurring the line between a preventive and acute medication," Dr. Newman replied. "We find from acute studies that the higher doses are more effective. If I've had a patient try a medication at low dose for three attacks, and tell them I want to try the same medication for the next three attacks, they say no."

Dr. Newman is director of the Headache Institute, St. Luke's–Roosevelt Hospital Center, New York City, and a consultant, adviser, and/or a member of the speakers' bureau for triptan manufacturers GlaxoSmithKline, Endo Pharmaceuticals, Pfizer Inc., Merck & Co., and Ortho-McNeil Inc.

Each triptan is available in different dosages, making it easy to reduce the dose if a patient experiences an adverse effect, Dr. Newman said. "Studies generally show … the side-effect profile does not differ significantly between the higher and lower doses.

There are currently seven triptans on the market, available in a number of formulations. All are available in tablet form, and some are available also as nasal sprays (sumatriptan, zolmitriptan), dissolvable wafers taken orally (rizatriptan, zolmitriptan), or injections (sumatriptan).

If headaches recur, treat attacks earlier, increase the dose, switch triptans, particularly to naratriptan or frovatriptan, add an NSAID, or switch to dihydroergotamine mesylate, Dr. Newman suggested.

"Do not give up on the triptan class because one does not work. There is evidence that some patients respond to one but not to another," Dr. Newman said. "And treat at least two migraine attacks before switching medications."

Because of the heterogeneity of migraines from one attack to another and between patients, patients need strategies to treat milder and more severe attacks, Dr. Newman suggested. "Give them a rescue medication so they don't have to call you at 3 in the morning."

An optimal treatment plan goes beyond medication, Dr. Newman said. "Discussion needs to focus on lifestyle and behavioral modifications that include identifying and avoiding potential headache triggers, and [the importance of establishing] proper sleep hygiene and regular meal and exercise times."

Early intervention is best. Patients need to manage their pain when it is mild. Patients may be treated 30 minutes into an attack when their pain is already moderate. Those who treat pain when it is mild use fewer medications, thus lowering the likelihood of rebound headache.

Dr. Newman recommended the Migraine Disability Assessment (MIDAS) questionnaire to gauge the degree of disability from the headache (Neurology 2001;56:S20-8). Patients with a higher-grade disability are much more likely to benefit from a specific treatment such as a triptan, compared with a general analgesic or NSAID.

The seven-item MIDAS questionnaire assesses days lost at school or work due to a headache, its impact on activities of daily living, headache frequency, and ratings of headache severity on a scale of 0-10. Other disability scales, such as the Headache Impact Test (HIT-6; Quality Metric Inc.), are also useful, Dr. Newman pointed out.

The MIDAS score, together with clinical judgment, ties in with a stratified care approach to migraine management. Low-end therapies include NSAIDS, analgesics, and triptans for so-called low-need patients who have infrequent but severe migraines. Consider combination analgesics, NSAIDs, antiemetics, triptans, and prophylactic therapy for moderate-need patients. Consider triptans, ergots, alkaloids, opioids, prophylaxis, and consultation for high-need patients. Other researchers validated the efficacy of such a stratified approach to management of migraine patients (JAMA 2000;284:2599-606). ■

Proper History and Physical Are Keys to Low Back Pain Dx

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — A careful history and physical exam, without the need for lab tests or radiography, can help identify any red flags in patients presenting with low back pain, Dr. David Borenstein said at the annual meeting of the American College of Physicians.

The history can distinguish mechanical from systemic disorders, and the physical exam can distinguish neurologic from nonneurologic conditions, said Dr. Borenstein of George Washington University, Washington.

"Laboratory tests are notably inconsequential," he said. "When you're taking your history and you don't think they have one of these systemic illnesses, you really don't have to do laboratory tests on these individuals."

Laboratory tests can be useful in distinguishing inflammatory from noninflammatory disorders, and radiologic tests can confirm a diagnosis derived from other means. But testing can just as easily confuse the issue.

It's critical to quickly identify the 5% or so of patients with cauda equina compression, often associated with an expanding aneurism or a herniated disc because they require emergency surgery. Typically these patients will have urinary retention, incontinence, or saddle anesthesia. In those cases, Dr. Borenstein recommended getting an MRI on an emergent basis.

Results of one recent study showed that patients with cauda equina compression do much better if they get surgery within 48 hours of the start of acute symptoms. Patients whose surgery was delayed often experienced severe and persistent motor deficits, persistent sciatica, and sexual dysfunction (Spine 2000;25:348-51).

In taking a history of a patient with low back pain, five areas of questioning can identify many red flags. If the answers to these constitutional symptom questions are all negative, "you can treat an individual with back pain conservatively without doing an x-ray, without doing lab tests, in fact by telling them they're going to get better—and being right most of the time," Dr. Borenstein said.

Weight loss and/or fever can signal either vertebral osteomyelitis or a vertebral neoplasm. Radiography—either a plain x-ray, a CT scan, an MRI, or a bone scan—can be helpful here.

Pain at night or with recumbency can signal either a bone tumor or a spinal-cord tumor. "If they tell you pain is worse at night, and they have any neurologic sign, that's a patient for whom I'd get an MRI," he said.

Morning stiffness that lasts for hours can signal spondyloarthropathy or ankylosing spondylitis. Making this diagnosis is now more critical because effective therapies have recently become available. An x-ray taken with Ferguson's view of the sacroiliac joints is helpful in this diagnosis.

Evaluation of a patient who has acute, localized bone pain, equivalent in intensity to a bone fracture "is one of the few times where our laboratory tests can be helpful," Dr. Borenstein said. He suggested getting an erythrocyte sedimentation rate, a CBC, and a chemistry profile. These tests can help differentiate the acute fracture of osteoporosis from a tumor, Paget's disease, or sickle cell disease.

Finally, if the patient has viscerogenic pain, the physician should determine whether the pain is colicky, tearing, or episodic. Colicky pain suggests a kidney or gall bladder problem; tearing pain suggests a vascular problem such as an aneurism; and pain that's episodic, coinciding with meals or with the menstrual cycle, suggests pancreatitis, peptic ulcer, or endometriosis.

Only about 10%-15% of patients presenting with lower back pain will have one of those red flags, Dr. Borenstein said. Most whose pain has a mechanical origin will get better within 4-8 weeks with conservative therapy that may consist of NSAIDs plus a muscle relaxant.

In fact, telling patients that they'll soon feel better itself has a therapeutic value. It's also good for them to be up and around as they are able, performing the normal activities of daily living. Studies have shown that patients who get 2 weeks of bed rest do no better than those performing normal activities. Patients should be counseled, however, not to go back to a vigorous exercise routine until the episode abates. ■

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