Discharge Planning Is Key in Managing Headaches

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LAS VEGAS — A successful post–hospital discharge headache plan requires three strong pillars: good headache health, good physical health, and good psychological health, Dr. Todd D. Rozen said at a symposium sponsored by the American Headache Society.

A weakness in any of those areas—uncontrolled headache, uncontrolled diabetes or hypertension, or unaddressed psychological problems—can ignite a cycle of pain and analgesic use that may result in a medication overuse headache and land the patient in the hospital again, Dr. Rozen said.

Discharge planning is probably the most important factor in preventing headache disability and rebound relapse, said Dr. Rozen of the Michigan Head-Pain and Neurological Institute, Ann Arbor. "The hard part is not what happens in the hospital. It's what happens after they leave. That's where all the work takes place."

The first step is to establish an effective abortive plan to keep headache pain under control, he said. That means picking and choosing which pain to treat. "The hardest step is learning that we don't treat mild pain anymore. If you've been an analgesic overuser, you have to retrain the brain to understand that it's not going to get medication every time it wants it."

The patient should not be a martyr, however. "Sometimes they go the opposite way and don't take their medication enough. Make sure they aren't underusing it, because allowing the pain to progress may actually make it worse," Dr. Rozen said.

Hydration, moderate exercise (20 minutes per day, two or three times per week), and relaxation techniques will help the patient cope with mild pain. For moderate pain, NSAIDs may be used, but no more than four times per week. If the pain is not accompanied by nausea, then the patient should take the NSAID alone. If nausea is present or if the pain is escalating, then the patient can add a dopamine antagonist, but no more than twice a week; these drugs are helpful in treating pain and also speed up NSAID absorption.

For severe pain, most patents probably will not be taking triptans, since they were most likely overusing those drugs. Dihydroergotamine is one option; it has a much longer half-life than a triptan and poses less of a rebound risk.

Every discharge plan should include rescue therapy. "There are always going to be times when none of these medications work," Dr. Rozen said. Indomethacin suppositories or atypical antipsychotics can be of use, as can high-dose, as-needed antiepileptics. Those that increase γ-aminobutyric acid (GABA) are probably most useful, since they work on the pain and are nonaddicting. Consider pregabalin, gabapentin, topiramate, or levetiracetam. Opiates are almost never used in this population.

An effective preventive-therapy program is essential. Most patients will do well on oral forms of whatever intravenous therapy they responded to while in the hospital: magnesium, a dopamine receptor antagonist, valproate, dihydroergotamine, corticosteroids, or antihistamine.

No discharge plan will be effective, however, if underlying psychological and physical problems aren't addressed. This requires appropriate referral, Dr. Rozen said. "Don't try to be the primary care provider for psychiatric conditions. You don't have that expertise."

The importance of addressing these problems cannot be overemphasized. Studies show that only 20% of headache patients with depression will improve, compared with 70% of those without depression. Uncontrolled diabetes, hypertension, and thyroid problems can have a significant impact on headache pain as well.

Follow-up is important with these patients, Dr. Rozen stressed. They should be seen every 4 weeks until you are sure they are doing well. "This is your opportunity to monitor their progress and cheer them on," as well as to adjust medication dosages and help set realistic goals.

"They need to understand that getting headache under control will take time," he noted. "By month 1, we shoot for 1 hour of headache-free time. By month 2, we look for a 20%-30% improvement, and by month 3, a 50% improvement. They can't expect to get better in just 2 or 3 weeks." ■