

# Teach Patients About Medication Overuse

BY MICHELE G. SULLIVAN  
Mid-Atlantic Bureau

HENDERSON, NEV. — Treating medication overuse headache involves a three-pronged approach of patient education, teaching pain coping skills, and addressing psychological issues that put patients at risk for relapse, Alvin E. Lake III, Ph.D., said at a symposium sponsored by the American Headache Society.

Most patients don't understand that excessive use of opioids can actually make them hypersensitive to pain, said Dr. Lake of the Michigan Head Pain and Neurological Institute, Ann Arbor. "They believe the pain is stronger than the medication, not that the medication is actually making them worse." This thought process can be the root of ever-increasing medication use, as the patient experiences "pain anxiety" and attempts to forestall pain by premedicating.

The first step is to teach patients how medication overuse exacerbates headache pain, he said. Only when they have a clear understanding of this relationship will they be open to adhering to medication limits.

Sustained opioid use downregulates opioid receptors and upregulates excitatory receptors. This results in increased synthesis of excitatory neuropeptides. "Opioid tolerance is a red flag for induced abnormal pain sensitivity," Dr. Lake said.

Overusing analgesics also interferes with effective prophylaxis, he said, citing a "seminal" 1990 study in which all patients received the same training in coping skills. Those who discontinued their daily analgesic and got a new prophylactic drug experienced the biggest improvement with their headaches.

Those who discontinued their analgesic but stayed on the same preventative improved as well, although not as much, while those who continued their daily analgesic experienced almost no improvement (Headache 1990;30:634-8).

"This study, which I use as a teaching tool, also shows patients that improvement doesn't happen immediately. They need to stay the course. It takes time for the receptors to remodel, and how much time depends on how long they've been taking the medication and how much they've been on," Dr. Lake said.

Simply taking away the analgesic isn't the answer, he stressed. Patients need to understand that drugs are not the only way to alleviate headaches, and that they will probably have to tolerate some level of pain. "The evidence, clinically and empirically, shows that it's very difficult for these patients to move to pain-free days. They have to find ways of dealing with headache that doesn't involve drugs."

Biofeedback, stress management, and antidepressants all may be effective tools in relearning responses to headache pain. A

2001 study concluded that a combination of stress management and antidepressants was more effective than was either treatment alone in reducing chronic tension-type headache (JAMA 2001;285:2208-15).

And a 2002 study of medication overuse relapse showed that 3 years after medication withdrawal, patients on a combination of biofeedback and prophylactic medication experienced significantly fewer headaches per month and used less analgesic medication per month than did those on prophylaxis only (Headache 2002;42:483-90).

Treating any comorbid psychiatric disorder is critical, Dr. Lake said. His own unpublished study of 267 consecutive patients shows how common psychiatric disorders are in headache patients: All of the patients had at least one Axis I disorder, including depression (70%) and anxiety (40%). Another 26% had an Axis II personality disorder. Of those with an Axis II disorder, 63% had medication overuse headache, compared with 42% of those without such a disorder. The presence of an Axis II disorder was significantly associated with a poor long-term outcome.

Hospitalization may be the best way to assess the presence of these additional problems. "This gives you an opportunity to observe not only the patient's behavior, but family interactions and marital problems that you might not see otherwise. When they come into your office they may be able to pull it all together for a half an hour, but when you see them day in and day out, you have the opportunity to get to know the patient and family. It's all right there in front of you," Dr. Lake said. ■

**Only when patients have a clear understanding of how medication overuse exacerbates headache pain will they consider adhering to medication limits.**

# Chronic Pelvic Pain Linked to Illness, Abuse

BY JOHN R. BELL  
Associate Editor

Pelvic disease, psychological morbidity, and a history of abuse are the factors most strongly associated with chronic pelvic pain in women, according to a metaanalysis including data on more than 90,000 patients.

Dr. Pallavi Latthe and colleagues at the University of Birmingham (England) evaluated 122 studies that examined dysmenorrhea, dyspareunia, and noncyclical pelvic pain, including recurrent pelvic pain. The reports included

**Factors most strongly associated were abuse, miscarriage, longer menstrual flow, endometriosis, C-section scar, and others.**

were published in six languages and were extracted from several large databases; a total of 94,927 women were assessed.

Studies were chosen based on inclusion of relevant clinical and statistical terms, as well as quality of the research design (BMJ 2006;332:749-55).

Patient characteristics associated with dysmenorrhea were being at least 30 years of age, having a body mass index of less than 20 kg/m<sup>2</sup>, smoking, menarche before the age of 12, irregular or heavy menstrual flow, premenstrual symptoms, clinically suspected pelvic inflammatory disease, sterilization, and history of being sexually assaulted.

The factors associated with decreased risk were use of oral contraceptives, being married, having children, exercising, and including fish in the diet.

For dyspareunia, associated factors were having undergone female genital mutilation, having clinically suspected pelvic inflammatory disease, and being peri- or postmenopausal. Depression, anxiety, and history of sexual assault were more common in women with dyspareunia.

Those factors most strongly associated with noncyclical pelvic pain were childhood or adult physical, sexual, or other abuse; miscarriage; longer menstrual flow; presence of endometriosis; clinically suspected pelvic inflammatory disease; C-section scar; pelvic adhesions; anxiety; depression; and somatization.

The investigators concluded that "strong and consistent associations" existed "between chronic pelvic pain and presence of pelvic pathology, history of abuse, and coexistent psychological morbidity . . . [providing] potential targets for new therapeutic strategies for treating women with this disabling condition, for which current treatment options provide little relief." ■

# Comorbid Illnesses Are Common in Migraine

BY MICHELE G. SULLIVAN  
Mid-Atlantic Bureau

HENDERSON, NEV. — The concomitant and comorbid conditions associated with migraine and chronic daily headache offer both therapeutic challenges and opportunities, Dr. Elizabeth W. Loder said at a symposium sponsored by the American Headache Society.

These problems may not be severe enough to warrant inpatient therapy on their own, but when combined with headache, they result in such a burden of symptoms that hospitalization might make sense, said Dr. Loder, director of the headache management program at Spaulding Rehabilitation Hospital in Boston.

"Sometimes it's expeditious to do other things in the hospital, even though you're not necessarily admitting them for that reason," she said. "For example, I think it's very useful to have polysomnography for oxygen levels done on all your headache patients admitted to the hospital. You'll find a lot of sleep apnea that way. Treating that in itself is important, but it may improve the headache situation as well."

Some of the most frequent findings are other pain disorders. "It's very uncommon

to have a headache patient in the hospital who doesn't also have some other pain disorder," Dr. Loder said.

Among the most common pain disorders in this population are fibromyalgia, back and neck pain, musculoskeletal pain, irritable bowel syndrome, and noncardiac chest pain. Physicians should be wary of prescribing opioids or narcotics to headache patients who have these symptoms, because "there is a risk that the patient will start to use them for the other pain problems, and then will have difficulty controlling the use. There's also new evidence that long-term use of opioids actually may aggravate pain and make the patient less responsive to other treatment," she said.

Raynaud's disease is also more common in migraine patients, as is a combination of Raynaud's and noncardiac chest pain. The cluster of symptoms may stem from underlying microvascular disease.

"The presence of Raynaud's has some treatment implications for migraineurs," Dr. Loder said. Avoid the use of  $\beta$ -blockers and ergots, as they exacerbate Raynaud's. Calcium channel blockers, however, may improve the Raynaud's symptoms while acting as a migraine preventive.

Microvascular disease may also be im-

plicated in the connection of migraine with coronary heart disease, Dr. Loder said. Numerous studies have documented the association, including the National Health and Nutrition Examination Survey, which found a doubling of the risk of heart attack in migraineurs. Subsequent studies have not upheld that conclusion.

"The evidence is conflicting," Dr. Loder said. "None of the studies were designed specifically to look at the association of migraine with heart disease, so you're relying on previously diagnosed migraine" as the variable. Since most diagnosed migraine usually is severe, often with aura, the study populations are probably skewed. "What we are probably seeing is the incidence of cardiovascular disease in this particular population. But the definite statement on this awaits a prospective study."

She said, however, that primary heart disease, including uncontrolled hypertension, severely limits migraine treatment options because triptans and dihydroergotamine are contraindicated in these patients. "Controlled hypertension is not a contraindication for triptan use, but patients might have other risk factors, so you might feel more comfortable assessing them in the hospital," Dr. Loder said. ■