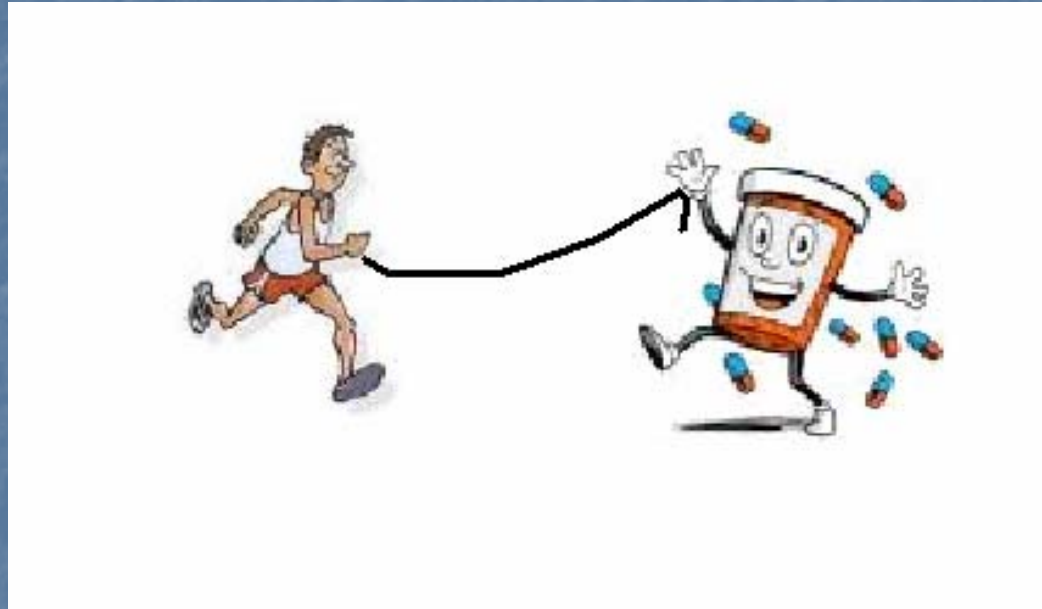


Chronic Daily Headache & The Role of Opioids

Presented by: Dr. R. Feroe

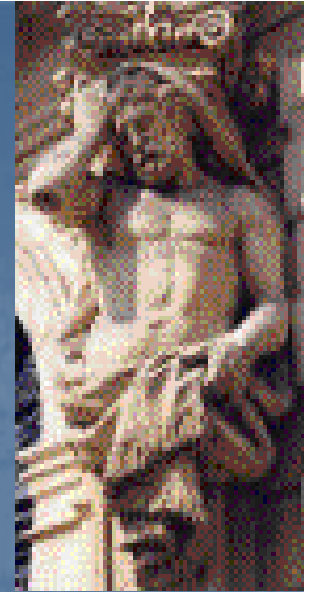
June 15, 2006

Opioids; a rehabilitation tool for Chronic Daily Headaches



Tie Opioids to overall treatment plan
focused on functional restoration with
patient as active participant

Chronic Daily Headaches (CDH)



- CDH is defined by the IHS.
- Chronic Migraine
 - Long lasting Headaches: tension type +/- or migraine
≥15 days/month > 3 months
 - Other types of CDH

Not much known of true prevalence &
pathophysiology CDH

- Access my online summary of CDH covering more topics in more detail than time permits today.

The CDH patient; the CDH doctor

- 45 female
- Long standing hx
- Worse after 4 kids
- Depressed, poor sleeper
- Parents drank
- Smoker- wants to quit
- 5 preventatives to date
- ER visits /month
- Other prns



Treatment Algorithms

- Old: Serial style treatment
 - R/O Medication Overuse Headache → 4 months of Preventative trials → Referrals
 - Why it sometimes does not work
- New: Concurrent treatments
 - Maximize Pain relief at same time plan for functional restoration implemented
 - Why it can help those failing old protocols

Medication Overuse Headache

'04 appended in '06

- HA Develops or worsens during med overuse
- Regular overuse of medication for > 3mo.
 - Ergotamine, triptans, opioids, or combination analgesic ≥ 10 days/month
 - Simple analgesics or any combo: ergotamine, triptans, analgesics, opioids ≥ 15 days/month without overuse any single class
- Improvement on W/D no longer required.

Protocols for Treating MOH

- Objective Guidelines not available
- Many protocols; IV & inpatient stay
- Stop all culprits for 1-2 months.

MOH treatment success?

- 50% in specialty care remit to < 15 headaches /month
- longer follow up studies, worse results
- 5-year study- relapse rate of 40%.
Relapse as high as 70% at 1 yr
- TTH, Opiate users relapse rates higher

Do they feel better?

- Pini et al-
- Of the 1/3rd still compliant at 4 years = worse QOL!

Pini L-A, et al. Long-term follow-up of patients treated for chronic headache with analgesic overuse. *Cephalalgia* 2001; 21:878-883.

Need controlled Trials

- Epidemiologic studies show CDH remits in absence of treatment in 57%
- So spontaneous remission may give results = intensive TX at referral center

Return on Investment

MOH treatment



- Not that big a problem: MOH in 1/3 with CM
- Long term results not sustainable roughly 50%
- May have Worse QOL with treatment
- Might do better TX with time alone

MOH

- Analgesic Overuse Is Not A Cause of Chronic Daily Headache David W Dodick
 - Headache: Volume 42 Page 547 - June 2002
- Analgesic Overuse Is A Cause of Chronic Daily Headache Stewart J. Tepper
 - Headache: Volume 42

Bottom line

- No placebo-controlled trials proving MOH
- No long-term, prospective, controlled trials demonstrate remission from withdrawal.
- Still more Q than A. Worth trial TX if not detrimental to patient.



How well do Preventives work and how do we select them?

- Few controlled trials preventatives in CDH
- Amitriptyline (Elavil) best documented efficacy
- Options from Headache Consortium Guidelines for migraine
 - Of Proven efficacy & mild-moderate side effects. Few make the list:
 - Elavil® (amitriptyline), Inderal® (propranolol), Depakote® (valproic acid). Adding Topomax® topiramate

Topiramate

- In the three largest trials...
Topiramate 100mg was associated with **one** less migraine per month than placebo
- Brandes JL et al, JAMA 2004;291:965-73
- Silberstein SD et al, Arch Neurol 2004;61:490-95
- Diener HC, J Neurol 2004;251:943-50

Long term results

- % remaining on preventative > 6 mo.
 - 36% (SSRI's).
 - 35% sodium valproate (Depakote)
 - 31% tricyclic antidepressants.
 - 22% B-blockers.
- 22-36%, lack of efficacy most common reason for stopping

Headache: *Vol. 41 Issue 6 Page 611 June 2001*

We Need Better Preventative Medications

L. Robbins

General NNT for Neuropathic Pain

- NNT 3.1 Antidepressants
 - TCA'S 2.3, Venlafaxine 4.0, SSRI'S 6.7
- NNT 4.2 Anticonvulsants
 - Gabapentin 4.7
- NNT 2.5 Opioids
- Numbers Needed to Harm for Opioids Great

Algorithm for neuropathic pain treatment: An evidence based proposal. Pain 2005

Volume 118, Issue 3, Pages 289-305 N. Finnerup, et al

Pro Preventative & Pro Opioid

 camps Join forces 

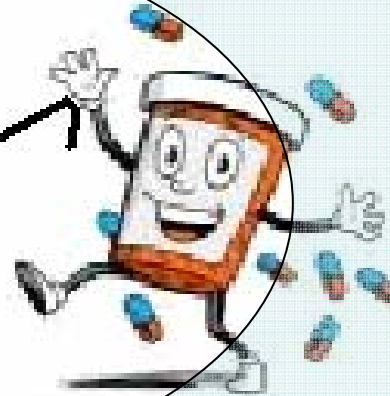
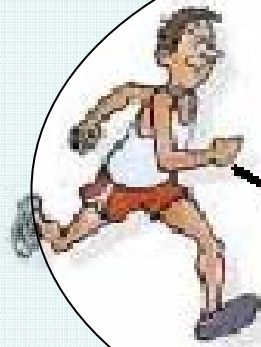
- Gold standard studies now show Gabapentin and morphine combined achieved better analgesia at lower doses of each drug than either as a single agent,

Gilron et al. N Engl J Med. 2005 Mar
31;352(13):1324-34

NEW Improved Algorithm

Limit Symptomatic Medications
Preventatives based on Co-morbidities

at same
time



at same
time

TX Other
Physical & Mental
Health Issues

at same
time

OPIOIDS
Titrate to
Function

TX with Opioids Results

- Saper et al - positive & enduring response in 26%
- Drinkard et al using methadone treatment response identical to Saper 26%.
- As good as standard preventatives in a refractory population

Various publications by J Rothrock, J Saper and L.Robbins

Can long acting or sustained opioids worsen CDH?

- Sustained morphine in *RAT* models of Pain seem to lower pain thresholds
- paradoxical pain produced in regions unaffected by initial pain

Review

Is Paradoxical Pain Induced by Sustained Opioid Exposure an Underlying Mechanism of Opioid Antinociceptive Tolerance?

Tamara King, Michael H. Ossipov, Todd W. Vanderah, Frank Porreca, Josephine Lai

In real human studies...

- 'commonly used' dosages of oral **opioids do not** result in abnormal pain sensitivity beyond that of patients receiving non-opioid analgesia.

Reznikov I, Pud D, Eisenberg E. Oral opioid administration and hyperalgesia in patients with cancer or chronic nonmalignant pain. *Br J Clin Pharmacol* 2005;60(3):311-318.

Pain is smart

- Opioids sometimes lead to tolerance
- May also sometimes lead to a pronociceptive process.
- Sensitization *may* add to clinical picture of pharmacologic tolerance.
- Clinically we stay ahead - adjust dose, rotate, and use adjuvants

Patient Selection for Opioids

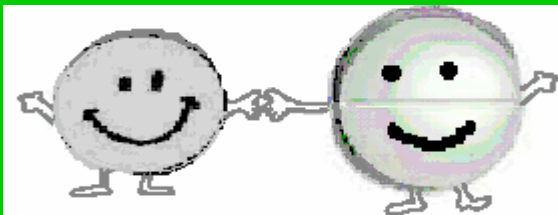
- *Very* hard to predict who will do well
- Identify Co-Morbidities then tie opioid TX to **co-management of co morbidities**
 - Example pain and BPD: While on opioids for headache attendance DBT group required.
 - Recovering ETOHer:

When to consider opioids

- Pain severe/disability great, lack of relief will worsen disability
- Standard preventatives failed or not tolerated, too toxic
- To Reduce Harmful TX's
 - levels of toxic medication are being utilized, ER being used.



Oh no Smiley Face they want to give you Botox and ruin your career. Quick, Try an Opioid First!



The Mechanics of Opioid TX

- Essential for good outcomes:
 - Addiction screening and Initial Urine Screen - Standard of Care
 - Trial only
 - Goal to manage not cure. Provide enough relief that focus can move to non pharmacologic strategies
- Monitor Function and titrate to Function
- Get help with complicated patients

Use long acting or CR opioids Exclusively

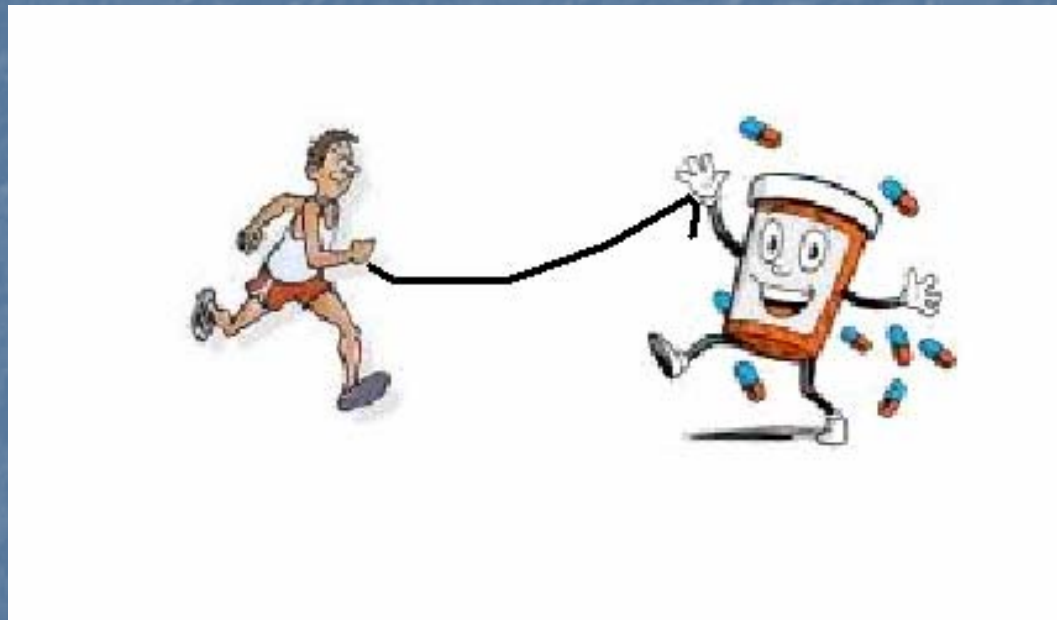
- Pacing skills
- Safety
- Sleep
- Less mini withdrawals, pain, anxiety, abuse, possibly less tolerance.
- Better QOL

Opioids and CDH

Conclusion

- In significant minority CR opioids give quick sustained response with **dramatic reduction in disability**
- More commonly, slow, less dramatic response
Pain control & Harm reduction with opiate,
While non pill strategies assist in functional restoration

How to tie Opioids to plan for functional restoration? How to help patients recognize the potential of non pill treatment?



Coming Next

Role of Psychology & Other Adjuvant Treatments to Chronic Daily Headache

Anthony Grootelaar, R. Psych
LifeMark Health Institute

The purpose of adjuvant treatments is to better control the triggers leading to decreased function and increased pain, which can occur in many different forms and situations:

- Cognitively
- Interpersonally
- Socially
- Through proactive choice and responsibility
- Biologically

Let me provide you with two examples that model this approach:

- Intermittent Explosive Disorder (IED)
- Diabetes

KISS Model vs.

KISS Model

vs.

KIC

KISS Model
vs.
KICK Model

The challenge is making the control or alteration of triggers which alter pain or function as important as defining causal dysfunction.

In making this transition,
there are three distinct
elements:

- I. Patient Education of Complex Treatment Protocols
- II. Adjuvant Treatment Referrals
- III. Acting as a Complex Practitioner (Techniques)

I. Patient Education

Validate that the patient's pain experience is real and debilitating for them.

I. Patient Education

Shift emphasis to attaining results that make the problem more manageable rather than make it go away.

What is sought is control rather than cure.

I. Patient Education

Emphasize that improvement in any domain will improve control of triggers and make CDH more manageable.

I. Patient Education

Therefore assessment of domains is important:

- Social
- Addiction issues
- Financial
- Interpersonal
- Stress/coping skills
- Etc.

What are the client's strengths and weaknesses in coping with these domains? Make the appropriate referrals.

II. Adjunctive Referral

- Psychologist
- Biofeedback
- Multidisciplinary pain clinic
 - Dietitian
 - Exercise Therapist

III. Acting as a Complex Practitioner (Techniques)

III. Techniques

Rather than a causal approach to problems, look for changes in behavior and explanations why that are provided by the client.

III. Techniques

Ask about participation in parallel treatments.

III. Techniques

What would be the smallest improvement that you would be happy with?

III. Techniques

Question the patient's commitment to
parallel treatments.
Attendance?

III. Techniques

Question the patient's stress coping skills.

III. Techniques

Good stress managers have four characteristics:

- Open and Curious Nature
- Wide and Varied Social Network
- Sense of Humor
- Internal Locus of Control

III. Techniques

Question the patient in these domains:

Did you get to church?

Did you visit your mother?

Reinforce use of skills and management strategies in control of pain.

Recap

1.) If KISS model is not working, shift to
KICK

(ie. parallel treatments necessary to manage
triggers)

Recap

1.) If KISS model is not working, shift to
KICK

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2.) Make referrals to helpful care providers
as available.

Recap

- 1.) If KISS model is not working, shift to KICK (ie. parallel treatments necessary to manage triggers)
- 2.) Make referrals to other care providers as available.
- 3.) Keep situation complex. Empower and the patient validate in terms of skill use in controlling pain.

Contact Us....

- Dr. R. Feroe

rferoe@lifemarkhealthinstitute.com

- Anthony Grootelaar

agrootelaar@lifemarkhealthinstitute.com

- Phone: 1.800.265.9197