Clinical Pearls for Treating Headache Patients

By Lawrence Robbins, MD, Fred Ludwig and Brooke Bassett, NP-C

Headache patients often have complex medical and psychological issues. The following “pearls” reflect the author’s philosophy in treating these patients.

Medication

- Start with low doses of medication, particularly with antidepressants and other preventives. Headache patients tend to be fairly somatic, and there is no need to push medicine very quickly.
- Stick with preventive medications for at least four weeks (or longer). If we abandon them too soon, we may not see the beneficial effect. However, few patients are willing to wait months for positive benefits from a medication.
- Consider newer abortive medications, such as Cambia. Cambia is powdered diclofenac potassium (not sodium: the sodium version, such as Voltaren, will not work as a powder). Cambia, used in water or apple juice, achieves detectable blood levels in as little as 10 minutes. Prodrin is a newer version of Midrin, with no sedative (Prodrin eliminates the dichloralphenazone), and 20mg of caffeine. Levadex (from Map Pharmaceuticals) is an inhaled version of DHE, expected to be approved by the FDA. Levadex will be a better product than Migranal Nasal Spray, but not quite as effective as injections of DHE.
- Consider natural alternatives that work, such as the butterbur derivative, Petadolex. Petadolex is a highly regulated “adulterated herb,” and it is the #1 preventive in Germany. I feel Petadolex is safe, has a long successful track record, and is almost as effective as our mainstream preventives.
- OnabotulinumtoxinA (Botox) should be considered early in the course of treatment. Botox is now FDA approved for chronic migraine (15 or more days per month). Botox has proven to be safe and effective (almost 60% of patients experience meaningful relief for 3 months). The high cost is a concern.
- Previous sensitivities and allergies to medications often determine where we go with meds. If the patient has had severe reactions to two selective serotonin reuptake inhibitors (SSRIs), a third is not a good choice. However, those reactions may not be readily apparent in the chart. If they are extremely fatigued on one beta-blocker, a second will probably not work for the long term.
- Weight gain is a major issue. Even though a drug may be more effective, choosing one that avoids weight gain (in those prone to it) is more likely to lead to long term success. Fatigue is another major reason for patients abandoning a preventive medication. Headache patients commonly complain of fatigue. Many of our preventives (amitriptyline, beta blockers, valproate, etc.) may add to weight gain and/or fatigue.

- While most patients are honest about analgesic use, some are embarrassed to tell us how much they are utilizing. Between over-the-counter analgesics and herbal preparations, many patients are consuming larger quantities of medications than we realize.
- Do not confuse addiction with dependency. When treating chronic daily headache, dependency has to be accepted. Dependency is acceptable, while addiction is not.
- In using opioids, you must be willing to say NO and set LIMITS. Avoid using opioids in younger patients, so as to avoid "opioid hyperalgesia." Once younger people are on frequent opioids for a period of time, they may be "sensitized," and we may have little choice but to utilize opioids.
- Heed red flags in your patients on opioids. While pervasive behaviors help to determine addiction, even one red flag early in treatment should be seriously considered. For instance: You see a new patient, begin Tylenol #3, and receive a call four days later from the patient stating "I got the generic, the regular works better, can you call some in?"
- Using a medication to establish a diagnosis may not be accurate. For instance, dihydroergotamine (DHE) and triptans have also been effective for relieving the pain of non-aneurysmal subarachnoid hemorrhage (SAH) and tumors.
- What to do when nothing works: Before "giving up" on a patient with severe, refractive chronic daily headache, consider "end of the line" strategies such as: daily triptans in limited amounts, Botox injections, monoamine oxidase inhibitors (MAOIs), daily long-acting opioids, stimulants, or a combination of approaches.

Patient perceptions

- Legitimize the headache problem as a physical illness. Statements such as "headaches are just like asthma, diabetes or hypertension: a physical medical condition" go a long way toward establishing trust between the patient and physician. When we mention that it is a medical condition—primarily inherited—and that there is too little serotonin in the brain in people with headaches, patients respond exceedingly well. Once we have established this, the patients are much more amenable to addressing anxiety, depression, etc. with therapy or other means. However, if we focus on the patient's stress, anxiety, depression, and psychological comorbidities first, they are often turned off to the physician unless we also state that we are treating the headaches as a legitimate medical illness.
- When we place patients on antidepressants, we need to make it clear that we are trying to directly help their headache by increasing serotonin. We also state that we certainly hope this helps anxiety, depression, etc. Patients are often confused as to the reason why they are given an antidepressant. It helps if we make it clear that we are not trying to treat their headache by treating depression, but rather trying to adjust serotonin levels.
- We must try to achieve a balance between medication and headache; we tell the patients that we are trying to improve the headaches 50% to 90%, while minimizing medications.
- Many patients are frustrated by the lack of efficacy and/or side effects of daily preventives. Tell them that only 50% (at most) of patients achieve long-term relief with preventives. This helps them to realize they are in a big boat, and that it is not their fault.

- Patients with chronic daily headache may view the headache situation in black and white terms. They will come back for a return visit and state, “Well, I still have a headache every day.” They need to accept that if we have gone from moderate-to-severe headaches (7 on a scale of 1-10) to mild-to-moderate (4 on a scale of 1-1 0), then the situation is improved and we should not change all the medication. If the patients keep a headache chart or calendar, this may help. Patients need to be willing to accept 50% to 90% improvement in frequency and/or severity of headaches.
- Being aware that there are cultural and ethnic differences in the perception and experience of pain can aid treatment.
- Pain patients are often desperate, and search the internet for a cure, or seek alternative practitioners. We should not castigate them for doing so; they are just looking for answers.
- Catastrophizing greatly inhibits patients from improving. Work with your patient on decreasing the level of catastrophizing and histrionics. This will improve the pain level and associated anxiety.
- When patients feel that they can actively help their headaches (“self-efficacy”), by medication or biofeedback or other means, it improves their sense of well-being. Whether by taking a medication, watching triggers, exercising, or doing yoga, etc., increasing “self-efficacy” enhances outcomes.
- Acceptance of their chronic illness (headache) is a helpful state of mind for patients to achieve. Acceptance is different than resignation. Acceptance helps to ease anxiety (“Isn’t there a cure? These must be curable”). The road to acceptance may take years, and involve many doctors and alternatives.

Broader health

- It can “take a village to help a person with severe pain.” Don’t try to do it all by yourself; get other villagers involved, including psychotherapy, massage, physical therapy, pain specialists, acupuncture, etc. Direct the patient to whichever of these other professionals is appropriate.
- In choosing preventives, look at comorbidities, particularly: anxiety, depression, insomnia, gastritis, gastroesophageal reflux disease (GERD), blood sugar, constipation, hypertension, asthma, and sensitivities or allergies to other drugs. These often determine which way to proceed with medication.
- Central sensitization is an important phenomenon that occurs in chronic headache, peripheral neuropathy, and probably also in irritable bowel syndrome (IBS), and fibromyalgia. Once this occurs, treatment is difficult.
- Virtually all patients should be on vitamin D, usually at least 2,000 units. Vitamin D is almost “the last man standing” among supplements. Multivitamins have more negatives than positives for many patients, and the same is true for antioxidants. Vitamin D helps many conditions, among them pain and depression.
- For patients with IBS (primarily diarrhea) and frequent headaches, consider a low-gluten diet. I have the patients limit wheat-based bread, cereal, and pasta. There are many gluten-free products.

- Aspartame may cause headaches in susceptible patients; aspartame is a commonly used sweetener in products such as Diet Coke and Diet Pepsi.
- Caffeine enhances the analgesic effects of aspirin (such as Excedrin) and of NSAIDS. However, overuse of caffeine may lead to medication-overuse headache. We limit caffeine to 150 or 200mg per day. The average home-brewed cup of coffee has 120 to 170mg. Coffee from Starbucks and other specialty stores has more caffeine: 23mg per ounce. Soft drinks have 50 to 60mg per cup, while tea has 0 (if herbal) to 50mg per cup. Excedrin contains 65mg of caffeine per tablet.
- Learn about, and recognize, personality disorders (Axis 2). Many medical clinics allow a small number of personality disorders to drain much of the clinic's energy. Get others (psychiatrists, etc.) involved and set limits.
- For depression to improve, it is important to control pain. Likewise, to help pain, we must treat depression.
- Attention Deficit Disorder (ADD) in adults is common (4.7% prevalence). Look for it since ADD decreases quality of life and is relatively easy to treat in adults.
- Watch for soft bipolar signs in headache patients who have anxiety and depression. Bipolar disorder tends to be under-diagnosed, and the clinical stakes for missing it are enormous. Bipolar disorder, primarily mild and soft (Bipolar 2 or 3), is seen in as many as 6% to 8% of migraineurs. While some of these patients will do well on an antidepressant, it is almost always necessary to add a mood stabilizer.
- We cannot promise patients that their headaches will improve with psychotherapy (as it often does not), but coping with headaches and the stresses that headaches produce is often improved with therapy. Unfortunately, because of stigma, time, and money, only a small minority of patients will actually go to a therapist. However, those that do go will usually benefit. Biofeedback is under-utilized and should be offered more often.

Strategies and procedures

- It helps to view chronic headache as a continuum or spectrum. The "in between" headaches may not fall neatly into the current tension or migraine categories. Whether these are severe tension or milder migraines, they often respond to the same medications.
- Kindling of the brain is important in depression, seizures, and headache. It is crucial to treat depression to remission, control seizures, and treat headaches. Possibly, if we treat younger patients with frequent headaches fairly aggressively, we may prevent the progression into chronic daily headache.
- The initial history and physical is the best time to consider a differential list of medications, because at that point we have a good grasp of the patient's comorbidities. If we list in the chart all other treatment possibilities (in case our initial medications do not work), later we, or our partners, do not have to reconstruct the entire history with the patients.
- Keep a drug-medication flow chart, which is easy to do with electronic medical records (EMR). Headache patients are constantly having medications stopped and re-started so that, over ten years, a patient may have been on 50 different medications at various times. It is impossible to

piece through 40 progress notes trying to determine what the next best course of action is. A drug-medication flow chart from the beginning would help immensely.

- In treating pain patients, utilizing pre-made stamps or EMR software can be helpful for documenting that a discussion occurred about side effects, risk/benefits, limits, etc. Opioid stamps for each visit include: level of pain and functioning, moods, overuse, physical exam (pupils/gait/speech).
- When dismissing a patient from your practice (for abusive or drug-seeking behavior, or other reasons) do not abandon the patient. Instead, offer three other physicians' names and phone numbers, suggest that you will transfer records, assist in any way to help obtain another physician, and give one to three months to find another provider. It is common for dismissed patients to complain to departments of regulation about "abandonment."
- While there is the official definition of pain, we prefer "Pain is what the patient says it is, and it's as bad as the patient says it is."