INDIANA PAIN ACADEMY Newsletter

President:
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Spring 2003 / Volume 3, Issue 1

*Welcome to the 2003 Spring issue of the Indiana Academy of Pain Newsletter. This is an all-migraine issue.*

*The focus of this issue is on the classification of headache. How do you tell the difference between muscle-tension headache and migraine? Does it matter? How do children fit into this classification?*

*Finally, we present some case studies and test your ability to classify headaches. Be careful, these are tricky!*



# Problems with Classification

By Randall Oliver, MD

The International Headache Society, based in the United Kingdom, developed a classification system for headache to provide guidelines in the diagnosis of headache. The intention was to clear confusion and to provide a standard of diagnosis.

The problem is that headaches do not fit nicely into each category. Many headache patients experience symptoms from both tension-type headache and migraine categories.

The key to correct classification is following the algorythm. For muscle-tension headache, vomiting may not be present. This is an important differentiation. For migraine, it is more common to have moderate to severe pain, while tension-type is usually mild to moderate pain.

Another problem arises around the distinction between migraine with aura and migraine without aura. Aura is present only 10-20% of the time. Distinguishing between the two, therefore, is not necessary.

For someone having an aura, it is easier to diagnose migraine. But when there is no aura, the confusion between muscle-tension headache and migraine surfaces. Neck tightness is present in the majority of migraine patients, further blurring the distinction between the two.

## Is Classifying Necessary?

Once a patient seeks medical treatment for headaches, he or she has often tried all of the over-the-counter medications for headache; has lost time, productivity, or both at work; and has suffered socially. Many members of our society, including physicians, view headache as merely a nuisance and not debilitating. This view makes patients relunctant to come to the doctor for a headache.

When a patient presents for your care, it is important to be accurate in the diagnosis. Unnecessary trials of medi-

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***NEXT ISSUE:***
**NUTRITION**
**AND**
**HOW IT AFFECTS PAIN**

INDIANA PAIN ACADEMY

# Case Studies: *Determine the correct migraine classification*

.) Molly is 24. She has had headaches for 2 years. They ccur about twice a week and last for 6 to 8 hours at a time. he says they started after an auto accident two and a half ears ago. The pain is in the right eye and right temple nd radiates to the base of her skull. She describes the ain as moderate and pulsating. She states that when it ccurs she does not feel like eating and on occasion has omited.

.) Aaron is a 45-year-old male who has had headaches or 30 years and has attempted many medications for his eadaches. He has had MRIs and CT scans and all are egative. His family practice physician once tried a mig- aine pill and it did not do anything. He is now taking a arcotic when his head hurts but he worries about it be- coming addictive. He complains of blurry vision and sensitivity to sound for about an hour before the pain starts. Shortly after his vision clears, the pain begins at the back of the head and progresses into the neck and shoulders. Once the pain becomes moderate he takes a narcotic and lies down. He says he has to lie down because any small movement makes the pain worse.

*3.)* Allen is 55 and has had headaches almost daily for one year. The pain is mild, but bothersome. He works as a computer operator and the pain is distracting. The pain is in both temples and radiates to the top of the ears. He describes the pain as pulling or tightness.

*(Answers on page 3)*

## s Classifying Necessary?

*Continued from page 1)*

ations with little or no results frustrates an already ustrated patient, while at the same time creating oubt in your ability to help him or her. Correct nd prompt treatment also ensures that the patient eceives medication specific for the condition. Migraine-specific medications are non-sedating. migraine patient is usually already spending me in bed, and a narcotic or sedative prolongs is time. The triptans allow the patient to return his or her life as quickly as possible.

## *Ultracet & Medicaid*

Dr. Randall L. Oliver, President of the Indiana Pain Academy, recently spoke to the Indiana Medicaid Board in Indianapolis on the topic of adding the pain medication Ultracet to the list of preferred drugs for Medicaid. This would would give doctors in the state of Indiana another non-opioid pain medication to prescribe for their patients without the hassle of getting prior authorization.

The board voted to go ahead with this proposal, sending the final decision to be determined by the rest of the board at a later date.

Dr. Oliver was also instrumental in getting Imitrex approved for Medicaid without prior authorization.

## *Want to join?*

## Indiana Pain Academy

Name _____

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Annual Membership Dues:
Physicians: $100/year
Others: $25/year

*Fax this form to Indiana Pain Academy at (812) 422-2421*

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## 1.1 Migraine without Aura

At least 5 attacks with at least 2 of the following:
- Unilateral
- Pulsating
- Moderate to Severe intensity
- Physical activity aggravates

At least 1 of the following:
- Nausea and/or vomiting
- Photophobia and Phonophobia

No organic disease

## 1.2 Migraine with Aura

At least 2 attacks with at least 3 of the Following 4 items:
- One or more fully reversible aura symptoms indicating brain dysfunction At least 1 aura symptom develops gradually over more than 4 minutes or 2 or more symptoms occur in succession
- No single aura symptom last more than 30 minutes
- Headache follows aura with a free interval of less than 60 minutes

No organic disease

*Key Points:*
Aura
Prodrome
Moderate to Severe Pain

## 1.7 Migrainous Headache

Fulfills all of the criteria but one, for one or more forms of migraine
Does not fulfill criteria for Tension-Type Headache

## 2.1 Episodic Muscle-Tension Headache

Less than 15 headaches per month lasting from 30 minutes to 7 days with at least 2 of the following:
- Pressing, tightening, nonpulsatile
- Mild or moderate intensity (may inhibit but not prohibit activity)
- Bilateral location
- Not aggravated by routine physical activity

In addition:
- No nausea or vomiting
- Photophobia or phonophobia may be present, but not both

## 2.2 Chronic Muscle-Tension Headache

Headache occurring 15 or more days per month for 6 months

Pain described by 2 of the following:
- Pressing, tightening quality
- Mild or moderate intensity (may inhibit but not prohibit activity)
- Bilateral location
- Not aggravated by routine physical activity

In addition:
- No vomiting
- No more than 1 of the following: nausea, phonophobia, or photophobia

*Key Points:*
No Nausea
No Vomiting
No Aura

# Quick Tips on Triptans

By Randall Oliver, MD

*1.)* Failure from one dose of a triptan does not mean that no triptan will work. Use the step approach in the use of triptans. For example, if an Imitrex tablet gives no relief, try the nasal spray or injection.

*2.)* Triptans are intended for abortive therapy. If it is necessary to treat more than twice a week, consider prophylactic therapy in conjunction with the abortive.

*3.)* Migraine sufferers in general often have been found to have no preference for a specific triptan. Some patients might do better with another option. See which one they think has fewer side effects, most convenience, and most efficacy.

## HYPERSENSITIVITY SYNDROME

People who get migraines are thought to be hypersensitive, meaning that a certain smell or sound can trigger a migraine in the patient. While having a migraine, these patients become even *more* hypersensitive. This is what forces a migraine sufferer to lie down in a dark room, away from sounds, smells, and light in order to cope with the pain.

Chronic pain sufferers also experience this syndrome. Having pain all the time doesn't make a patient more tolerant to pain. On the contrary, it makes them more sensitive to pain. They become hypersensitive as a result of ha g chronic pain.

# Childhood Migraine

By Randall Oliver, M.D.

In my practice at the Oliver Headache & Pain Clinic, I have observed that in nearly all cases, excepting those of head injury or severe psychological stress, headaches in children are migraineous. A common clinical finding is a family history of migraines. There is a strong correlation between parents and children with migraines, leading to the belief that migraine is a genetic disease. Another factor that is nearly always present is a Type A personality. Namely, the child is intelligent, polite, meticulous, and always striving to please. This factor can be used as a secondary diagnosis tool.

Pa larly in children, migraines can include symptoms other than a headache, such as abdominal distress, cyclical vomiting, personality changes, and sudden fatigue. Fifty percent will experience nausea and no light or s l sensitivity. The majority present bifrontal pain, when pain is present. For abortive purposes, we have often prescribed simple analgesics such as acetamino-

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## *Answers to Case Studies*

*(from page 2)*

1.) *Migraine without Aura:* moderate, pulsating, unilateral, nausea, vomiting. You may have been thrown off thinking that an auto accident causes muscle pain, but auto accidents can also be a triggering event for a genetically-prone migraine person. She probably has a family member with migraines.

2.) *Migraine with Aura:* fully reversible aura, two aura symptoms at once, headache follows aura within 60 minutes, moderate pain, and aggravated by activity. Remember, childhood headaches are migraines. At this point, this may actually be a narcotic-induced rebound migraine. Even though a triptan has been tried, it is worth trying another in a higher dose or injection to be certain.

3.) *Chronic Muscle-Tension Headache:* tightening quality, mild, bilateral, does not prohibit work, no nausea, aura, or vomiting.

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# Childhood Migraine

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phen, aspirin, ibuprofen, and Midrin (isometheptene mucate, dichloralphenozone, and acetaminophen), all dosed according to the age of the child. Our best results, however, have resulted from migraine-specific medicines such as those of the triptan family and dihydroergotamine, or DHE. For prophylaxis of childhood migraines, the mainstay is a vascular medicine or an anti-seizure medication.

National Headache Foundation's

## National Headache Awareness Week
## June 1-7

*"Take control of your headaches, take control of your life."*

for more information, contact the NHF at:
**www.headaches.org**

## *RESOURCES:*

**National Headache Foundation**
820 N. Orleans, Suite 217
Chicago, IL 60610
1-888-NHF-5552
*www.headaches.org*

**International Headache Society**
Oakwood
9 Willowmead Drive
Prestbury, Cheshire
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Tel: +44(0)1625 828663
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