INDIANA PAIN ACADEMY Newsletter

STATE CHAPTER OF NORTH AMERICAN PAIN ACADEMY

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Winter 2002 / Volume 2, Issue 3

Welcome to the Winter issue of the Indiana Academy of Pain Newsletter. These next two issues will focus primarily on Migraines. This issue dives into the frequent debate of "sinus headache." What is it truly? How do we best treat it? What information does the patient need? What implications are found in regards to recent studies? Why is coding for sinus headache so difficult? We shed some light on these questions in this issue.

We thank you for your interest and welcome any discussion or comments. We also welcome any questions or concerns regarding migraines and will print these in the next issue.

The Myth of Sinus Headache

By Randall Oliver, M.D.

There has been debate recently over the "myth" of sinus headache. Is sinus headache really migraine? Roger Cady, M.D. of Springfield, Missouri, hoped to shed some light on the subject with his recently published research study that tested if migraine medication relieves the symptoms of "sinus headache." The study revealed that 60% improved on one Imitrex 50mg tablet. This shows that at least 60%, and possibly more, of these so-called "sinus headaches" are truly migraines. If 60% improved on 50mg, then treating the other 40% with a step higher, such as Imitrex 100mg tablet, nasal spray, or injection, would probably show an even better number who find relief from the headache. The reason the pain is felt in the sinus region is the activation of the trigeminal system. During a migraine, this activation can cause allodynia (or pain and discomfort) of the scalp, face and extremities. This can also be found as tenderness combing the hair and difficulty wearing glasses or contacts, of which there is no abnormality of the scalp or eyes. Just because a migraine felt in the sinus area does not necessarily mean there is a disorder of the sinuses.

The participants were surveyed regarding satisfaction with this treatment of "sinus headaches," and those who responded to Imitrex felt more satisfied with the Imitrex than with their previous sinus treatment. Even if you still believe in the "sinus headache" as an entity, we at least now can show relief with the use of triptans. But for this population of patients to receive the best care, they should receive directed migraine treatment, both abortive and preventive.

NEXT ISSUE:

COMMON MISTAKES PHYSICIANS MAKE IN CLASSIFYING HEADACHES AND HOW TO CHANGE THIS.

The focus will be on the diagnosis and differentiation of migraines. We will discuss the IHS classification of migraine with aura, migraine without aura, and tension-type headache. Case studies will be presented. Any case study of an interesting migraine case that was difficult to classify are welcome. In the next issue we will also discuss the difficulty diagnosing childhood migraine and treatment options.

INDIANA PAIN ACADEMY

Coding for Sinus Headache

As you may already know, there is no ICD-9 code for sinus headache. This is because the condition that is being treated is usually migraine. The following codes are available for billing for the various headaches:

MIGRAINE

342.2	retinal
346.0	with aura
	classical
346.1	atypical
	common
346.2	Abdominal (syndrome)
	allergic (histamine)
	lower-half
	variant
	basilar
346.8	hemiplegic
	ophthalmoplegic
346.9	idiopathic
625.4	menstrual

HEADACHE

307.81	tension
	nonorganic
	emotional
	psychophysologic
346.1	sick
346.2	allergic
	cluster
	histamine
346.9	migraine type
	migraine
346.98	vasomotor
349.0	*due to:*
	lumbar puncture
	saddle block
	spinal
	spinal fluid loss
	postspinal
627.2	menopausal
784.0	headache
	vascular

The only code above that comes close to sinus is "allergic" headache (346.2). It is actually cluster migraine Therefore, if you are seeing patients with sinus headache, you cannot bill for it. It is not a recognized ICD-9 diagnosis. Also, patients who think they have sinus headache are more satisfied with Imitrex 50mg than with their previous sinus medication treatment.

TRUE SINUSITIS

Cecil's Textbook of Medicine 20th edition states: "True sinusitis is accompanied by purulent drainage and fever and other signs of acute infection." It is not accompanied by nausea, photophobia, or phonophobia.

Chronic sinus conditions do not cause chronic headaches. Remember, a one-time acute sinus infection and headache is totally different from frequent headaches and chronic sinus drainage. Sinus drainage commonly accompanies migraine. It is usually the consequence of the migraine headache and not the cause.

YOUR QUESTIONS...

questions from our members

Q. *I have experienced patients who are insistent on a narcotic for immediate migraine relief. How do I tell them no without seeming uncaring or unhelpful?*

A. Remember our oath to "first do no harm." The best medical care treats ailments with the least possible risk. Be firm and make it understood that you will not prescribe narcotics for migraine pain relief. Then explain that you are doing this in the patient's best interest. It is also helpful to tell the patient that he or she has had these migraines for some time and it may take a trial and error of medications to get the migraines under control. Remain firm. If you eventually give in, you tell the patient that you can be manipulated. Rebound may also occur and the patient will then have headaches more often than before your treatment. *First Do No Harm.* Don't make things worse.

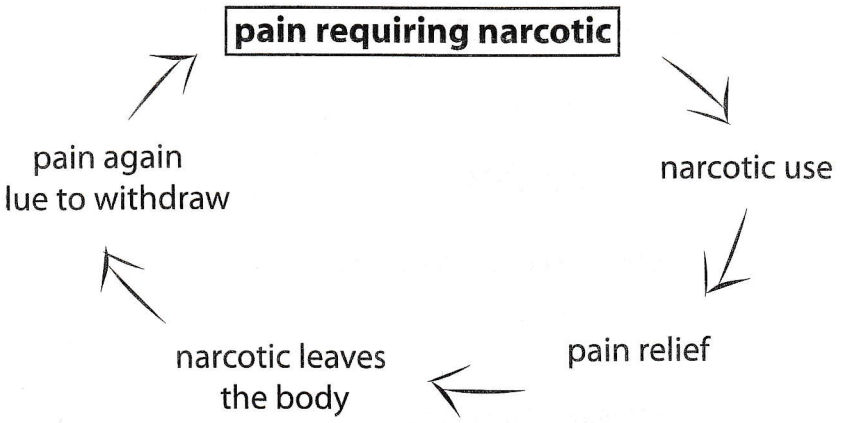
Q. *For prophylactic treatment of migraine, what dose do you find most effective when using Depakote?*

A. This is one of the most effective migraine preventative medications that we have available. However, it works 50% of the time to reduce headaches by 50%. Dosages are 500mg, 1000mg, and 1500mg. It may be given all HS or divided into doses. Drug levels are of no use at all. Dose to clinical efficacy. *(Note: Birth defects are common with the use of this drug, so insist on concurrent birth control use in female patients.)*

A Quick Note on Narcotics

by Randall Oliver, M.D.

Narcotics should only be used in migraine if all other options have been exhausted. Use of a narcotic more than twice a week leads to rebound headache. This means the patient will experience more headaches as a consequence of narcotic use. Once the rebound cycle has begun, it takes 12 weeks off of the medication for the seratonin in the brain to normalize and for a normal response to pain to return.



This condition is very hard to convince the patient of because they see the simple facts that he or she has pain and the narcotic takes the pain away. So avoid this condition and you and the patient will not have to struggle to get out of it. Stadol nasal spray is a particualarly potent offender for causing rebound headaches. Other common rebound medications include:

* Butalbital combination (eg: Fiorinal, Esgic)
* ASA
* Acetaminophen

PATIENT EDUCATION

Many patients will not believe that they are not having a sinus infection or sinus pain. They expect you to give them a prescription antibiotic, nasal spray, or antihistimine. They have taken the over-the-counter sinus medications and found only minimal to no relief. The patient truly feels the pain in their face or sinus area.

These patients who are experiencing frequent headaches need education to understand that these are actually migraines so they can be treated accordingly.

PAIN TERMS

Allodynia---Pain due to a stimulus that does not normally provoke pain.

Migrainous---Does not fill all of the diagnostic criteria of migraine, but may still respond to migraine treatment.

Status migrainous---Persistent migraine that does not go away by itself.

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Indiana Pain Academy

Annual Membership Dues:
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Fax this form to Indiana Pain Academy at (812) 422-2421

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Analgesic Ladder:

Guidelines for Pain Control

By Randall Oliver, MD

From time to time the Indiana Pain Academy will try to set guidelines. As medicine and science, pain medicine in particular, is not an exact science, these guidelines are not deemed to be absolute. They are to assist the clinician practice better medicine and have a structure to work within. It is recognized, however, that individuality of treatment is the hallmark of good medical treatment.

The analgesic ladder *(figure 1)* forms the stepwise treatment of plan of chronic pain treatment. The steps show a progression from simple analgesics to more potent analgesics. The idea is to not start with opioids initially.

Neither must less potent analgesics be stopped at each level. Ultracet can be continued with a routine opioid on as breakthrough. Treatment of the comorbid chronic pain symptoms of depression, anxiety, insomnia, fatigue, and sexual dysfunction must be concurrent.

It is also suggested that short-acting opioids not be used for routine chronic pain treatment. They generally work only three to four hours and are therefore useful for breakthrough pain only. Routine, 24-hour use of opioids should be long-acting medications, such as MSContin, OxyContin, Duragesic, and Methadone. Short-acting opioids cause a roller coaster pain relief pattern *(figure 2)*.

This would be inadequate for blood pressure and diabetes mellitus control and is equally not medically appropriate for 24-hour pain control.

Adjunctive modalities and medications should be added at any level when appropriate. All opioids given routinely should be long-acting. Short-acting opioids should be used for short-term or temporary pain only. Long-acting opioids are more appropriate for long-acting pain *(figure 3)*.

Figure 1

Simple Analgesic
Acetaminophen / Aspirin

(Max dose 4000 mg/day)

↓

NSAIDS

(Max doses on page 5, see figure 4)

↓

Ultram (tramadol) or
Ultracet (tramadol/acetaminophen)

(Max dose 400 mg/day)

↓

Ultram or **Ultracet routinely**

with moderate strength opioid
for breakthrough pain

↓

Routine moderate strength opioid

↓

Routine high potency opioid

Figure 2

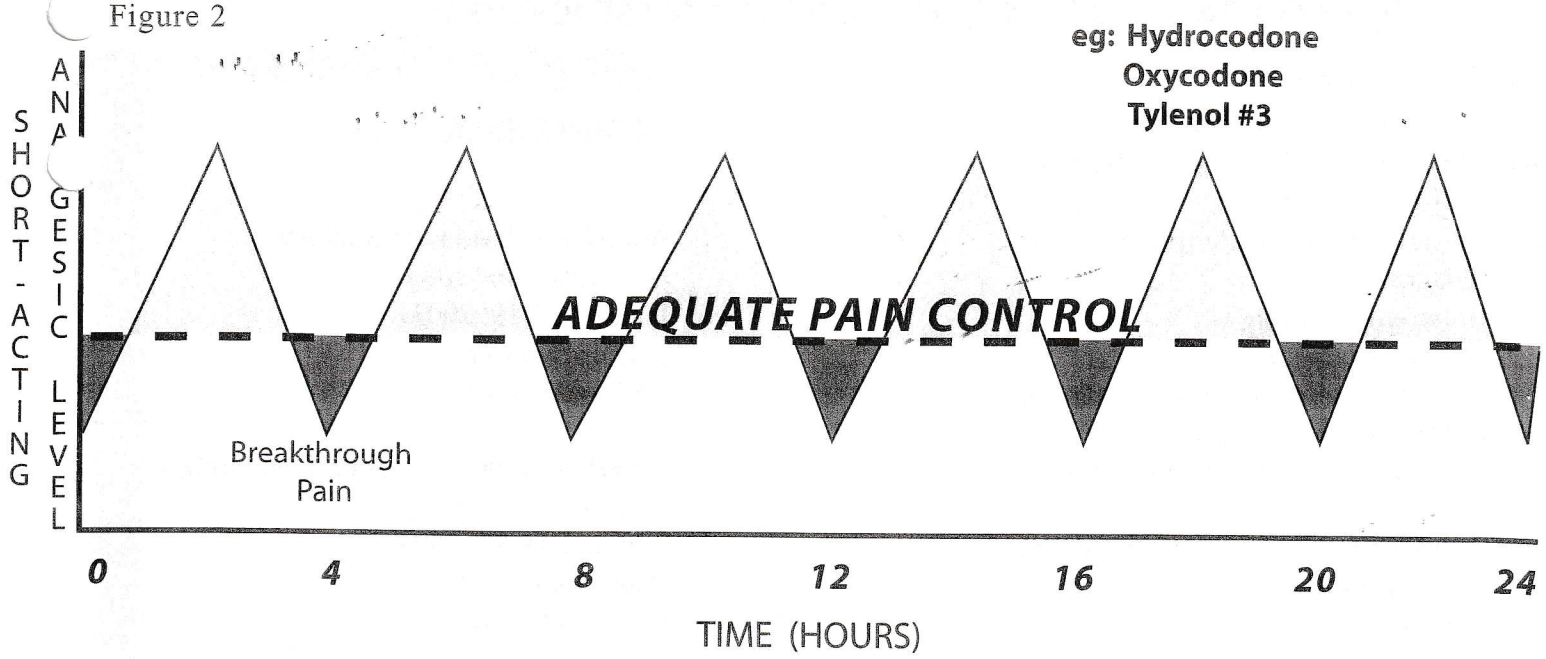
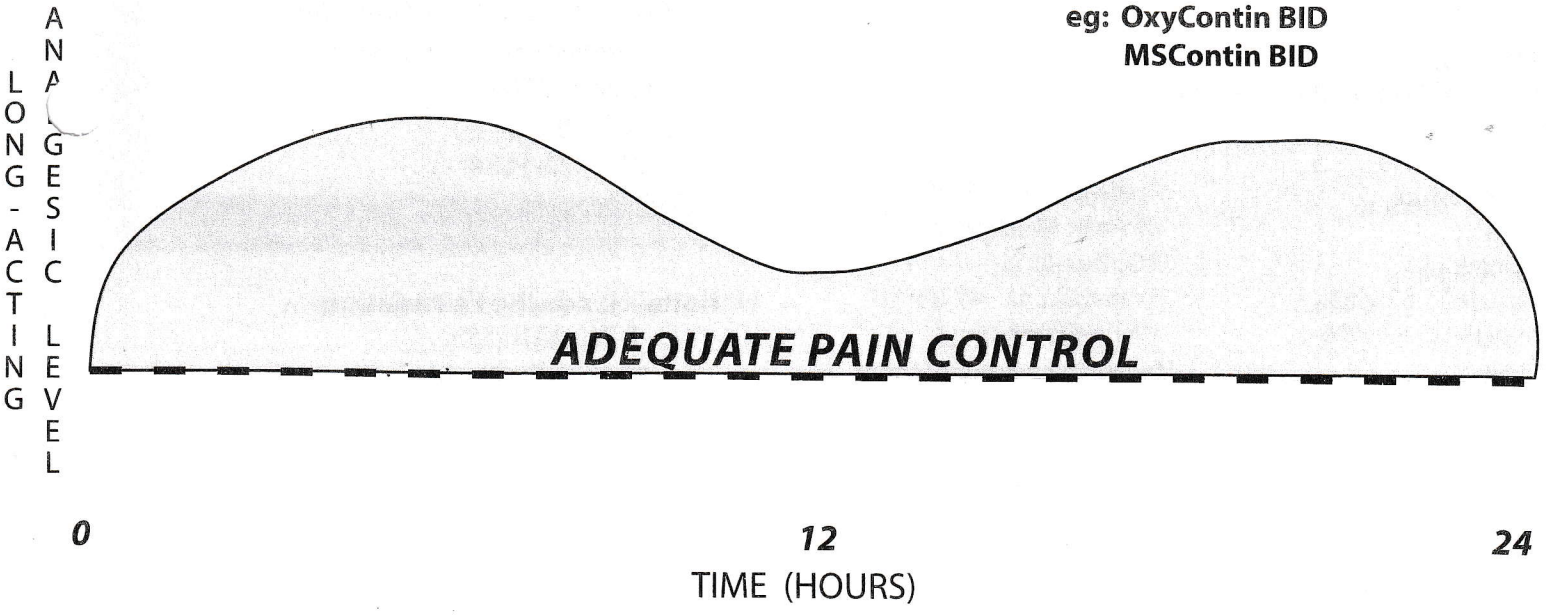


Figure 3



NSAID DOSAGE EQUIVALENTS

Ibuprofen	2400
Naprosyn	1000
Relafen	1000
Celebrex	200
Vioxx	50
Mobic	30

Figure 4

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International Headache Society Headache Classifications

1.1 Migraine without Aura

A. At least 5 headaches fulfilling criteria B-D
B. Headache lasts 4 to 72 hours (if untreated or unsuccessfully treated)
C. Headache has at least two of the following characteristics:
    1. Unilateral location
    2. Pulsating quality
    3. Moderate or severe intensity (inhibits or prohibits daily activities)
    4. Pain aggravated by routine physical activity
D. During headache, at least one of the following associated symptoms:
    1. Nausea and/or vomiting
    2. Photophobia and phonophobia

COMING EVENTS...

American Headache Society
Headache Now 2003
January 17-19, 2003
Cancun, Mexico
1-856-423-0043

American Academy of Pain Medicine
19th Annual Meeting
February 18-23, 2003
New Orleans, LA
1-847-357-4731

Indiana Pain Academy
Oliver Headache & Pain Clinic
7th Annual Pain Symposium
March 1, 2003
Evansville, IN
1-812-425-9824

RESOURCES:

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