

If you decide to use Chronic Opioid Therapy for Refractory Headache: Monitoring Adherence and Benefit©

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The benefits of chronic headache treatment are reflected by a patient's return to a more normal, less headache-focused life, rather than by an improvement in pain level. These can be assessed by measuring decreased use of the health care system (fewer emergency department visits, acute medical and psychiatric admissions, decreased physician office visits, decreased polypharmacy); return to productive activities (not just paid work), decreased pain-related depression, improved sleep and resumption of normal family and social relationships.

The decision to use long-acting or maintenance opioids must be made on an individual basis. Some patients with chronic headache will show improved function and decreased headache on these medications. In successful therapy, rapid dosage escalation and aberrant drug-related behaviors such as addiction are not problems. A subset of patients with chronic headache do poorly on maintenance opioids. They require frequent dosage escalations, may be noncompliant with therapy and demonstrate paradoxical worsening, rather than improvement, in function. Those patients should be withdrawn from opioid therapy and managed with other treatments. The John Graham Headache Center has found the following principles helpful in monitoring adherence and benefit with chronic opioid therapy:

1) Use a written agreement or “contract”

While not a contract in the legal sense of the word, a written document that outlines the conditions under which you will prescribe opioids or other controlled substances decreases the chance of misunderstanding. Many versions of such contracts exist. A sample is attached here.

We recommend that urine drug screens be obtained randomly, rather than on a scheduled basis. Drug screening can identify patients who are taking medications or substances other than those prescribed, but is also useful to identify those who are not taking what is prescribed. In this case, diversion of the drug can be suspected. In stable patients, these need be performed only once or twice a year.

2) Continued therapy should be contingent on improved function

Continuation of opioid therapy should in most cases be made contingent on improvement in a patient's ability to function. Headache relief alone is not the goal. Neither is complete pain relief. Rather, reduction of headache to a level that allows reasonable function is a more realistic goal.

Many patients believe that the presence of chronic headache means that they cannot or should not participate in occupational, social or academic activities. They may fear aggravation of their headache, or worry that overexertion can even cause permanent physical harm. In fact, participation in appropriate work, school and social activities is generally therapeutic for patients with chronic headache pain. In the majority, the benefits of social interaction, regular sleep-wake cycles and self-esteem that productive activities promote far exceed any drawbacks. In general, patients should be encouraged to remain as active as possible. Decisions to support disability status, withdrawal from school or the avoidance of social activities or hobbies should be very carefully considered. Although the intention –relieving the patient of an activity which may seem to aggravate headache – is laudable, very often discontinuation of such activities does not improve the headache and leads to further isolation, depression and reinforcement of the sick role.

3) Put opioid use in proper perspective and use other medications with caution

The use of medication in chronic headache is best viewed as one component of the patient's overall management plan. Medication alone is unlikely to be effective in dealing with the problem, and its importance should be placed in perspective.

Many medications that afford short-term relief of symptoms can cause longer term complications that interfere with successful treatment. Medications prescribed for sleep, muscle spasm or anxiety are often in this category. Their use over a prolonged period of time can cause sedation, poor concentration and emotional detachment that impede the patient's ability to function. Patients may also come to rely on the sedative or psychoactive effects of medications in an effort to modulate emotional as well as physical pain. In many cases, medications are no longer helping for their original indication, yet patients and physicians are reluctant to discontinue their use, fearing that "things may get worse" if they are stopped.

The concept of liberal use of short-acting pain medication at the earliest sign of headache which promotes function in patients with acute pain may paradoxically encourage medication overuse and dependence in headache patients. Frantic efforts to eliminate or pre-empt headaches with ever-escalating doses of potent narcotics and sedatives are doomed to failure. These medications often exacerbate depression, sleep disturbance and social isolation. Patients may become tolerant to the effects of the medication, using more and more in search of headache relief, or may come to associate the "high" they get with opioid or sedative drugs with headache relief. Over time, these patients learn to equate altered sensorium with pain relief. This may lead to difficulty when physicians attempt to introduce other strategies for the treatment of chronic headache; patients may be reluctant to turn to therapies they view as more cumbersome and less reliable than short-acting narcotics. The patient who has come to associate altered sensorium with pain relief may regard adjuvant drugs, disease-specific medications or long-acting opioids as less than optimally effective, since the altered sensorium they equate with pain relief does not accompany use. In this situation, patient insistence that only short-acting opioids are helpful results in what appears to physicians to be "drug-seeking" behavior.

3) Nonpharmacologic headache control techniques

Biofeedback, self-hypnosis and other relaxation strategies are useful adjuncts to other forms of treatment for chronic headache. They often reduce, though not eliminate, the use of pain medication and improve a patient's sense of control over headache. In general, they can be expected to serve as adjuncts to other headache control strategies. These strategies are most effective when used preemptively on a regular basis; they work less well once headache is established. Many of these techniques are taught by psychologists, who can be useful in identifying counterproductive and maladaptive behavior patterns as well. Patients often benefit from cognitive-behavioral therapy aimed at altering beliefs and ideas about headache and improving coping mechanisms.