Second Annual CME Meeting

Southern Headache Society

Challenges In Headache Medicine

Saturday, October 6th Handouts

Afternoon Concurrent Sessions

Fundamentals of Advanced Care

1:10 PM ***Advanced Care for Primary Headaches***
D. Michael Ready, MD

3:30 PM ***Tools of the Trade: Building a Better Headache Practice***
D. Michael Ready, MD

Tertiary Care for Primary Headaches

So You Want to be a Headache Specialist?

or

What have I learned that you might want to know

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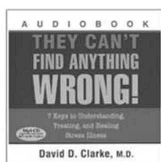
Disclosures

- Advisory board for Allergan & MAP
- Myers - Briggs ISTJ
- Family Physician
- Headache Clinic for 4 years
- UCNS Certified
- Just one blind man at the elephant

Objectives

- Understand Headache Epidemiology
- Recognize the pattern of Primary Headaches
- Understand the organization of a Headache Referral Center
- Learn what resources are available for patients and clinicians
- Make it worth your time

A couple of Pearls



They Can't Find Anything Wrong
If you only read one book this year
www.stressillness.com
It Will Change Your Practice

Mary Jo Rapini – Psychotherapist
www.maryjorapini.com

Outline

- Preamble on Pain
- Parameters
- Procedures
- Patients
- Bibliotherapy
- What its not – to tell you what to do but to suggest a way you may do it.

Care, Comfort, rarely Cure

- **Maybe if I share the path I walk then a little more of your pain will vanish.**
- **I want you to heal, whoever you are. I don't care what pain you've brought the world, I just want yours to subside.**
- **No matter what, your path is yours.**
- **Dont follow misery or worry.**
- **Devote every moment of your life to improving your dreams.**
- **Love your world. Cherish the good you do.**
- **Let go of hatred. Dream of love.**

What is Pain ?

Cartesian Pain Model

- Rene Decarte 1596-1650
- French Philosopher / Mathmatician
- *Cognito ergo sum*
- Mind / Body exist as separate
- Dominated medical thought for almost 400yr
- Henry K. Beecher, MD
- Wall/Melzack–Gate Control

Limbic Influences in Migraine

- All Pain has meaning
- The Sorrow that hath no vent in tears may make organs weep — Henry Maudsley
- (When) the mind is hurt the body cries out
  Italian Proverb
- The body remembers what the mind forgets
  – J.L. Moreno
- The pain of the mind is worse than the pain of the body" -- Publilius Syrus (Roman author, 1st century B.C.)

Not All Pain is Nociceptive

- San Francisco Spine study 1992
- Five childhood traumas: Loss of parent, Hx of Substance abuse, emotional neglect, physical abuse, sexual abuse
- No risk factors = 95% chance surgical cure
- 1-2 risk factors = 73% chance surgical cure
- 3 or more risk factors = 15% chance of a surgical cure
- Increased incidence of Chronic Daily HA in victims of Sexual Abuse.

Pain Schools

- "Painful as it may be, a significant emotional event can be the catalyst for choosing a direction that serves us-and those around us - more effectively. Look for the learning."

Louisa May Alcott

Osler's Razor

- It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has

Sir William Osler

Why?

Attitudes are more important than facts

Karl Menninger, M.D.

Evaluate & Treat as Appropriate

- What does that mean?
- I've given up!
- Eleanor Roosevelt to Harry Truman
- Restore quality of Life
- Prevent progression to disability

Case 1

- 61yo H ♂ TBI /c LOC >30y HAs 25/30 days
- Primarily L sided /c N/V, Allodynia, Neck Pain
- Sleep Non-restorative, Onset delayed 1 hour
- Often awakens with headaches
- No prior preventive meds. Uses APAP

Case 2

- 27yo C♀ ICU nurse. Onset @ 5y +FH
- Episodic to CDH over last 2 years
- 2 prior hospitalizations for headache no DHE
- Sleep non-restorative, Schedule erratic
- Awakens with HAs,
- N/V, Photophobia,
- Darvocet / Excedrin Migraine
- Recently started on Topirimate

What a Headache Specialist Does

Why we should feel good
about
what we do

The Road to Saperville

- 1st Stop -- Primary Care Physician
- 2nd Stop – Community Neurologist
- 3rd Stop – Headache Clinic
- MHPNI, Headache Care Center, Cleveland Clinic, Mayo, Baylor, etc

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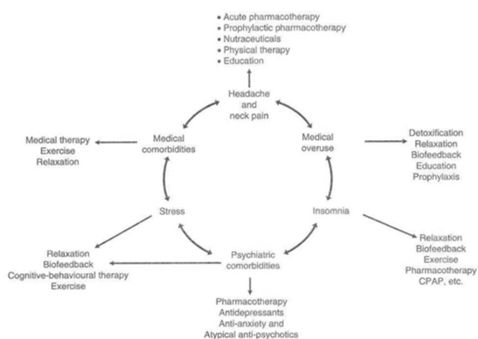
The Big Picture



What a Headache…

Patient Needs

- A Path to healing
- Foundation
- With that Foundation you build a plan
- Believe that what they do will make a difference
- Self Efficacy

Provider Needs

- Perfectly Honest, Perfectly Kind
- Recognize the Pain
- Validate the experience
- Colleagues
- Foundation

Headache Provider Challenges

- All of your patients are in pain
- Almost all of your patients are other clinician's failures
- We'll never be lonely
- We'll never be rich
- It's gonna leave a mark
- Develop a healing environment

My Office

Why Project a Vision of Healing?

The words we speak have a direct and definite effect upon your thoughts.

Dr Norman Vincent Peale

Starting place

- Collaborative Model
- Two experts in the room
- We need & deserve the best experts we can get
- What are the patient's expectations?
- What do you need to do?
- Silk Purse from a Sow's ear

What Does the Evidence Show? USPSTF Levels of Evidence

Level I: Evidence obtained from at least one properly designed randomized controlled trial .
Level II-1: Evidence obtained from well-designed controlled trials without randomization .
Level II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
Level II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled trials might also be regarded as this type of evidence.
Level III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

Evidence Based Medicine

Is this another religion?
What is the role of EBM?
How is EBM generated? Inclusion / Exclusion
What studies create the best evidence?
How does the "evidence" from a therapeutical trial apply to the individual patient

Caplan, LR. How well does EBM help neurologist care for individual patients? Reviews in Neurological Diseases 2007 (4)2: 75-84

Knowledge Parameters

- Absence of Proof isn't proof of abscence
- Believe, Know, Prove
- Altar of EBM
- Edmeads on EBM
- Those who practice by their clinical expertise alone are bound to repeat their own mistakes
- Those who practice EBM alone are bound to repeat the mistakes of others

Evidence-Based Medicine in the Real World

- Class 0: Things I believe
- Class 0a: Things I believe despite available data
- Class 1: Randomized Controlled trials that agree with what I believe
- Class 2: Other prospectively controlled clinical data
- Class 3: Expert opinion
- Class 4: Randomized controlled clinical trials that don't agree with what I believe
- Class 5: What you believe that I don't

Limits of EBM

(EBM's) main appeal is to health economists, policymakers and managers, to whom it appears useful for measuring performance and rationing resources — Singh & Ernst

Limits of EBM

"the practice of EBM means integrating individual clinical expertise with the best available external clinical evidence from systematic research"

David Sackett

What a Headache Specialist does

- Triage
- Intake
- Staging
- Expectation
- Education
- Coach
- CARE!

Triage

- Who do you need to see right away?
- Cluster (my personal)
- Chronic Migraine / Acute rescue
- School or Work absences
- Red Flags?
  - New HA in pt over 50 Years of age
  - Serious risk morbidity/mortality

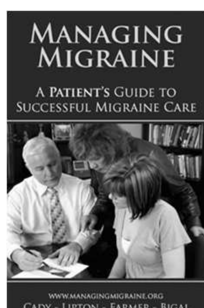
Intake

- Allows pt to tell their story
- Helps to determine the pattern
- Helps to identify the perpetuating factors
- Help identify pattern that leads to dx
- May have more than one type of headache

Staging Migraine

- Developed by Lipton, Cady, Farmer, & Bigal
- First doctor/patient book
- Based on frequency not severity of HA

www.managingmigraine.org



Stage1: Episodic Migraine

- Emphasis on acute abortive therapy
  - OTCs
  - Triptans
  - NSAIDs
- Early intervention – complete response
- Evaluation on mechanism of injury and pre-morbid biology of patient
- Education focused on resuming normal function
- Acute medication limits as headache progress
- Preventive pharmacology
- Behavioral interventions

Stage 2: Transforming Headache

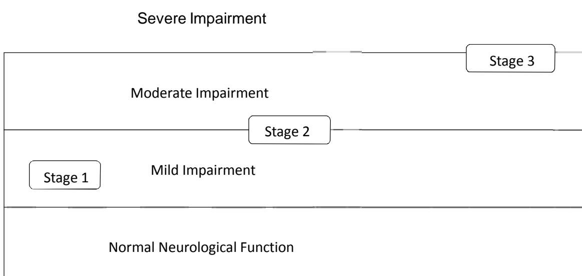
- Preventive pharmacology
- Targeted use of abortives
- Strong emphasis on behavioral intervention
- Screen and treat co-morbidities
- Perpetuating Factors > Precipitating Factors

Stage 3: Chronic Daily Headache

- Behavioral intervention -- absolutely essential
- Preventive pharmacology -- unavoidable
- Screen & aggressively treat co-morbidites
- Educate, educate, educate
- Establish reasonable goals and expectations
- Targeted use of abortive medications
- Emphasis of Quality of Life

Migraine Stages

Episodic **Chronic**



Cady RK, et al. *Headache*. 2004;44:426-435.

Expectations

- Patient
- No headaches
- Less often, less intense, responding better to your right now mediciation
- Provider
  - Diaries
  - Appointments
  - Phone Calls
  - Must engage your life

Education

- Headache Class
- Written material
- Web based resources
- Nurse instruction
  - Pathophysiology
  - Self care
  - Abortive & Rescue care

Coach / Cheerleader

- Have to believe you can get better
- Belief creates the actual fact
- Where are you, Where do you want to be?
- Who's been where you at and gotten to where you want to be?
- How'd they do that and what can I learn from them?
- How many people with a chronic condition get better by staying in bed?

Guide on the path to healing

- I'll do anything to lose weight….
- Are we ready to engage?
- They may not be ready.
- Never care how much you know…
- Guide through the 5 P's

Stop the Train

- Frame the condition – what are you trying to do?
- Precipitating (Triggers) vs. Perpetuating factors
- Perpetuating factors lower your threshold
- Lower the threshold, easier to have a headache
- Each Perpetuating factor as a locomotive engine

Preventing Progression

- Slowing the Perpetuating train
- Must Re Train – Unlearn what you have learned
- Avoid the provokers
- Strengthen the protectors

The Challenge of Disability

Acute Migraine

- Inseparable from the condition – 4.6 days a year on average
- 37% had 5 or more headache days a month.
- 53.7% reported severe impairment.
- 7.2% reported no attack related impairment.
- 25% account for 90% of total lost work time
- FMLA – What the law requires
- Provider certifes a “serious medical condition”
- Not required to use any specific form

Severe Migraine Is Ranked in the Highest Disability* Class by WHO

Disability Class	Severity Weights	Indicator Conditions
1	0.00-0.02	Vitiligo of face, weight for height less than 2 SDs
2	0.02-0.12	Watery diarrhea, severe sore throat, severe anemia
3	0.12-0.24	Radius fracture in a stiff cast, infertility, erectile dysfunction, rheumatoid arthritis, angina
4	0.24-0.36	Below-the-knee amputation, deafness
5	0.36-0.50	Rectovaginal fistula, mild mental retardation, Down syndrome
6	0.50-0.70	Unipolar major depression, blindness, paraplegia
7	**0.70-1.00**	**Active psychosis, dementia, severe migraine, quadriplegia**

*Assessments of disease severity determined by Global Burden of Disease researchers using the person trade-off method, which includes judgments about the trade-off between quality and quantity of life. Spectrum ranges from 0 (perfect health) to 1 (death).

WHO = World Health Organization.
Menken M. *Arch Neurol.* 2000;57:418-420.
Murray CJ, Lopez AD. *Lancet*. 1997;349:1347-1352.

The Challenge of Disability

Chronic Migraine

- You cant get better if your trying to prove you’re ill
- Disability once acquired tends to persist -- pts /c moderate pain at baseline, 80% were disabled at 1 year
- 92% pts /c moderate to high disability from HA remained disabled after 3 years
- Only 12% of initially non d/a pts became disabled over same time

Risk Factors for Disability

Correlates of current disability

- Strong: Pain >5/10, HA freq, depression
- Possible: Distress at pain, Worrying about pain, Low internal locus of control,
  Low self efficacy,
  Fear of pain

Predictor for later disability

- Strong: High use of acute meds, Current disability,
- Probable: Depression, Onset /c trauma, Increase HA freq, Low SEC, Obesity
- Possible: high life events stress, Sleep difficulty
- Depression, Stress Rxn to injury, Preinjury hx of HA, Neck pain & dizziness at 4 weeks post injury

Chronic Migraine Risk Factors

Modifiable

- Attack frequency
- Obesity
- Snoring/OSA
- Stressful life events
- Medication overuse
- Caffeine overuse

Not modifiable

- Age
- Female sex
- Low education or socioeconomic status
- Genetic factors
- Head injury

Ashina S, et al. *Curr Treat Options Neurol*. 2008;10:36-43.

Introduction to the Sensitive Brain

- Maintain the Brain to Prevent the Brain
- Patient education
- Sensitive Brain that doesn't like change
- Brain you're born with & environment your in
- Validation of the condition & experience
- Self Efficacy

A nod to Bob Kanicki

- Reality in terms others can understand
- Sports car brain
- Ferrari Brain
- High Performance, High Maintaince
- Maintain the Brain
- More time on the street, less in the shop

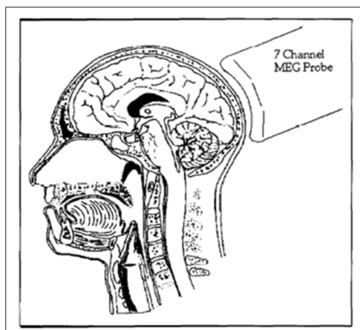
Patient Prefered Explanation

- You are genetically predisposed to migraine because of abnormal hyperexcitability of neurons in certain regions of the brain.
- We believe that this hyperexcitability is caused by in part mutations in channels on the surface of neurons that, when triggered, allow for the abnormal flow of sodium, calcium, and other brain chemicals in and out of the cell.

How did I get here?

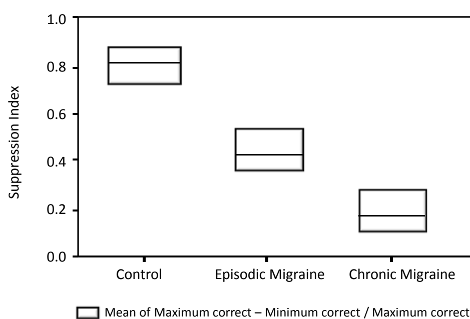
- Sensitive Brain. Doesn't like change
- World according to Goadsby
- Choose the wrong parents

Magnetoencephalography in Migraineurs



Aurora SK, et al. *Headache.* 2007;47:996-1003.

Sensory Retention in Migraineurs



Aurora SK, et al. *Headache.* 2007;47:996-1003

The Migraine Brain

- Genetic hyperexcitability:
  - Lower threshold for activation
  - Longer retention of sensory information
    - Between episodes of migraine
    - During episodes of migraine
- Hyper-vigilant 24/7
- A sensitive brain that doesn't like change
- Always more than a headache!

Provider Toolbox

- Patient Identification
- Measures
- HIT, MIDAS
- Headache Self Efficacey
- Headache Disability Index
- Headache Fear
- Pain Catastrophizing Scale

Headache providers Toolbox

- The Headaches
- Wolff's Headaches
- Headaches Simplified
- The Cleveland Clinic Headache
- The Jefferson Headache Manuel
- Headache Levin/Newman

Headache Treatments

- **Preventive** –reduce frequency, intensity, and improve response to acute meds
- **Abortive** – pain freedom in 2 hours
- **Rescue** – when the stop medicine didn't

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Saves You Money!

- 18-month comparison study
- Acute vs acute/preventive therapies
  - Office visits ↓ 51%
  - ED visits ↓ 82%
  - CT scans ↓ 75% MRI scans ↓ 88%
  - Medication costs ↓ $48 - $138/month/patient

Silberstein SD et al. *Headache*. 2003.

AAN Preventive Recommendations

Level A

- Divalproex Sodium
- Sodium valproate
- Topiramate
- Metoprolol
- Propranolol
- Timolol
- Frovatriptan (MRM)

Level B

- Amitriptyline
- Venlafaxine
- Atenolol
- Nadolol
- Naratriptan (MRM)
- Zolmitriptan(MRM)

Prevention polypharmacy

- β blockers plus TCAs for depression or insomnia
- β blockers plus SNRI for depression & fibromyalgia
- β blockers plus Topirimate in obesity
- β blockers plus valproate for bipolar disorder
- Topirimate plus antidepressants for bipolar or insomnia
- Topirimate plus pregabalin fibromyalgia in migraine
- Topirimate + SNRI + pregabalin in depression in fibromyalgia
- Valproate plus lithium or Lamotrogine in bipolar
- Tizanidine + amitriptyline

Prevention Pearls

- Pick the low hanging fruit
- Start with supplements www.puritan.com
- Pick a med that helps a perpetuating factor.
- Start low and go slow.
- Consider "Re – Challenging" you never step in the same river twice.

Migraine preventive therapy

Possible reasons for lack of efficacy

- Inadequate duration (<6-8 wk) at suboptimal dose
- Poor Pt adherence (side effects, half-life, unrealistic expectations)
- Concomitant drug-induced headache – Prevention unlikely to work in MOH
- Newly developed medical condition causing a secondary headache
- Failure to appreciate a migraine brain

Headache Treatments

- **Preventive** –reduce frequency, intensity and improve response to acute meds
- **Abortive** – pain freedom in 2 hours
- **Rescue** – when the stop medicine didn't

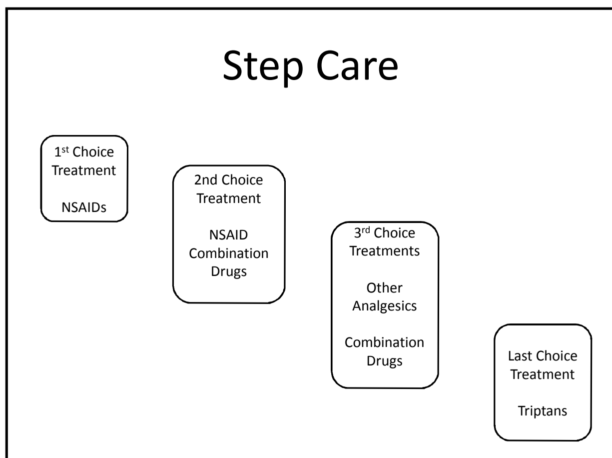
Abortive Therapy

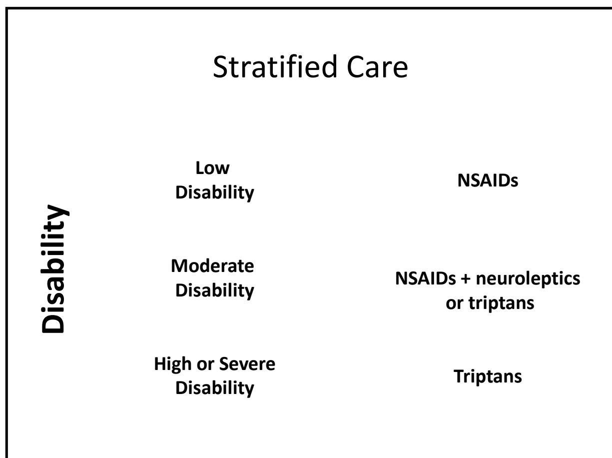
- Goal is pain freedom in 2 hours
- Treat at mild pain (prior to central sensitization)
- May use polypharmacy

Oral Therapies

- Non-triptan
  - NSAIDS
  - Combinations
    - APAP/ASA/caffeine
    - Analgesics
  - Antiemetics
- Triptans
- Ergotamines
- When to consider
  - First-line therapy
  - Adjunctive therapies

There is no medication that is perfect for all migraine attacks or all circumstances in which treatment is needed.





What I do

- Soooooo Off-Label & Remember my patients aren't yours
- 3 tablets Effervescent ASA + Mg 500mg or
- Ibuprofen 1000-1200mg + Mg
- Naproxen 500mg + Mg
- Augment /c Metoclopramide or Prochlorperazine
- Triptan – Suma & Nara generic. Generic Suma $3/pill www.healthwarehouse.com

Tertiary Care for Primary Headaches

So You Want to be a Headache Specialist?

or

What have I learned that you might want to know

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Round II

Headache Treatments

- **Preventive** –reduce frequency, intensity and improve response to acute meds
- **Abortive** – pain freedom in 2 hours
- **Rescue** – when the stop medicine didn't

Why should I treat Acute Headaches?

- Have to keep these people out of the ED
- Primary HAs are not an emergency
- Not the best place – too bright, too loud, often ignored
- Can't risk exposure to opiates
- More likely to V.O.M.I.T. in ED

Clinical Headache Rescue

- Assoc. Neurologist of S. CT AHS SA Poster
- Drop in HA Clinic – Prevent ED visits
- 9/05 - 8/07 500 pts
- Time to Present = 104 hours (8-240h)
- VAS pain: Entry 8.5 Discharge 1.5
- Txt: IVF (94%), Ketoralac (84%), Suma sq (78%), Prochlorperazine (52%), Metoclopromide (21%), DHE (8%), Mg (4%)
- Average charge $426 Average payment $272.64

Clinical Headache Rescue UAB experience

- 200 pts. Randomized Optimal Self Admin or Optimal Self Admin + Optional in-clinic Headache rescue

Optimal Self Adm		Clinic Rescue
		423 visits
		33.6K (**$80**)
73	ED Visits	**27**
147.9K(**$2027**)	ED Direct Cost	45.3K (**$1609**)
		79% no d/a > 24'

Clinical Headache Rescue UAB experience

- 89% very satisfied

Drug	#	Drug Cost
Droperidol 2.75mg	218	3.00
Diphenhydramine 50mg	201	1.25
DHE 1mg	167	42
Prochlorperazine 5-10mg	141	11.5
Promethazine 50mg	68	4.
Ketoralac 30mg	38	9 + 11 (saline)

Acute Headache Interventions

- IV >> IM >> PO
- Sumatriptan 6mg IM/SC
- Dihydroergotamine 1mg IM/SC/IV
- Ketorolac 30mg IV / 60mg IM
- Neuroleptics – Dopamine Antagonists (Droperidol, Metoclopramide, Prochlorperazine)
- Steroids
- Others – Mg^{++}, Valproic Acid, Diphenhydramine
- Procedures – Occipital Nerve Block, Lower Cervical Intramuscular Injections

DHE vs. Suma
Are you Ready 2 Rumble?

- DHE 1mg SQ vs sumatriptan 6mg SQ
  - At 2 hours could receive second dose of same medication
  - Two hour relief: 85% Suma Vs. 73% DHE ($p=0.002$)
  - 24 hour relief: 77% Suma Vs. 90%DHE ($p=0.004$)

DHE Pearls

- Patients want it for rescue
- May mix with lidocaine to reduce injection site pain
- When given IV, need ot use the highest sub-nauseating dose
- May be infused over 8 – 24 hours

Ketorolac

- Dose: 30mg IV or 60mg IM
- Cautions/ Contra-indications:
  - Typical Non-steroidal risk
- What to expect:
  - IM shots cause localized burning pain

Dopamine antagonists

- Prochlorperazine (Compazine): 10mg IV SIVP
- Metoclopramide (Reglan): 10mg IV SIVP
- Droperidol: 2.75mg IM, 2.5mg IV
  - Black box warning for QT prolongation
- Haloperidol (Haldol) Drug of choice in many countries
  - 5 mg IV following 500 - 1000cc bolus of normal saline
- Olanzapene 2.5-10mg po or im prn q 6- 8 hours

Wang,SJ. Silberstein SD Young WB Droperidol Treatment in Status Migrainosis and Refractory Headache.Headache1997

Silberstein SD,Young WB, Acute Migraine Treatment with Droperidol. Neurology Vol60 number2 2003.

Honkaniemi,J. Headache 2006,May:46(5)781-7

QT issues & Phenothiazines

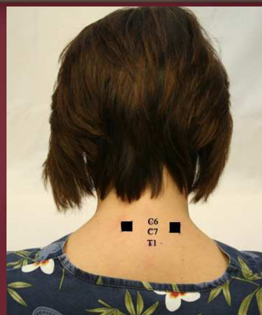
- Screen patients for risk factors
- Pretreatment ECG
- Follow-up ECG
- Usually only an issues with long-term repetitive dosing
- Inconsistent warnings from the FDA

Rescue Polypharmacy

Procedures

- Lower Cervical Intramuscular Injections
- Occipital Nerve Block
- Sphenopalentine Ganglion Block

Lower Cervical Intramuscular Injections



- Headache 10/06
- 417 ED Pts / 1 yr
- 65% relief in 15m
- Repeat injection brought additional relief
- Worsened HA in 1%

Lower Cervical Intramuscular Injections

- 3mL bupivicane 0.5%
- 25g 1.5" / 27g 1.25"
- 2-3cm lateral to the spinous processes between C6 & C7
- AE /CI
- Vasovagal, Neck stiffness, usual injection risks

Occipital Nerve Block

- Local anesthetic (bupivicaine).5% xylocaine 1% --Duration of anesthesia doesn't correlate to duration of relief
- Steroid (triamcinolone 40mg/mL) evidence doesn't support general use
- 3mL total per side
- 25 or 27 gauge needle
- May place as a "ridge" of anesthesia, "trigger points", or fixed.

Occipital Nerve Block

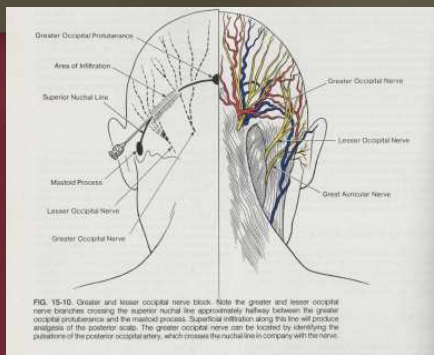


FIG. 15-10. Greater and lesser occipital nerve block. Note the greater and lesser occipital nerve branches crossing the superior nuchal line approximately halfway between the greater occipital protuberance and the mastoid process. Superficial infiltration along this line will produce analgesia of the posterior scalp. The greater occipital nerve can be located by identifying the pulsations of the posterior occipital artery, which crosses the nuchal line in company with the nerve.

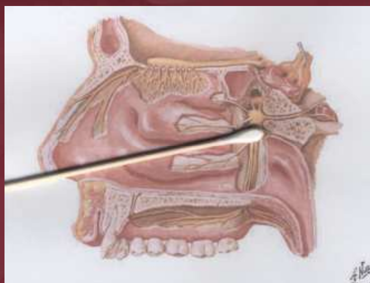
Occipital Nerve Block

- AEs & CIs
- Prior hx of craniotomy over injection site
- AEs primarily related to steroid- fat atrophy, alopecia, pigment change
- Vagal response – Happened to me X 3 in over 6000 blocks

Occipital Nerve Block

Sphenopalentine Ganglion Block

- Over 100 years old
- Fell into disfavor
- Reemerged in '80s
- Patients may self administer
- Lidocaine
- May use cannula



Sphenopalentine Ganglion Block

Our Patients Speak

Case 1 - 61yo H♂ /c hx TBI

- Initial placed on Magnesium, Tizanidine
- Placed B ONB
- ↓ Freq 3/7 days, + Memantine (NMDA receptor blocker)
- @ 1 yr HAs 1/7 days mild
- Severe HAs 1/60 days responds to ONB

Case 2 – 27yo C♀ ICU Nurse

- Dexamethasone 4mg BID X 7d
- Magnesium, CoQ10, Tizanidine, B ONB
- Metoclopramide to augment acute meds.
- No improvement placed on DHE for 10d
- Ketorolac 60mg IM rescue
- F/U HAs ↓ 3/7 days started Topirimate
- HAs reduced to 1/7 days /c severe 1-2/30d
- Titrated off Topirimate after 9m of stability

Behavioral Interventions

- Biofeedback
- Thermal Biofeedback
- Relaxation Response
- Heart Rate Variability

No Narcotics for Headaches

- Major risk factor for Medication Overuse HA
- Once established it's a self fulfilling prophesy
- Jakubowsk,et al. 2005 Wolfe Award paper
- 64%-71% Migraine pts pain-free 1' /p ketoralac iv
- Only factor that predicted ketorolac failure: hx of opioid txt in the non-responders
- Rewires the brain to perpetuate the HA state by inhibiting the breakdown of glutamate

Dealing with Difficult Headaches & the people who have them

- Chronic Migraine
- Medication Overuse Headache
- New Daily Persistent Headache
- Addiction
- Post Traumatic Stress D/O
- Amor de lejos

MANAGING DIFFICULT PATIENTS

Observations from Saperville

- Most people get better
- For those who don't get better it is often because the cost of getting better is greater than the cost of staying sick.

What kind of Person

- Fear
- Past medical experience
- It's all in your head
- You're going to have to learn to live with it
- Angry
- Addicted
- Non-adherant
- Somatizing
- Dysfunctional

The Readiness is All!

There is a tide in affairs of man
which taken at the flood
leads onto fortune.
Omitted, all the voyages of their life
is bound in the shallows and the miseries
William Shakespeare

How to Make a Difficult Patient

- Comorbid Psychiatric Problems
- Past or Present Substance Abuse
- Past Experiences /c Pain or disease
  - -- What does the pain mean?
  - --Abuse / Death
- Stress

Techniques for Managing Difficult Patients

- Start with Clear Expectations
- Communicate Office Policies Clearly
- Use Treatment Plans When Necessary
- Document Behavior
- Establish limits

Techniques To Manage Difficult Patients

- Convey empathy
- Avoid defensiveness -- Bless your heart.
- Side-step arguments -- Don't get in the mud with a pig.
- Reinforce the Positive
- Manage Countertransference

Difficult Patients - Key Points

- Behavior problems can result from comorbid psych or substance abuse issues, previous traumatic experiences /c pain, stress, or personality conflicts
- Identify challenging patients early.

Difficult Patients - Key Points

- Learn techniques that will help manage difficult patients success fully.
- Simple behavior management skills are easily learned &very effective.
- Seek help /c difficult patients & situations. Know when to obtain consultation,

Engage!

- Act as if it makes a difference – It does!

Engage

- Need to Maximize Active Coping
- Set functional limits, regardless of pain
- Henry Ford
- The purpose of pain – if not to warn of present damage it is to distract from the past.
- Live in denial of disability not discomfort
- Pain behavior reinforce the pain

Best Pain Quote Ever

- Many of us spend our whole lives running from feeling with the mistaken belief that you cannot bear the pain.
- But you have already borne the pain.
- What you have not done is feel all you are beyond the pain.

Saint Bartholomew

Getting off the road to Saperville

- Must be an active participant
- Must see the way
- Loose the Fear
- Pay yourself 1st

It Will Hurt

- It will take time.
- It will require dedication.
- It will require willpower.
- You will need to make healthy decisions.
- It will require sacrifice.
- You will need to push your body to the max.
- There will be temptation to quit to slow down.
- But, I promise you, when
- You reach your goal,
- It's **worth it!**

Expectations

- There will be pain
- Focus on what's important – Prevention!
- Learning to Live (Well/Better) with the Pain
- Have to use Behavioral interventions
- Start in the beginning
- Improves outcomes
- Self taught / Coach

Understand Pain

- Wall Melzack Gate Control Theory
- Opens the gate
- Closes the gate
- Later adapted to the idea of a matrix

Understanding Pain

- Separate signal from suffering
- Humans can tolerate a lot of pain
- Everything smells good to a dog – pain is just one input
- Migraine like a child throwing a tantrum
- Sense / Nonsense

Increasing Self Efficacy

- The little engine that could
- The stronger the perceived self efficacy to withstand pain, the longer the subjects tolerated the mounting pain stimulation
- Effective cognitive coping is associated opioid release

Bandura A, O'Leary A J Pers Soc Psychol 1987; 53(3):563-571

It's all in your head

- Being comfortable with being uncomfortable
- Need positive self talk
  - In the face of challenge
  - Motivate, use coping instructions
  - Self reinforcement – Acknowledge what you've done
- Identify, label distorted thought
  - OMG! STSU! Its never going to get better!
  - Its gonna kill me!
  - Feeling are not facts
- Apply logic – challenge distortions
- Rate Negative beliefs – how certain am I ?

William James

- The "As if" principle
- Acceptance of what has come…
- The greatest discovery of my generation is the knowledge that human beings by changing the inner attitudes of their minds, can transform the outer aspects of their lives.

Challenge Your Patients

- Performance rises to the level of expectations!
- Where Are You?
- Where Do You Want To Be?
- Who's been where you're at & gotten to where you want to be

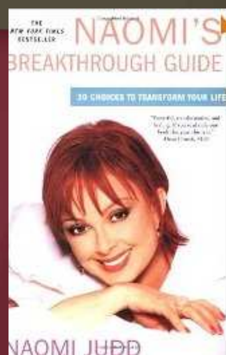
Bibliotherapy

- Motivate the individual or individuals with introductory activities
- Provide time for reading the material
- Allow incubation time
- Provide follow-up discussion time, using questions that will lead persons from literal recall of information through interpretation, application, analysis, synthesis, and evaluation of that information
- Conduct evaluation & direct the individual--involves self evaluation & evaluation by the practitioner

Why do I Gotta?

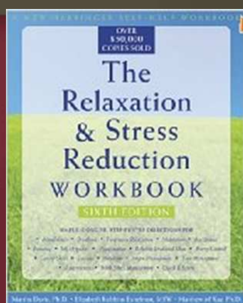
- All difficulties are easy
  when they are known
  William Shakespeare
- The man who is prepared, has half his
  battle fought
  Miguel de Cervantes

Books You Should Know



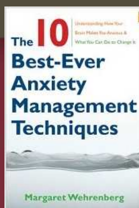
- Keynote at AAPM in 2008
- Focus on healing
- Becoming a detective
- Child is the father of the man
- More important to know what kind of person has the disease
- If choices you made got you here, other choices can get you out
- Self Efficacy defined

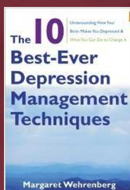
Books You Should Know



- Relaxation & Stress Reduction Workbook
- Martha Davis, Ph.D
- ****1/2 - 95 reviews
- Also available in Children's version
- Stock this book in your exam rooms instead of People

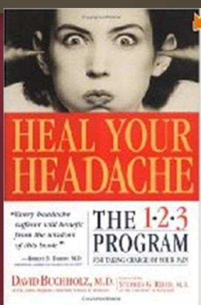
Books You Should Know





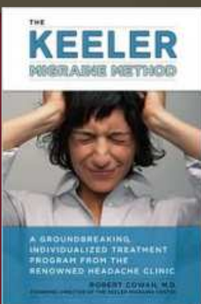
- 10 Best Ever ___ Management Techniques
- Anxiety ****1/2 - 26
- Depression ****1/2 – 8 reviews
- Anxiety also available as Workbook

Books You Should Know



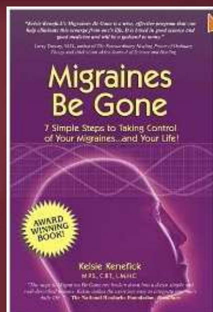
- Heal Your Headaches
- David Buchholz, MD
- A how – to book for managing your Migraine Brain
- ****1/2 - 333 reviews

Books You Should Know



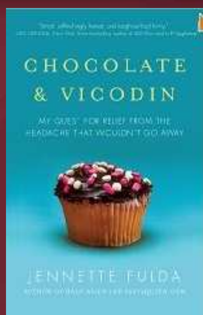
- The Keeler Migraine Method Robert Cowan, MD
- Nov 2008
- ****1/2 (10 reviews)

Books You Should Know



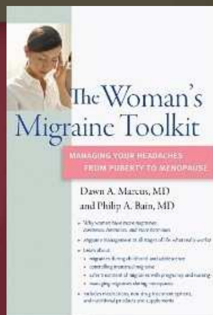
- Migraines Be Gone
- ***** --28 reviews
- Personalized Biofeedback
- Author Sponsored Website

Books You Should Know



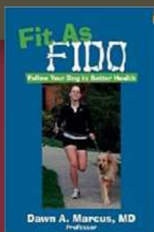
- Chocolate & Vicodin
- Pt. Memoir NDPH
- Best description of the relentlessness of daily headache
- May be painful for docs

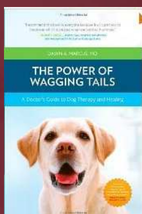
Books You Should Know



- The Woman's Migraine Toolkit
- Dawn Marcus, MD
- Disclosure
- The Best
- ****1/2 – 9 reviews

Books You Should Know



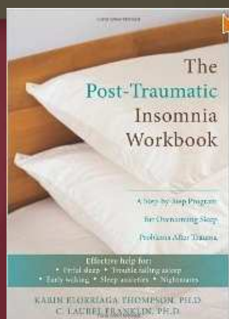


- Fit as Fido
- ****1/2 – 5 reviews
- The Power of Wagging Tails
- ***** 12 reviews
- If they won't do it for themselves then maybe they'll do it for their dog

Books You Should Know

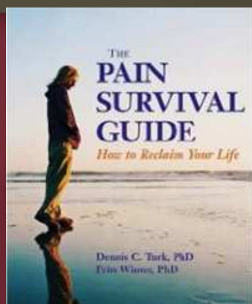
- Quiet Your Mind & Get to Sleep
- **** - 6 reviews
- Collen Camey Ph.D

Books You Should Know



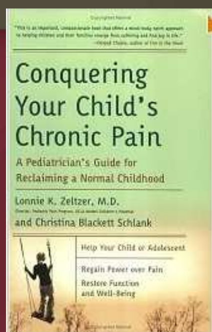
- The Post Traumatic Insomnia Workbook
- ***** - 2 reviews
- Karin Thompson Ph.D.

Books You Should Know



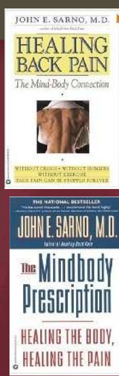
- The Pain Survival Guide
- Dennis Turk, Ph.D
- **** – 21 reviews

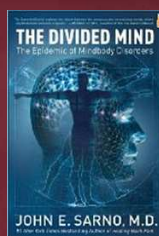
Books You Should Know



- Conquering Your Child's Chronic Pain ***** 10 reviews
- Lonnie Zeltzer, MD

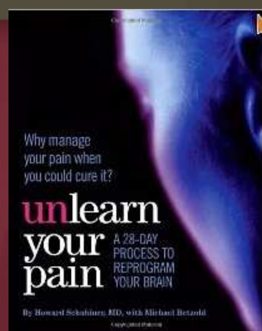
Books You Should Know





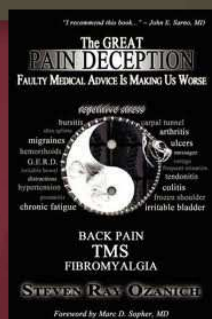
- **John Sarno, MD**
- Mind Over Back Pain
- **** -- 68 reviews
- Healing Back Pain
- ****1/2 519 reviews
- The Mindbody Rx
- ****1/2 – 178 reviews
- The Divided Mind
- ****1/2 – 70 reviews

Opps I forgot this one



- Unlearn Your Pain
- A "how to" book on how to become more comfortable with being uncomfortable
- ****** 45 reviews

An Incredible Patient Book

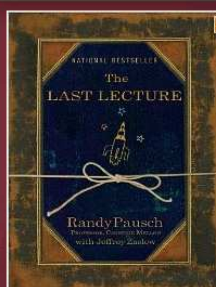


- The Great Pain Deception
- www.paindeception.com
- Patient of Sarno
- Connects the dots on MindBody syndrome

***** 22 reviews

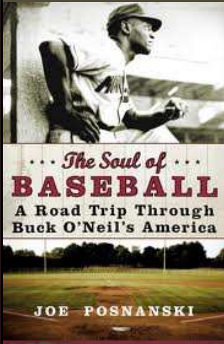
21/22 reviews 5 stars

Book You & Your Patients should read



- The Last Lecture ****1/2 -- 1167 reviews
- Achieving Your Childhood Dreams
- Brick Walls
- Don't know how not to have fun
- Also available on video

Who is Buck O'Neil?



- 1st Baseman KC Monarchs
- Manager & Scout for years
- Founded Negro League Museum
- Spearheaded admission of 17 Negro League player to Cooperstown
- Never had a bad day
- Never let himself think ill of another person

Need the Ups

Pain is deeper than all knowledge,
Laughter is higher than all pain.

Elbert Hubbard

The World According to Buck

or

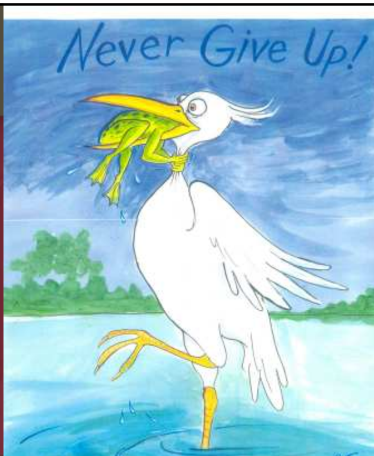
t

Our Role as Healers

- Stress related complaints – Especially in chronic illness
- Use care with a mechanical (acute) model
- Limbic Augmented Pain
- The sorrow that hath no vent in tears ...
- Disease from Distress
- Excuse from their lives
- Acknowledge Limits "I can't fix this"

Closing

- Godfather Principle –
- Leave the gun, get the Cannoli
- Business not Personal --It the patient's dz
- Why are Psychological Issues different from medical? Its all in your head!
- 15 Minute Hour – Best they know how.
- Hamlet -- Treat every man as he deserves
- Humility – Don't ever think…
- MD – Stands for "Massive Denial"



World According to Yoda
Keeping an Open Mind

- Premature Conclusions
- So certain are you …
- The Role of Education
- Mind what you have learned, save you it can!
- Self Efficacy/Positive Thinking
- Luke: I don't believe it!
- Yoda: That is why you failed

Classical Thought on Pain

If you are distressed by anything external, the pain is not due to the thing itself but to your own estimate of it;

(A)nd this you have the power to revoke at any moment.

Marcus Aurelius

Contemporary Thought on Pain

Pain is temporary. It may last a minute, or an hour, or a day, or a year, but eventually it will subside and something else will take its place. If I quit, however, it lasts forever.

Lance Armstrong

Future Thoughts on Pain

- Pain is a thing of the mind. The mind can be controlled.

Spock (Leonard Nimoy), "Operation-Annihilate!" stardate 3287.2

All Things Are Ready, If Our Minds Be So!

William Shakespeare

Identifying the Pattern

- Tease out the patterns
- Are there more than one?
- What would superimpossed HA look like?
- CM / NDPH
- Cluster / Episodic Migraine
- Episodic Migraine / IIH
- HC / MOH

The Wisdom of the Body

- CNS nociceptive pathway is the Migraine pathway
- Limited number of pain sensitive structures within the skull
  - Vasculature
  - Sinuses
  - Cranial nerves
  - High cervical nerves
- Blood or sterile inflammation may be perceived through the same nociceptive pathways
- Interrupting this pathway (with triptan, anti-emetic, NSAID) may improve pain, regardless of the cause