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# Alfred Health GP News

## Welcome to the February edition of Alfred Health GP news.

Contact us for any queries on
9076 2620, or email us at gp.liaison@alfred.org.au

In light of the recent codeine rescheduling, this month we have a special focus on **codeine dependent headache.** This includes details of a new clinic at The Alfred for patients with codeine-dependent headaches needing prompt specialist review, and some helpful tips on managing your patients from Alfred Neurologist Dr Elspeth Hutton.

### The Alfred Urgent Codeine-dependent Headache Clinic

An Urgent Codeine-dependent Headache Clinic has been established at The Alfred, commencing on 21st February 2018. The clinic will be held on Wednesday afternoons in the Alfred Outpatient clinics, 2nd floor Phillip Block. The clinic will be staffed by neurology consultants Dr Elspeth Hutton and Dr Trudy Cheng.

The clinic caters for patients affected by the changes in codeine rescheduling whose headaches are difficult to manage and would benefit from urgent specialist input. Please include any imaging results, recent blood results and a list of previously trialled medication (both preventative and acute), as well as the patient's current medication list with the referral. Please fax referrals addressed to either Dr Hutton or Cheng to The Alfred Specialist Consulting Clinics fax 9076 6938.

### Managing the patient with headaches using OTC codeine

Many patients rely on over the counter medications to manage headache, without seeking medical advice. An Irish study[1] of patients presenting to their pharmacy for headache management found that codeine was the preferred analgesic (43%), although triptans were the most effective, and 53% had never been diagnosed by their GP. Thirty to fifty percent had episodic migraine and 11% chronic daily headache. Chronic migraine affects 1-2% of the population, with an annual rate of transformation from the episodic form of 2.5%[2]. Opiate use for episodic migraine is one of the greatest risks (44% increased risk) for transformation to the chronic form[2].

Medication overuse headache is a significant problem in headache management. The main drivers of its development are the use of opiate analgesics, triptans or ergots on more than 10 days per month. People with comorbid depression, anxiety and poor sleep are more susceptible to developing medication overuse, and these issues should always be explored and appropriately managed in patients with headache. Around 30% of patients will have a significant reduction in headache severity and frequency if the only change made in their management is the cessation of codeine use.

The harms associated with long-term codeine use extend beyond the risk of medication overuse headache and transformation to chronic migraine. These are well documented, and include:

- Accidental overdose and death, particularly with polypharmacy or other drug use
- Worsening overall pain, development of body pain and opiate-induced hyperalgesia
- Immune suppression
- Depression and anxiety
- Decreased sexual function and disruption of the menstrual cycle

***Tips for managing your codeine-dependent headache patient:***

The first step is reassurance that there are many more effective and better tolerated ways of managing their chronic headache that do not carry the same risks as codeine use. It is important that the patient does not feel that they are being persecuted or blamed for their codeine dependence. It is also important that they understand that it is not the best long-term option for them, and is probably actually making their headaches worse. Explaining that the headaches they get as the dose wears off which prompts them to take another dose is not actually a sign of how well the medication is working, but rather a sign of withdrawal headache emerging can be helpful. It is also helpful to give patients a timeline. Codeine withdrawal will ultimately help their headache control, but they need to get through the withdrawal period first, which can last around 3 weeks. During this time, they may have some transient worsening of headache, as well as other symptoms like anxiety, cold sweats, diarrhoea and nausea, depending on the degree of their dependence.

***Patient self-care for headache management:***

In all patients with frequent or chronic headache, lifestyle measures to manage headache should be reinforced. These include:

- An adequate quantity of good quality sleep, with regular hours of sleep. If patients have problems with sleep initiation, consider a trial of melatonin 2 mg 1 hour before bed for 4 -6 weeks to reset sleep cycle in conjunction with the practice of good sleep hygiene.
- Eat regular meals, low in simple sugars and refined carbohydrates. Don't skip meals.
- Drink plenty of water to stay well-hydrated. 1.5 – 2 litres per day is a good amount for most people unless they require fluid restriction for medical reasons.
- Regular exercise. Walking, swimming and cycling are all good options for people with headaches. Running and aerobics (anything that involves jumping / thumping) can aggravate headache and may be better avoided.
- Limit caffeine to a maximum of 2 cups per day. Avoid after 3 pm if problems with sleep.

- Avoid known headache triggers. Common food triggers for migraine include chocolate, strong cheeses, MSG, citrus, preserved meats and alcohol.
- Good workplace ergonomics, particularly for computer users. Use regular 'mini-breaks' every 45 min to stand, stretch and rest the eyes for a few minutes.
- Regular use of a relaxation technique to help manage stress is also helpful. This might include meditation, yoga, progressive muscle relaxation, breathing techniques, or a guided relaxation using a phone app.

***Supporting withdrawal:***

It is generally best to give the patient a **written plan to gradually wean** off their opiate over 7-10 days (depending on the daily morphine equivalent).

- A suitable plan for someone taking 2 Panadeine four times a day might be: reduce the dose to one tablet four times a day for 3 days, then one tablet three times a day for three days, then one tablet twice a day for 3 days, then one daily for 3 days then cease.
- Another option is to reduce the dose to two tablets twice a day, and then restrict the number of days it can be taken: e.g. 5 times a week for one week, then 3 times a week for one week, then twice a week for one week then cease

If the patient is finding (or likely to find) it difficult to do this, using a **bridging strategy** can help. Options for bridging therapy include:

- 2-3 weeks of SR Naprosyn 750 – 1000mg daily; or
- 2 weeks of prednisolone: 1 mg / kg (max 60 mg) for 3 days, then 50 mg for 3 days, then 37.5 mg for 3 days, then 25 mg for 3 days, then 12.g mg for 3 days, then cease; or
- Unilateral or bilateral greater occipital nerve block.

These medications should be discontinued after the withdrawal period is successfully navigated. Appropriate prophylaxis for gastric ulcers and monitoring blood sugars must also be considered.

***At the same time as reducing codeine, it is important to start a preventative medication, if appropriate:***

In any patient experiencing more than 3-4 days per month of headache, a preventative should be considered. In order to choose an appropriate preventative medication, the underlying headache phenotype must be determined. To do this it is necessary to take a headache history going back to when the headaches first started, and phenotypic features are often clouded by medication overuse. This may mean going back to the teens or even childhood. More detailed information on headache diagnosis and how to select a preventative is available in the most recent edition of the Neurology Therapeutic Guidelines.

***Key features of common primary headache types & suitable preventatives:***

***1. Migraine:***

- Moderate to severe headache lasting 4-72 hours with associated nausea / vomiting, photophobia, phonophobia, osmophobia, motion sensitivity.
- Bilateral or unilateral, can alternate sides
- Often described as pulsing or pounding.
- Affects ability to undertake normal daily activities
- May have preceding aura lasting 15-30 min (visual > sensory > motor)

- Often positive family history
- May have known triggers: alcohol, foods (chocolate, strong cheese, MSG, citrus, preserved meats), dehydration, sleep deprivation / excess, hot / stormy weather, menstrual period, stress / relaxing from stress etc.
- Perimenstrual headaches, travel sickness and easy hangovers are often clues.

Some suitable preventatives for migraine: Consider amitriptyline (start with 10 & build up to 50mg at night), propranolol (start with 10-20 mg and build up to 40-80 mg bd), topiramate (start with 25 mg and build up to 50-100 mg bd), sandomigran (start with 0.5 mg and build up to 1.5mg at night), verapamil SR (start with 90mg and build up to 240mg daily), candesartan (start with 4-8mg and build up to 24-32mg daily). There are many more preventative available. If a patient is not responding to / tolerating a reasonable dose in 8-12 weeks, consider changing to another agent, or referral to a neurologist for further advice.

Suitable acute treatment options for migraine:

Soluble aspirin 900-1000mg OR ibuprofen 400-600 mg – MAX 15 days per month
Tripans – to be used on no more than 10 days per month

***2. Tension-type headache:***

- Mild-moderate headache, lacking associated features
- Lasts 30 min to 7 days
- Often described as pressure or tightness – 'band-like'
- Often does not impair ability to undertake normal daily activities

Some suitable preventatives for frequent tension-type headache: Consider amitriptyline (start with 10 & build up to 50mg at night), mirtazapine (start with 15 mg and increase to 30 mg as tolerated) or venlafaxine MR (start with 75mg and increase to 150 mg as tolerated)

Suitable acute treatment options for tension-type headache:

Soluble aspirin 600-900mg OR ibuprofen 400 mg OR naproxen 500-750 mg OR paracetamol 1g – MAX 15 days per month.

***3. Trigeminal Autonomic Cephalgia (e.g. Cluster headache, Hemicrania continua, paroxysmal hemicranias):***

- A group of rare headache disorders that if suspected, should prompt specialist referral to a Neurologist for diagnosis and management.
- All are characterised by a strictly one-sided headache with associated (typically ipsilateral) autonomic features, such as tearing, conjunctival injection, ptosis, rhinorrhoea, tinnitus, unilateral facial flushing or sweating.
- Cluster headache is one of the most severe pains described, and should be referred urgently so optimal management can be initiated. If the patient is experiencing frequent episodes, consider starting verapamil 40-80 mg tds while awaiting specialist review. Acute attacks may respond to subcut sumatriptan, rizatriptan wafer or nasal sumatriptan. High flow oxygen, 100% at 12-15 L/min by non-rebreather mask can also abort an acute attack.

1. O'SULLIVAN, E.M., SWEENEY, B. MITTEN, E. & RYAN, C. 2016. Headache management in community pharmacies. *Irish Medical Journal,* 109(3): 373
2. LIPTON, R.B. 2015. Risk factors for and management of medication-overuse headache. *Continuum*, 21(4), 1118-1131.

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## Asthma and allergy course

The Allergy unit at The Alfred warmly invite you to join us for an educational symposium in allergy, to be held on **Saturday 17th March, 2018** from 8.30am to 4pm at the AMREP Education Centre, Alfred Hospital, Melbourne

The cost is $150 (early bird) for registration by 25th January 2018, $180 after 25th January 2018.

Topics will include aero-allergy, thunderstorm asthma, drug allergy, food allergy, paediatric allergy, anaphylaxis & venom allergy, allergic skin conditions, occupational & environmental allergy.

The RACGP has accredited the course for 40 category one points. To qualify for the points, participants must complete the predisposing and reinforcing activities and the feedback form, as well as attending the symposium. Details of these will be sent upon registration.

Registration is at the Try Booking website. If the link doesn't work, please copy and paste this address into your browser: https://www.trybooking.com/SCPG

## GPs are invited to attend Grand Rounds at The Alfred

The Alfred Hospital Grand Round is the premier weekly event on campus where physicians, surgeons, radiologists, pathologists, anaesthetists, researchers, Alfred Health registrars and other trainees enjoy a convivial and educational atmosphere with a broad cross-section of their colleagues. GPs are warmly invited to attend.

The Alfred Grand Rounds are held **each Thursday in the AMREP seminar room, from 12.30 – 1.30pm.** Lunch is provided from 12pm. Each session begins with a 5-minute clinical vignette for discussion, followed by the main presentation of 45 minutes' duration, with time for questions.

The program includes speakers from most disciplines, including medicine, surgery, anaesthesia, trauma and the on-site research institutes.

Upcoming Grand Rounds are:

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| Thursday, 22nd February | ***Wait a minute, haven't we fixed this already?* Reducing the Risk in Naso-Gastric Tube Management**<br>Presented by A/Prof Bill Johnson & Dr Rob Feiler |
| Thursday 1st March | End of Life Working Group |
| Thursday 8th March | Cardiothoracic Surgery & Transplantation |
| Thursday 15th March | Rheumatology |

**Please note, the scheduled topics for the Grand Rounds may change.**

For further information or to receive details of each week's Grand Round by email, please contact Priyanka Chahal on 9903 0198, or email P.Chahal@alfred.org.au.

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**GP Liaison Service at Alfred Health – we're here to help!**

Our GP Liaison team – Dr Josie Samers and Tracey O'Connell – are here to assist you in navigating Alfred Health. Whether it's a missing discharge summary, assistance with getting an outpatient appointment or suggestions on how we can do things better, we are here to help. Our office is attended on Mondays, Tuesdays and Fridays; phone 9076 2620 or email us gp.liaison@alfred.org.au. We welcome your suggestions and feedback.

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