SCOTTSDALE, ARIZ. ---- Withdrawing patients from overused headache medications needs strong physician support. Dr. Todd D. Rozen told clinicians at a symposium sponsored by the American Headache Society.

Dr. Rozen, a neurologist at the Michigan Head-Pain and Neurological Institute in Ann Arbor, Mich., said chronic daily headache patients must understand at the outset that the brain has to be reset and takes time to heal after long time overuse of medication. Eventually they may have fewer headaches, he said, but they will not be headache-free after withdrawal.

Quickly discontinue the overused medication, because tapering it does not work, Dr. Rozen advised.

Meanwhile, prepare the patient to deal with pain, he advised. “You have to have a treatment strategy for mild pain, moderate pain, [and] severe pain.” Mild pain is the hardest to treat because the strategy is to pursue alternative therapies such as hydration, relaxation techniques, biofeedback, and aerobic exercise, but not medication.

For moderate pain, Dr. Rozen suggested indomethacin or naproxen sodium with or without a dopamine receptor antagonist. Start at 3-4 days per week, tapering down to 2 days per week. If the patient has nausea, add an antiemetic.

For severe pain, rescue therapy should be limited to two times per week. “It is helpful if patients are sedated. They have had this headache all day long. It helps if they sleep well.”

Outpatient therapy usually works for patients who have overused triptans, but some need inpatient therapy. Triptan withdrawal is relatively fast and some patients can simply stop their medications, he explained. But triptan withdrawal also can mimic opioid withdrawal with associated nausea, diarrhea, and abdominal pain. Inpatients can be switched to intravenous DHE (dihydroergotamine mesylate) and outpatients can be given Migral NS. A steroid taper is another option, but a longer-acting triptan is rarely the best option.

When weaning patients from butalbital, the first step is to determine their butalbital level, Dr. Rozen continued. If it is above 10mcg/mL, the patient is at risk of withdrawal seizures and needs to be weaned off the drug as an inpatient.

For patients with very low butalbital levels, he suggested outpatient care and prevention of withdrawal symptoms with clonazepam. Don’t try to taper patients from butalbital, he said; they are using it to treat anxiety and will not stop. Phenobarbital is another option, he added, but be prepared to vary the dose.

Patients abusing opioids almost always have to be hospitalized, according to Dr. Rozen. At first, short acting Oxy IR can be substituted for several days or use buprenorphine. These can be augmented with fluids to wash out the opioid, clonazepam as needed for anxiety, clonidine transdermal patches, auricular acupuncture for nausea, and encouragement.