

Headache Toolbox

Opioid Therapy for Migraine

Opioids are naturally occurring or synthesized derivatives of opium commonly known as “narcotics.” **Short-acting opioids** often are used for the acute treatment of migraine headache, which is moderate to severe in intensity. Orally self-administered opioids that are commonly prescribed include codeine (typically prescribed with acetaminophen, eg, **Tylenol #3**), hydrocodone (typically prescribed with acetaminophen, eg, **Lortab, Vicodin**), meperidine (either alone, eg, **Demerol**, or with promethazine, eg, **Mepergan**), and oxycodone (either alone, eg, **Oxy IR**, or with aspirin, eg, **Percodan** or with acetaminophen, eg, **Percocet**). More potent short-acting opioids include hydromorphone (**Dilaudid**) and morphine.

Self-administered short-acting opioids also are available in an intranasal formulation (butyrophe- none: **Stadol**) and a “lollipop” (hydromorphone: **Actiq**). Intranasal Stadol is notoriously addictive, and patients who are naïve to opioid therapy typically experience bothersome side effects with its use (even including hallucinations and delusional thinking).

All of the short-acting opioids have the potential for promoting physical dependence, psychological addiction, or both. These drugs are meant for intermittent or short-term use, and along with the dependence/addiction potential, extended use tends to lead rapidly to tolerance (ie, higher and higher doses of the opioid are required to produce an ever diminishing clinical response).

Do not be fooled! No one is immune to the addictive potential of the short-acting opioids. These drugs are to be used with caution and extreme discretion. . .if at all. Patients should receive prescriptions for opioid medication from 1 physician source only, and the pre-

scriptions provided should specify precisely how long the quantity of the drug dispensed is intended to last; it is the patient’s responsibility to take the opioid as prescribed and make the quantity prescribed last for the duration specified. Requests for early refills rarely should be met with a positive response.

When using a short-acting opioid to treat acute migraine headache, one should administer the medication (in the dose prescribed) as soon as the headache reaches a moderate to severe level of intensity; delay in administration may result in a suboptimal therapeutic response, with the headaches only reduced (but not eliminated) and destined to worsen again within a short period of time. . .necessitating yet another dose of medication and thus increasing the potential for dependence, addiction, and tolerance. All of the opioids may cause nausea or pruritus (“itching”); these are *side effects*, not allergic reactions. On the other hand, if pruritus is accompanied by a rash or edema (swelling) involving the lips, tongue or throat, the patient should assume that he/she is indeed allergic to that particular medication. All of the short-acting opioids may produce sedation and should not be taken in conjunction with alcohol or other sedative drugs. One should be very cautious about driving, operating heavy machinery, working at heights, or engaging in other potentially dangerous activity after taking an opioid.

Overuse of short-acting opioids also may lead to worsening of a migraine patient’s primary headache disorder; patients with chronic migraine in particular are at risk for aggravating their disorder through overuse, drifting gradually from increasingly frequent headache attacks to a state wherein they suffer daily or

even constant head discomfort. To avoid medication overuse headache—as well as dependence, addiction, and tolerance—patients should restrict their use of short-acting opioids to a maximum of 2 days per week. In addition, there is accumulating evidence that even relatively low-level use of the opioids may render patients less responsive to other types of migraine medication and, most ominously,

promote a more unfavorable outcome in the long term.

In summary, this class of medications can be extremely useful in treating acute pain, but the short-acting opioids typically are not appropriate for chronic, long-term use. They are indeed a “double-edged sword,” and their use must be closely monitored by physician and patient alike.