

Judy had something really important going for her. She had insight. She didn't tell me that she had a pain problem, not a drug problem. She knew in her heart that she had both, and she knew that she was never going to get well until she came off painkillers. Her commitment to see an addictionologist was an act of great courage. She had been through withdrawal once, and it had been a bitter experience. She was fearful of doing it again, but it had to be. She was admitted to the hospital and after a tearful, despondent first day, she achieved, under the sponsorship of Subutex, an uncomplicated withdrawal from her opiates.

Recovery from opiate addiction (or pseudoaddiction) is, we would like to think, a miraculous event, and it is. But the notion that with recovery from addiction the person will live happily ever after is naïve, and we have already seen examples of that. Judy's three years of opiate use had, in a very real sense, rewired her brain and altered the infrastructure. It takes a while, sometimes a long while, to rewire that organ back into wellness.

Judy did get better off the opiates. Her constant, unrelenting headache (transformed migraine) went away. She could play with her children again and, she told me, she awoke each morning hopeful for the new day. She had even taken a canoe trip with a church group, an activity unthinkable but a few weeks before. Unfortunately, however, her migraines began occurring with ever-greater frequency, and there were more emergency room visits for opiate injections. I didn't really expect her migraines to go away when we stopped the opiates. I did believe, however, that freed of opiates she would respond to one of the many splendid drugs we have for the prevention of migraine. I tried several of them again, (she had been on most of them before), but they simply didn't work. I had failed my patient, and I had no recourse but as an act of mercy to resume the Actiq lollipops, which had indeed been effective pain relievers. Maybe, at the least, I could keep her out of the emergency room. I had to tell her, and it broke my heart, that I had nothing more to offer. I suggested referral to a colleague at the university.

I was hopeful that the new neurologist, younger and more attuned to contemporary technology than I, would suggest placement of a vagus nerve stimulator. Experimental and dramatic therapy to be sure, but it

just might have worked. It was not to be. He prescribed an anticonvulsant that Judy had taken before and told her it would be a long while before it started working. He also told her that if she had a severe migraine, she could come to the clinic for the administration of intravenous Depakote, a sometimes dramatically effective treatment for the acute migraine. Judy complied, and after a two-hour, head-splitting automobile trip, she was admitted to the hospital and given Depakote intravenously. It did not work at all.

I hate failure worse than God hates sin. I have written that when I fail, I usually know why, but I don't know why I failed with Judy. She had so many things going for her—a devoted husband, healthy children, and parental support. She had an education, and she had skills. Her depression and her transformed migraine had been lifted by withdrawal from opiates (at least most of them), but her migraine attacks have defied virtually every known form of pharmacy for that disease.

She is ever in my mind—and my heart. I keep in touch with her by periodic e-mail.

Her response to the most recent:

*Dr. Cochran:*

*Thanks so much for contacting me. Things are a little different for me these days. I spent ten days at the Atlanta Headache Clinic, where I saw Dr. Harold Richardson. My headaches continue on a daily basis, but I am semi-functional, and I think I am heading in the right direction. His first step was to get me off narcotics . . . again! It went much easier this time than the last. He had a pic line in me and treated me with all kinds of concoctions. He used a "triple shot" to treat acute headaches—it is a combo of Ativan, Haldol, and Cogentin. It works at least 75 percent of the time—though I have to use it more often than I'd like. I'm also on Methergine for a few days, which is supposed to break the bad cycle I am in now. The biggest change is that I am on Nardil as a preventative. It hasn't had time to do much, but again, I am hopeful.*

*I will let you know how things progress. I will return to Atlanta in December, so we will see how it goes. I miss coming to see you, and it means the world that I am still in your thoughts.*

*Take care,  
Judy*

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Both Cindy and Judy were told by their physicians that they had analgesic rebound headache. The fact that they were told this by the same physicians who prescribed the analgesics in the first place is, in the most favorable term I could use, ironic.

In my opinion, analgesic rebound headache is really not a disease. It is merely an expression of a very common effect of pharmacy. It is kindred to hundreds, if not thousands, of other rebound phenomena, and analgesic rebound headache does not deserve the importance it is given by identifying it as a disease. Nevertheless, this is what has happened, and the story of how it has happened, at least as I perceive it, is a sad one indeed.

Sure, people will rebound from analgesics. That is to say, symptoms reappear (often worsened) when the duration of the drug's activity ends. This will certainly happen with opiate analgesics (and disciples of the rebound headache school believe the same thing will happen with Tylenol, aspirin, and non-steroidals). It matters not, however, whether the analgesics are given for headache, or for painful neuritis, or for lumbar disc disease, or for irritable bowels, or whatever. Rebound pain will occur in all. There is no need to dignify the rebounding headache as something special, different, and unique from all of the others.

The rebound phenomenon occurs throughout all of pharmacy. If a person with hypertension does not take his medication at the appropriate time intervals, the blood pressure will rebound and rise, sometimes astronomically high. If the diabetic does not take her insulin in a timely manner, the blood sugar will rebound—again often quite high. People with depression rebound when they miss a few days of their antidepressant, and people with anxiety rebound when therapy is not taken

appropriately. If the epileptic stops the anticonvulsant therapy that controls his seizures, he will, I assure you, rebound. There are many other examples—almost countless examples—but I think you see my point. The symptom or disease for which a drug is successfully administered will reappear if that drug is not taken appropriately and in a timely manner, sometimes extravagantly so.

Cindy got well, at least for a while, without stopping her Hydrocodone. I never gave any serious thought to terminating her analgesic therapy (her use of it was modest and appropriate, and it did give her some relief). I did feel that it was necessary to bring Judy off her analgesics. She had to be detoxed not because she had analgesic rebound, but because her use of opiates was dangerous and perhaps even life-threatening. Moreover, removal from the (usually) depressant opiates would correct that disease and free her from the transformed migraine that accompanied it. Lastly, there was the hope that off opiates, one of the many drugs we use for the prevention of migraine would work; but sadly, it was not to be.

Now let me present you with a very common clinical scenario. The drug Imitrex was the first of the triptans for the treatment of migraine. Drugs of more recent derivation have in some measure supplanted it for one reason. Many migraineurs report

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that although Imitrex will relieve the migraine, the pain often returns after a matter of some four to six hours. This is recognized by all as a rebound effect, comparable, we would certainly surmise, to an analgesic rebound phenomenon. Now, would the physician tell his patient that if she simply stopped using the Imitrex, the migraines, for which it was given in the first place, would go away? No, of course not. But that is exactly what was told to Cindy and Judy. The disease for which the drug was given would go away if they simply quit using the drug that controlled their disease. Would we tell the hypertensive that his high blood pressure would go away if he stopped using drugs to control it? Or

the diabetic his insulin? Or the arthritic his cortisone? I have never, in my entire career, seen a patient with headache get well simply by withdrawing from opiates—or Tylenol, aspirin, or non-steroidals. And I do see a lot of them getting well by the application of appropriate drug therapy for their chronic pain even while they are still on painkillers.

Cindy's and Judy's physicians (including me) were, and I can assure you of this, highly frustrated by their inability to get their patient well. As the office visits continue and the sense of failure pervades, the stress imposed on the physician by repeated failure becomes intolerable. The doctor, a human being like the rest of us, employs a defense mechanism. He exercises transference. He transfers his responsibility, his guilt, and his blame away from himself where it belongs, onto the patient. "If you will just quit taking those pain pills, your headache will go away." By this mechanism, the patient is forced to assume responsibility for recovery from her disease. It is not the doctor's problem anymore.

It hurts to write this, but I must. The analgesic rebound headache is well known to all neurologists. Indeed, it is probably the most common diagnosis in all neurology. Why, then, did it take Cindy's neurologist three years and Judy's six months to make the diagnosis and to initiate treatment? Do you not see it? Cindy and Judy did not have analgesic rebound headache until their physicians could think of no other form of treatment. Sadly, it is only when all else has failed that analgesic rebound raises its ugly head. Analgesic rebound headache is not a derivation of science. It is a derivation of physician frustration.

I have written harsh words, but I believe them to be true.