

# HEADLINES

**A PUBLICATION OF THE EAST BAY HEADACHE SUPPORT GROUP**  
A member of the American Council for Headache Education (ACHE) support group network

**VOLUME 14, ISSUE 2**  
**MAY 2009**

## **May 5th Meeting:**

### **Managing the Misery of Insomnia ... Sleep Disorders and Headache**

Sleep is essential for every person's health and wellbeing, but headache sufferers know that pain has a negative impact on sleep. On May 5th we're pleased to have Dr. Alan Brast talk about sleep disorders and give us some tips on how to improve our quality and quantity of sleep, even while living with our headache conditions. Bring your questions!

Alan Brast was an Air Force Medical Specialist, and then received his Ph.D. in Human Relations and Counseling, and is board certified in Suicidology. He is also a Licensed Medical / Clinical Hypnoanalyst with extensive expertise in Anxiety, Phobia Disorders and Psycho-Trauma. He has served on Contra Costa County's Trauma Team as a counselor, and is a university professor. Dr. Brast is currently affiliated with John Muir Medical Center where he is the facilitator for the Leukemia / Lymphoma / Multiple Myeloma group as well as the HIV / AIDS, Breast Cancer Couples and Grief and Loss Groups. He also is a popular speaker for the Health Educational Offerings provided by John Muir Medical Health.

We will meet in the Hanson Room, downstairs at John Muir Medical Center—Walnut Creek Campus, **Tuesday evening, May 5, from 7:30 to 9:00 p.m.** Call Carol at 925-229-5550 for more information.



**NATIONAL HEADACHE AWARENESS WEEK**

**JUNE 7 - 13, 2009**



The goals of **National Headache Awareness Week**, sponsored by the National Headache Foundation, are:

- To gain recognition of head pain as a real and legitimate condition.
- To encourage sufferers to see a physician for proper diagnosis and treatment.
- To let sufferers know there are new treatments available.

Contact the National Headache Foundation at 888-NHF-5552 or <http://www.headaches.org> for more information. On their Web site soon they'll list the lecture and special education programs scheduled to be held all around the country during the week of June 7-13.

## **Future Meetings:**

**September 15:** To be determined

**November 17:** To be determined

To recommend a speaker or suggest a topic, contact Leslie at [davisgold@gmail.com](mailto:davisgold@gmail.com), or Carol at 925-229-5550.

# Using Sleep to Manage Headaches May Cause Insomnia

And that may lead to more headaches, new study suggests

Feb. 16, 2009—*Healthday News*  
By Tate Gunnerson

Headache sufferers often treat their pain by taking naps to sleep it off, but they run the risk of developing insomnia by disrupting their normal sleep patterns and perpetuating the cycle of headaches, a new study shows.

“Going to sleep was one of the main things people tried to treat their headaches, and they rated it a very effective treatment,” said study author Jason C. Ong, an assistant professor of behavioral sciences at Rush University Medical Center in Chicago. “It could be that people are taking naps or using sleep as a way to try to cope with pain, but that could actually lead to more sleep disturbance at night.”



The Rush researchers recruited 65 women from undergraduate psychology courses at a university in the southeastern United States, 32 of whom suffered from tension-type headaches (TTH), while the other 33 women experienced minimal pain and were placed in the control group. Fifty-eight percent of the headache sufferers said that sleep problems triggered their headaches, while only

18 percent of the control group said that was the case. Eighty-one percent of the headache sufferers also reported using sleep to manage their pain, a coping mechanism they rated as the most effective self-treatment.

“The most important aspect of the study suggests that a very common coping strategy for TTH—going to sleep or taking naps—may interfere with the normal physiological drive to sleep, thus causing insomnia which is a trigger for TTH,” said Dr. Frederick de la Vega, a neurologist at Scripps Memorial Hospital in La Jolla, Calif. “It’s a catch-22,” said Ong. “Going to bed might help relieve your pain, but when you try to go to sleep at night, what happens then?”

Further studies are needed to determine if insomnia actually causes headaches (or vice versa) or whether the two are simply related, Ong said. The study was published in the February 15, 2009 issue of the *Journal of Clinical Sleep Medicine*.

Developing more effective pain-management strategies may be the best way to disrupt this headache-insomnia cycle, the researchers said. Unfortunately, different types of headaches may call for different treatments, and it’s often difficult to determine the best approach. “The treatment for migraines is somewhat different than TTH,” said de la Vega. “The question is whether better management during wake-hours, so as to avoid just taking a nap, could prevent the disruption of the physiology of sleep at night, and that answer is uncertain but makes intuitive sense.”

Ong said: “Doing some kind of relaxation technique is one way to cope with pain, so that might be one thing to attempt. Are there existing interventions that might be helpful for people who have both insomnia and headaches or do we have to come up with something else?”

The experts agreed that people who suffer from headaches or insomnia should see a doctor to discuss the best individual treatment. “The main thing is that if people have headaches and also sleep difficulties, they should communicate that information to their health-care provider,” said Ong. “Migraine sufferers should see their primary doctor or preferably a neurologist,” added de la Vega.

“Appropriate prophylactic and quenching medications should be tried, food/activity triggers should be avoided, and if insomnia is a trigger, an assessment of sleep hygiene may be helpful.”

Found on the Internet at [http://www.nlm.nih.gov/medlineplus/news/fullstory\\_80514.html](http://www.nlm.nih.gov/medlineplus/news/fullstory_80514.html)

## New RX for Migraine

It’s been 17 years since there’s been a major new drug for migraines. Now one is up for FDA approval, and specialists are calling it a breakthrough. Research indicates **telcagepant** is about as effective as the widely used drugs known as triptans. But unlike those drugs, it doesn’t cause side effects like chest discomfort or throat tightness. More important, because triptans constrict blood vessels, they can be dangerous for people with cardiovascular disease or high blood pressure. Telcagepant doesn’t affect vessels and may be an option for patients with both headaches and heart woes.

Found in the May 2009 issue of *Reader’s Digest*.

The intention of the East Bay Headache Support Group is to provide information and resources. It does not provide medical advice, which should be obtained directly from a physician.

## Migraine Variants in Children

There are several disorders that have close ties to migraine, although they fool us because they do not always appear to be much like the migraine headache as we know it. These are called migraine variants and they often occur in children. When migraine variants occur, they may be confused with other health conditions, and it is not uncommon for several different other health conditions to be considered while searching for the correct diagnosis. The three most-common variants are:

- Abdominal Migraine
- Benign Paroxysmal Vertigo
- Cyclic Vomiting Syndrome

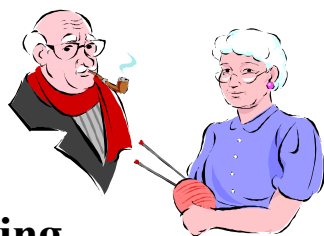
**Abdominal Migraine** is often associated with stomach pain instead of head pain. The pain is often diffuse across the abdomen and can be crampy, dull or sharp in nature that can last between 1-72 hours if untreated or treated unsuccessfully. The pain may be midline in location, moderate or severe in intensity, surrounding the bellybutton, and not clearly localized. Pain can be severe enough to interfere with normal daily activities. There may be loss of appetite, nausea, and/or vomiting associated, loss of pallor, photophobia or phonophobia. Children may find it difficult to distinguish anorexia from nausea. The history and physical examination will not show signs of gastrointestinal or renal disease. Some children will have headache as well as abdominal pain. Most children with abdominal migraine will eventually develop migraine headache later in life.

**Benign Paroxysmal Vertigo** occurs usually in toddlers or young children. The child will suddenly become unsteady or off-balance and refuses to walk. They may appear pale or sick and are usually irritable or fussy. They often want to be held and when placed down to walk, they will either

refuse or be very wobbly on their feet, walking with feet spread wide apart, as if they were drunk. Benign paroxysmal vertigo is often associated with nystagmus or vomiting; unilateral throbbing headache may occur in some attacks. The attack lasts from a few minutes to hours and often resolves with sleep. Between attacks, the child is perfectly normal. Since the attacks are usually brief and infrequent, often no treatment is needed. These children will have a normal electroencephalogram.

**Cyclic Vomiting Syndrome** also occurs in school-age children. This condition consists of episodes of vomiting. There may be associated abdominal pain, headache, photophobia or phonophobia. The vomiting is usually quite forceful and frequent and occurs 4-5 times each hour for at least 1 hour. These episodes may last from 1 hour or up to 5 days. Often, attacks occur in a pattern so families can predict when an attack may occur. Attacks may begin in the early morning hours and may be severe enough to cause dehydration. Attacks can be severe enough to require emergency room visits for rehydration and if frequent enough, migraine preventive medications may be used to decrease the frequency and severity of attacks. History and physical examination do not show signs of gastrointestinal disease.

Found on the Web site of the American Council for Headache Education:  
<http://www.achenet.org/education/patientsMigraineVariantsinChildren.asp>



## Aging and Migraines

By Li Ming Wong

Aging is a fact of life. Getting older means increasing frailty and susceptibility to illness, but it can also be a

boon to migraineurs. Only 2-10% of the elderly population experiences migraines (as opposed to up to 28% of adults under 65), and elderly women are still more likely to have them than their male counterparts.

Migraines can happen at any age, but they peak around age 40, and then frequency of attacks decrease for most people. Many migraineurs who have suffered with this condition for years experience a reduction in the frequency and severity of attacks after age 55.

About two thirds of migraineurs stop having attacks altogether by age 65. Patients over 65 who still have migraines report drastically decreased severity, duration, and frequency in their attacks. They are also less likely to experience the gastrointestinal upset that accompanies migraine in younger people.

The downside to all this good news is that adults over 65 who suffer from migraines are more likely than younger patients to experience disability because of their affliction. Many physicians are uncomfortable with treating senior citizens for migraines because therapeutic methods used on younger people are often not tested for safety in an older patient. Additional conditions and the medications used to treat them complicate the problem. Seniors are more likely to be on one or more prescription drugs and each new medication increases the risk of adverse drug reactions. This possibility makes some doctors reluctant to offer senior migraineurs pharmaceutical assistance.

The onset of migraines after age 50 is very rare and should be investigated with a doctor to rule out the possibility of secondary causes. Late onset does not rule out migraine (only 1/3 of senior headaches are due to secondary conditions) but it makes it less likely.

Found on the Internet at  
[http://www.streetdirectory.com/travel\\_guide/109764/headaches/aging\\_and\\_migraines.html](http://www.streetdirectory.com/travel_guide/109764/headaches/aging_and_migraines.html)

**Notes...**The East Bay Headache Support Group features medical and other professionals as speakers at its meetings. Notes are taken of most presentations and made available for a suggested donation of \$2.00 each, or read them on our Web site at [www.headachesupport.org](http://www.headachesupport.org).

Past topics include: Biofeedback therapy, genetics, caregiving, dietary headache triggers, chiropractic treatment, pharmaceutical remedies, hormonal triggers, reducing stress in the workplace, dealing with holiday stress, acupuncture and Chinese herbal therapy, children's headaches, temporomandibular joint disease (TMJ), somatic headache relief, compounding medications, allergies, experimental headache drugs, prevention of stress headaches, non-traditional therapies, tension-type headaches, menopause, head injury headaches, environmental medicine, emotional impact of headaches, sleep disorders, chronic pain management, exercise headaches, cluster headaches, 5-HTP, Emergency Room visits, dealing with frustrations, Botox injections, naturopathic medicine, the Alexander Technique, effective nutrition for headache pain management, acupuncture, medication overuse headache, and many more.

**The East Bay Headache Support Group** is a nonprofit organization dedicated to providing a forum for headache sufferers. The support group meets four times per year—selected Tuesday evenings in February, May, September, November—from 7:30 to 9:00 p.m., at John Muir Medical Center-Walnut Creek Campus. It is open to all headache sufferers and their families, and interested persons. The meetings are free; however, donations to cover printing, postage, and Web site expenses are appreciated! The support group meetings include lectures by guest speakers, question and answer sessions, and informational materials.

**Directions to John Muir Medical Center-Walnut Creek Campus:** Take Highway 680 to the Ygnacio Valley Road exit in Walnut Creek. Travel East toward Mount Diablo approximately 1-1/2 miles, and turn right onto La Casa Via at the top of the hill. Turn left into the medical center parking lot, and park in the parking garage. Take stairs or elevator to the lower level and follow signs to the meeting room.

**We value your input!** Call, write, or e-mail us if you have comments or suggestions, or would like to help. The planning committee welcomes new members to help organize meetings and find speakers, and publish and mail newsletters. Call Carol at 925-229-5550 or send an e-mail to Leslie at [davisgold@gmail.com](mailto:davisgold@gmail.com).

**TIME DATED  
MATERIAL**

**Visit our Web site!  
[www.headachesupport.org](http://www.headachesupport.org)**

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