

DRUG & THERAPEUTICS LETTER



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Medication Overuse Headache

Patients commonly take analgesics for headaches. However, chronic use of analgesics for headache can cause headache as a withdrawal phenomenon. Epidemiological data suggest that 4% of the population misuse pain medication, and that a minimum 1% of the general population in Europe, North America and Asia suffer from medication overuse headache.

In the most recent headache classification (International Classification of Headache Disorders: ICHD-II) medication overuse headache is subdivided according to the drugs involved,

such as ergotamine, triptans, opioids, NSAIDs and combination medications.

It is important that headaches due to overuse of medication are distinguished from those which are caused directly by medication, such as nitrates and related compounds. Although medication overuse headache is associated with tolerance and drug use to prevent withdrawal symptoms, it can usually be distinguished from drug dependency. Patients are less likely to have cravings or to escalate the quantity of drugs they take.

Those 'at risk' for medication overuse headache are patients with frequent migraine or tension-type headache. Patients taking analgesia for other reasons (for example, arthritis) are only at risk of developing medication overuse headache if they also have a history of headaches.

Recent data suggest that 'triptans' (serotonin agonists, such as

sumatriptan) produce medication overuse headache more quickly, and at a lower frequency of use than either ergotamine or simple analgesics like aspirin or paracetamol.

It may affect patients from childhood to old age and may arise from apparently infrequent (three times weekly) or relatively short-term treatment. Medication overuse headache is estimated to be responsible for 30% of chronic daily headache, and accounts for 10-60% of patients attending specialist headache clinics. A high index of suspicion is therefore appropriate for any patient presenting with frequent headache.

There are no useful diagnostic tests for medication overuse headache. The history is by far the most important item of information. A critical aspect of the history is the temporal course of the headache, with transformation from intermittent pain or headache to continuous, or frequent (at least every alternate day) headache. The characteristics of medication overuse headache are not uniform. The headache may vary in severity, type and location.

Medication overuse headache is not associated with focal or lateralising neurological symptoms. However, patients with a history of migraine who develop medication overuse headache may experience an aura before the headache emerges.

The essential treatment of medication overuse headache is withdrawal of the offending medication, but in most cases that is easier said than done. Some patients find it very difficult to accept that the medication they use to treat their headaches is actually making their situation worse.

Following successful withdrawal of the overused medication, migraine prophylaxis, careful assessment of precipitants, counseling, a headache management plan and clear limits on the use of analgesia may all be required in order to prevent relapse. Studies suggest that following withdrawal of the offending drug, medication overuse headache will relapse in approximately 40% of patients. This relapse is most likely to occur in the first 12 months following withdrawal.

The prevalence of medication overuse headache is high and the condition is usually present for a long time before it is recognised and

treated. Consider medication overuse headache as a possible cause in all patients with daily or alternate-day headache, particularly among those with a prior history of migraine or tension-type headache. Medication must be withdrawn to treat the condition. A comprehensive management plan should be implemented to prevent relapse.

Reference:

David Williams. Medication overuse headache. Australian Prescriber 2005;28(6):143-5

Brief Information

Prescribing by Dental Surgeon for HIV Infection

The prevalence of people living with HIV infection is expected to rise and these people are increasingly likely to seek care from practitioners from different specialities. Dental clinicians need to be aware of changes occurring in the management of HIV infection, the increase in number and complexity of antiretroviral regimens and the potential for drug interactions with commonly prescribed drugs. For example, erythromycin, metronidazole and miconazole have potential interactions with some

antiretroviral drugs that may require close monitoring, alteration of drug dosage or timing of administration. Consultation with an HIV expert is strongly recommended before starting any new medication in patients taking antiretroviral drugs. Furthermore, unusual and rare adverse effects such as peri-oral paraesthesia can occur with antiretroviral drugs.

Dental clinicians should be aware that approximately 50% of patients living with HIV/AIDS are smokers. These patients therefore have an increased likelihood of oral diseases such as periodontal disease, leucoplakia and oral squamous cell carcinoma so thorough dental examination, treatment and monitoring is required.

Drug Committee, TUTH

The Drug Committee has achieved following in addition to the those published in earlier issue of this bulletin (July-Sept. 2005)

- disposal of drugs expired in the hospital pharmacy since the establishment of the hospital.
- opening of an in-patient sales counter on the first floor of the hospital.

- ensuring quality and cheap drugs in the hospital. The purchase is based on the list of manufacturers approved by various departments of the hospital.

Eye problem reported with Sildenafil (Viagra)

Sildenafil is used widely for treatment of erectile dysfunction. It acts by inhibiting phosphodiesterase 5 (PDE5) enzyme responsible for metabolism of cGMP that causes relaxation of smooth muscle of corpus cavernosum and penile arteries.

The adverse effects of sildenafil is largely predictable on the basis of its effect on PDE5. Headache, flushing and rhinitis may be observed with its use.

Sildenafil also is a weak inhibitor of PDE6, the iso-enzyme responsible for photo-receptor signal transduction and sildenafil has been

associated with visual disturbances most notably changes in perception of colour hue or brightness.

WHO Drug information (Vol. 19, 2005) has reported a small number of post marketing reports of sudden visual loss, attributed to NAION (non arteritic ischemic optic neuropathy), a condition where blood flow is blocked to the optic nerve.

FDA advises patients to stop taking this medicine and contact a doctor or healthcare provider immediately if they experience sudden or decreased vision loss. Further, they should be asked about history of severe loss of vision in the past before instituting the therapy.

So far, it has not been determined whether this oral medicine for erectile dysfunction was the cause of the loss of eye-sight or whether the problem is related to other factors such as high blood pressure or diabetes or to a combination of these problems.

"Drug and Therapeutics Letter" is also available now in the following websites:
<http://www.teachinghospital.org.np/diu.html>, <http://www.iom.edu.np/diu.html>

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