TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LIX, No. 1

January 2002

An estimated 45 million Americans experience them regulary and for half of these people, the problem is severe and can be disabling.

So, what can be done about

Headaches

pages 6 – 16

plus

TOMA's 46th MidWinter Conference & Legislative Symposium with Legislative Update Luncheon guest speaker, Senator Mike Moncrief

Program Information & Registration Form
pages 23 – 25

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The Journal of the Texas Osteopathic Medical Association

JANUARY 2002

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CALENDAR OF EVENTS

JANUARY 16 – 20
"Ninth Winter Medical Symposium"
Sponsored by the Nevada Osteopathic Medical Association
Location: Harveys, South Lake Tahoe, NV
Contact: NOMA, 702-434-7112; or nvoma@aol.com

FEBRUARY 7 – 9
"Primary Care Update"
Sponsored by the Kirksville College of Osteopathic Medicine
Location: The Monte Carlo Resort, Las Vegas, NV
CME: 24 hours category 1-A credits anticipated
Contact: Rita Harlow, Director of CME, KCOM
800 W. Jefferson Ave., Kirksville, MO 63501
800-626-5266, Ext. 2232
cme@kcom.edu or www.kcom.edu

FEBRUARY 8 – 10
"TOMA 46th MidWinter Conference & Legislative Symposium"
Sponsored by the Texas Osteopathic Medical Association
Location: Renaissance Dallas North Hotel, Dallas, TX
CME: 17.5 hours category 1-A credits available
Contact: Jill Weir, TOMA Projects Coordinator
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FEBRUARY 25 – MARCH 1
"Keystone Midwinter Conference"
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Resort, CO
CME: 40 hours category 1-A credits available
Contact: CSOM, 303-322-1752; or www. ColoradoDO.org

MARCH 1 – 5
"12th Annual Update in Clinical Medicine for Primary Care Physicians"
Sponsored by the University of North Texas Health Science Center
Location: Harvey's Resort and Casino, Lake Tahoe, NV
CME: 20 hours category 1-A available
Contact: UNTHSC Office of CME, 800-987-2CME

MARCH 5 – 10
"39th Annual Convention and Scientific Seminar:
Sponsored by the American College of Osteopathic Family Physicians
Location: Buena Vista Palace Resort and Spa
Lake Buena Vista, FL
Contact: ACOFP, 800-323-0794 or 847-952-5100
Fax 847-228-9755 or www.acofp.org

APRIL 11 – 14
"17th Annual Clinical Conference"
Sponsored by the American Osteopathic Academy of Sports Medicine
Location: Omni Shoreham Hotel, Washington, D. C.
Topics to include: strength training updates, the latest on upper extremity diagnosis and treatments, hands-on workshops, OMT workshop, updates on various injection therapies, concussion management.
Contact: AOASM
7600 Terrace Ave., Suite 203
Middleton, WI 53562
info@aoasm.org or www.aoasm.org
608-831-4400; FAX 608-831-5122

APRIL 18
"D.O. Day on Capitol Hill"
Sponsored by the American Osteopathic Association
Contact: AOA, 800-621-1773

APRIL 19 – 20
"16th Annual Spring Update for Family Practitioners"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Dallas Southwest Medical Center, Dallas, TX
CME: 13 hours category 1-A
Contact: UNTHSC Office of CME at 817-735-2539 or
800-987-2CME or www.hsc.unt.edu

APRIL 20
"57th Annual Meeting of the TOMA House of Delegates"
Location: Austin, Texas
Contact: Paula Yeamans
TOMA Associate Executive Director
800-444-8662 or 512-708-8662

APRIL 25 – 28
"102nd Annual Convention"
Sponsored by the Oklahoma Osteopathic Association
Location: Shangri-La Resort, Afton, OK
Contact: Lynette McLain, OOA
800-522-8379 0r 405-528-4848
lynette@okosteo.org

MAY 2 – 5
"105th Annual Convention"
Sponsored by the Indiana Osteopathic Association
Location: Adam's Mark Hotel Downtown, Indianapolis, IN
CME: 30 hours category 1-A credits anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

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ON THE WEB in January

ON THE WEB is a monthly feature of the *Texas D.O.* announcing headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website <www.txosteo.org>.

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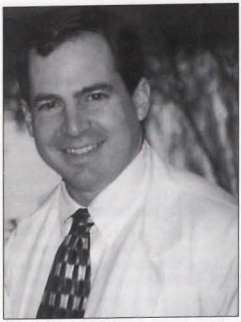

A Closer Look at Chronic Daily Headaches

by Charles A. Popeney, D.O.

An estimated 38,000 persons suffer from migraine headache in the United States at an estimated cost of nearly 13 billion USDA.[1] Women are affected five times as commonly as men, with the peak prevalence at age 40 (average age 25 to 45)[1]. Most experience episodic symptoms, including aura (15%) and respond to pharmacologic management[2]. Up to 6% (approximately 2.2 million), however, experience more frequent symptoms. These patients have headaches greater than 15 days in a month with each headache lasting greater than four hours. We categorize these as primary chronic daily headaches (CDH). CDH patients impose an enormous burden on themselves, families, and society as well as a great challenge to treating clinicians.

CDH is classified into four headache syndromes: transformed migraine (78%), chronic tension type headache (15.3%), hemicrania continua, and new daily persistent headache (6.7%).[3]

In dealing with chronic daily headaches you must first exclude secondary causes (organic etiology). This could include sphenoid sinusitis, idiopathic intracranial hypertension (high pressure headache), intracranial hypotension (low pressure headache), posttraumatic headaches, cervicogenic headache, and dental disease (TMJ).[3] Thus, the work-up on any CDH is to rule out secondary causes (CT of sinus, MRI of C-spine, TMJ x-ray, and spinal tap with opening pressure). When secondary headaches are ruled out, you then classify the headache into one of the four primary chronic daily headache categories.

Seventy-eight percent of the primary chronic daily headache patients will have transform migraine (TM).[3] Therefore, the discussion below will focus on transformed migraine.

A transformed migrane (TM) is a chronic headache in patients with prior history of IHS episodic migraine with increasing headache frequency and decreasing severity of migrainous features[4]. At this point they have features of both migraine (acute attacks) and tension type headache (day- to-day pain). TM often develops in the setting of symptomatic medication overuse with the severity and progression that is commonly disabling, incapacitating and refractory to current treatment[2]. Two important principles to address in TM patients are prevention and symptomatic medication overuse.

Migraines can be thought of as a relapsing, progressive, cumulative disorder over time. To understand this fully, we must look at the presumed pathophysiology of transformed migraine. It is known that abnormal excitation of peripheral nociceptive afferent fibers (e.g., dura mater, meningeal vessels) leads to central sensitization of trigeminal nociceptive pathways (Figure 1).[5] Many years of frequent bouts of poorly controlled episodic migraine (frequent bouts of central sensitization) leads to long term potentiation and facilitation of this nociceptive pathway.

Chronic bombardment of second order neurons (Figure 1) by impulses from multiple peripheral nociceptors may cause these neurons to become spontaneously active, resulting in daily or near daily disabling headaches[6]. Preventing central sensitization from occurring is disease modifying. By far, our best option for management of transformed migraine is prevention. We prevent patients from becoming transformed by early and effective diagnoses and treatment of episodic migraine. Early headache attack intervention with specific agents such as the tryptans, as well as early prophylactic pharmacotherapy, is crucial.

How else can we effectively change and prevent transformed migraine? Recognizing patients transforming to TM including analgesic overuse, and making the proper referral to a headache specialist could also be disease modifying. Eighty percent of TM patients are overusing symptomatic medications (simple analgesics, combination analgesics, narcotics, Butalbital, ergots, tryptans) on a daily basis.[3]

Symptomatic overuse in TM patients may facilitate nociception via on-cells within the rostroventromedial medulla[7]. Increased on-cell activity may enhance the central nervous system's response to both painful and nonpainful stimuli, and modulate the activity of the trigeminal neurons[7,8]. Indeed, TM may result in part from neuronal activity in trigeminal nucleus caudalis as a result of enhanced on-cell activity[7,8]. Withdrawing of offending agents is a major principle in management of TM patients. Effective ways of doing this will be discussed later.

So far we have discussed the two most important principles of transformed migraine – prevention and correction of symptomatic medication overuse. We have also outlined the proposed pathophysiology behind both.

We must now continue with basic principles of transformed migraine treatment: Nonpharmacologic treatment, including treatment of comorbid and behavioral distur-

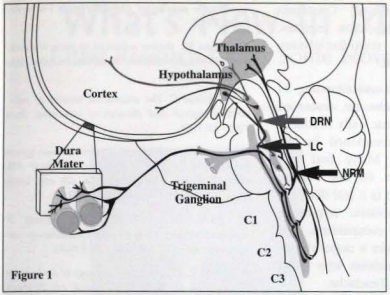

Figure 1

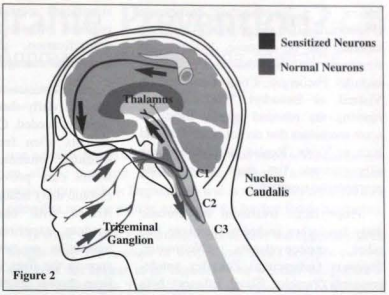

Figure 2

bances, and pharmacotherapy (preventative and acute).[9] Nonpharmacologic treatment goal is to enable healthful patient behavior. Educating the patient about the disorder and expectations is important. Regulating eating and sleeping patterns, discontinuing smoking, and exercise are always helpful.[9]

With chronic headache pain, it is very important to look beneath the symptoms. If you are only addressing headache pain as a medical problem, you are simply not going far enough. Assessing the lifestyle and family dynamics impacting the condition is helpful.[10] A multi-disciplinary approach such as biofeedback, OMT, and psychotherapy including cognitive and behavioral approaches add to the effectiveness in helping these disabled patients. Addressing comorbidity and CDH such as depression, anxiety, panic, alcohol abuse, fibromyalgia, IBS, and personality disorders is also important.[9]

The limitations of some pharmacologic agents to relieve chronic pain raises the question of whether alternative procedures for pain control can be brought into action clinically.[11,12]

Historically, experimental and clinical pain has related noxious stimulus intensity with degree of perceived pain. However, the input and its consequence is not fixed, but can be modified by a range of psychological and emotional factors, such as attention, distraction, anxiety, and hypnosis in both experimental and clinical conditions. Excessive literature review indicates that this psychological influence on pain is best described in a framework of powerful neuronal networks in different brain structures with multiple targets and faceted pharmacology.[13-16]

For example, the cognitive behavioral model of pain proposes that cognitive factors (expectations, reflections, memory, attention) and behavioral factors (social, environmental, work, physical activity) influence our response to noxious stimuli.[17] Our challenge is to understand in more detail the neurobiology of the psychological modulation and how it could help chronic daily headaches.

Briefly, these modulatory systems consist of both facilitating the inhibitory networks, which via up and downstream pathways in the brainstem control pain responding neurons in the spinal cord and in the brain.[14-16] At the spinal level intrinsic interneurons and descending systems from the brain control pain transmission. At other pain relays in the brainstem, thalamus and cortex, as well as hypothalamus (limbic system) direct and indirect inhibitory and facilitating systems are present which descend to the trigeminal nucleus caudalis and the upper cervical dorsal horn (Figure 2). Dysfunction within this descending inhibitory system over time could facilitate the development of chronic daily headache and may be important in the clinical evolution of transformed migraine. The inhibitory role of the endogenous pain modulation is indicated by the recruitment of pain inhibition during various psychological conditions, such as hypnosis, expectations, or placebo analgesia.[18] It is also known that experimental clinical pain can be modified by cognitive processes.[13] Understanding the above leaves a set of treatment possibilities to add to the beneficial effects of pharmacologic agents.

Let us now address pharmacologic management. Pharmacologic management should include appropriate medication to break the cycle, prevent frequent attacks, abort acute attacks, and combat rebound headaches.[9]

First, as mentioned earlier, recognizing and treating the syndrome of rebound headache is vital. One must recognize the self-sustaining rhythm of predictable and escalating headache frequency and medication use. These patients' headaches are refractory to otherwise appropriate symptomatic and preventative treatments. Rebound headache patients, while overusing symptomatic medication, gain little efficacy from abortive (tryptans and prophylactic) treatment. After rehabilitation, the patient may benefit from prior abortives and prophylactics that were ineffective during symptomatic overuse.

How do we handle rebound headache? This is a challenge. Symptomatic medication withdrawal results in escalation of headaches as well as potential for withdrawal symptoms. These patients may need hospitalization. As an outpatient, cautiously taper medications that cause rebound (barbiturates, opiates, other analgesics). A 20% reduction a week is recommended. While detoxing from opioids, Clonidine can be helpful to prevent withdrawal symptoms. You should monitor blood pressure while on Clonidine. Also, Zanaflex (alpha-2 agonists) may also prevent withdrawal symptoms as well as acting as an admirable prophylactic medicine for underlying transformed migraine. To prevent Butalbital withdrawal symptoms (Fioricet, Fiorinal), changing the

patient to a longer-acting barbiturate (Phenobarbital 30 mg or 60 mg) and then tapering can be effective. Symptomatic treatment of withdrawal symptoms includes Phenergan, Compazine, Reglan, Vistaril, or Benadryl. While you are tapering the rebound agents, substitute acute medicines that do not cause rebound such as Vioxx, Reglan, or indomethacin suppositories. You must also initiate prophylactic treatment.

Prophylactic treatment for chronic daily headaches includes Depakote and other anticonvulsants (Neurontin, Topamax, Gabapentin), Zanaflex, antidepressants (Pamelor, Elavil, Effexor), beta blockers and calcium channel blocks. In transformed migraine patients rational polypharmacy is usually the rule.

Most of the time TM patients need infusion protocols to break the cycle of daily disabling headaches. DHE (dihydroergatomine) 45 IV q 8 hours for three days with Reglan preceding can be helpful. In addition, IV Depacon infused over 48 hours can break the continuous headache cycle. This protocol usually requires a tertiary referral, hospitalization, or intensive outpatient services.

Lastly, aborting acute attacks should always include tryptans. All tryptans should be cycled through a transformed migraine patient if necessary. Nonspecific medicines that can be helpful include Toradol IM, Migrainol, Compazine IM, Vioxx, Zanaflex, and steroids.

In the end, with ongoing neuro modulatory treatment for transformed migraine the potential for further disease modification is possible. For example, a recent study on the use of peripheral nerve stimulation (C1 through C3) in the treatment of transformed migraine showed it to be an effective promising modality for reducing headache severity, frequency and disability.[19]

In conclusion, transformed migraine and other chronic daily headache is a widespread disorder, and is by far the most disabling of primary headache conditions. Sufferers are frequently affected by daily pain, poor quality of life, disability, severe drug dependence, and significant cormorbidities. Treatment requires complex medication regimes, detoxification, and multidisciplinary behavioral management.

As physicians, an understanding of chronic daily headache as discussed above is needed. Chronic daily headache patients often feel abandoned by the medical community. Many feel that health care providers do not believe chronic daily headache is a real disorder. Armed with our holistic approach, wisdom, experience, compassion, and innovation, we can make a major difference in the lives of patients who suffer from chronic disabling headache.

References:

1. Lipton R, Humelsky S, Stewart W. Epidemiology and impact of headache. Silberstein S, Lipton R, Nalessio D. eds. Wolff's headache and other head pain. 7th ed. Oxford University Press 2001;85-107.

2. Silberstein S, Super J, Freitag F. Migraine: diagnosis and treatment. Silberstein S, Lipton R, Nalessio D. eds. Wolff's headache and other head pain. 7th ed. Oxford University Press 2001;121-237.

3. Silberstein S, Lipton R. Chronic daily headache including transformed migraine, chronic tension type headache, and medication overuse. Silberstein S, Lipton R, Nalessio D. eds. Wolff's headache and other head pain. 7th ed. Oxford University Press 2001;247-282.

4. Silberstein SD, Lipton RB, Solomon S, Mathew NT. Classification of daily and near-daily headaches: proposed revisions to the HIS criteria. Headache 1994; 34(1):1-7.

5. Burnstein, Latier, Yarnitsky. The development of cutaneous allodynia during a migraine attack. Clinical evidence for the sequential recruitment of spinal and supra spinal nociceptive neurons in migraine. Brain 2000; 123: 1703-1709.

6. Cook AJ, Woolf CJ, Wall PD. Prolonged C-fibre mediated facilitation of the flexion reflex in the rat is not due to changes in afferent terminal or motor neuron excitability. Neurosci Lett 1986; 70:91-6.

7. Silberstein SD, Lipton RB, Goadsby PJ. Headache in clinical practice. ISIS medical media. Zeneca Pharmaceuticals. Oxford 1998:41-58.

8. Silberstein SD, Lipton RB, Goadsby PJ. Headache in clinical practice. ISIS medical media. Zeneca Pharmaceuticals. Oxford 1998:101-114.

9. Neurology Ambassador Program. New York, NY: July 2001.

10. Bridging the Gap, Summer 2001 issue: pg 2-3.

11. McQuay HJ, Moore RA. An evidence based resource for pain relief. Oxford: Oxford University Press, 1998.

12. Jensen TS. Recent advances in pain research: implications for chronic headache. Cephalalgia 2001;21,765-769.

13. Eccleston C. The attentional control of pain: methodological and theoretical concerns. Pain 1995; 63:3-10.

14. Fields HL, Basbaum AI. Central nervous system mechanisms of pain modulation. In: Wall PD, Melzack R, eds. Textbook of pain, 4th edn. Hong Kong: Churchill Livingston, 1999:309-29.

15. Fields HL, Heinricher MN, Mason P. Neurotransmitters in nociceptive modulatory circuits. Ann Rev Neurosci 1991; 14:219-45.

16. Yaksh TL. Central pharmacology of nociceptive transmission. In: Wall PD, Melzack R, eds. Textbook of pain, 4th edn. Hong Kong: Churchill Livingstone, 1999:253-308.

17. Turk DC, Meichenbaum D, Genest M. Pain and behavioral medicine: a cognitive-behavioral perspective. New York: Guilford, 1983.

18. Price DD. Factors that determine the magnitude and presence of placebo analgesia. In: Devor M, Rowbotham MC, Wiesenfeld-Hallin Z, eds. Progress in pain research and management, Vol. 16 Seattle: IASP Press, 2000:1085-95.

19. Popeney, C, Alo K. Peripheral Neurostimulation for the treatment of chronic, disabling, transformed migraine. Recently submitted for publication.

Figure Legend

Figure 1: Central Sensitization. (11)
1st order – Sensitization of peripheral nociceptors (Meningeal vessels, dura)
2nd order – Trigeminal nucleus caudalis and dorsal horns of C1, 2, 3 of spinal cord.
3rd order – Thalamus

Figure 2: Modulation of Migraine by Descending Inhibitory Pathways.
Descending inhibitory pathways, via cortex, hypothalamus, thalamus, locus coeruleus, dorsal raphe nucleus and nucleus raphe magnus ending in trigeminocervical complex. Convergence of anterior intracranial structures (dura mater, blood vessels) via the trigeminal ganglion is noted at the same level.

Charles A. Popeney, D.O., a board certified neurologist, is in private practice at Fort Bend Neurology in Sugar Land, Texas. He is a former associate professor of the Department of Neurosurgery at the University of Texas Health Science Center at Houston. Dr. Popeney is a 1991 graduate of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in Fort Worth.

What's New in Migraine Prevention?

Latest Research Offers Some Novel Approaches to Managing Migraine

by Frederick G. Freitag, D.O.
Associate Director, Diamond Headache Clinic, Chicago, Illinois

Migraine research is starting to steer toward new preventive therapies, and this is a welcome change for many sufferers. What's behind the trend?

First is the need that headache specialists saw for better preventive medications for many patients. Triptans can offer a welcome respite from the misery of migraine, but they haven't really "solved" the problem. Furthermore, triptans have their limits; they aren't appropriate for every patient, and can't be taken every day.

Many healthcare specialists believe that better preventive measures are the answer to lower costs and less disability for migraine sufferers. Finally, increased understanding into the causes of migraine disorders and pain syndromes has helped pave the way for new research into preventive agents.

Most long-term headache sufferers have been through their share of antihypertensives and antidepressants. But many of the newest drugs being tested offer novel approaches to preventing migraine. This article reviews several new approaches that may offer hope for headache prevention.

Topiramate

Some migraine preventive medications started out as treatments for epilepsy. Of the anti-epileptics, the best-studied to date has been topiramate (Topamax®, Ortho-McNeil). Approved for treatment of seizure disorders, topiramate has shown promise in early clinical trials for prevention of migraine as well as chronic migraine, daily headache, and chronic cluster headache. Large-scale trials comparing its performance against placebo are in progress now, and may eventually lead to FDA approval for this agent in migraine management.

One reason for the interest in topiramate for migraine prevention actually has to do with one of its side effects. Weight gain is an all-too-common drawback for patients using migraine medications such as Depakote®, and is sometimes regarded as a price that must be paid in exchange for having fewer headaches.

In some people, topiramate tends to have the opposite effect: weight loss. The amount of weight loss varies between patients and does not appear to be dependent on whether the patient is already overweight. The weight-loss side effect may be mitigated by adjusting the medication dosage. Needless to say, I have many patients who are very interested in a medication that would prevent headaches and help them lose weight, too!

With that, I would caution that not everyone loses weight with the medication, and some people experience other side effects that can be problematic. Topiramate is in a class of medications known as carbonic anhydrate inhibitors, and is related to diuretics or "water pills." These medications produce several effects that are more a nuisance than dangerous, but can be disturbing enough to cause some people to stop the medication. These include numbness or tingling sensations, which may occur anywhere in the body, and alteration of the sense of taste, especially for carbonated beverages. There is a small risk of developing kidney stones. Finally, topiramate might diminish the effect of birth-control pills; some women may need to change pills or use alternative forms of contraception.

Other Anti-Epileptics

Three other anti-epileptic drugs have received some attention in migraine management: levetiracetam (Keppra®), oxcarbazepine (Trileptal®) and zonisamide (Zonegran®). None of these agents have been subjected to the same level of clinical testing in headache as topiramate has. Early evidence suggests that all three agents may offer some benefit for migraine prevention, and the drugs appear to be well tolerated so far.

Zonisamide has many similarities to topiramate, including the potential for weight loss. It also possesses some unique pharmacologic activity that may play a role in migraine—it is active at one of the monoamine oxidase inhibitor (MAOI) enzymes (not the one requiring all the restrictions), and on some chemicals associated with brain inflammation in migraine.

Cox-2 Inhibitors

Anti-inflammatory agents, such as the natural salicylate substances from which aspirin is derived, have been used to treat headaches for much of recorded history. Newer nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen are easier on the gastrointestinal system. GI safety improved even more with the introduction of cyclooxygenase (COX-2) inhibitors, a drug frequently prescribed for arthritis.

continued on next page

Inflammatory mechanism have long been linked to migraine. In the 1940s, "pioneer" headache researcher Dr. Harold Wolff demonstrated that inflammation occurs during a migraine headache by opening up the patients' skulls during their attacks; something we don't do any longer!

Inflammation occurs through two known chemical pathways: one is controlled by the enzyme cyclooxygenase and involves prostaglandins; the other is mediated by chemicals called leukotrienes, the same substances involved in asthma symptoms. Prostaglandin's link to migraine has been acknowledged for decades, and prostaglandin inhibitors such as NSAIDs are commonly used in headache treatment. While leukotriene's role in inflammation has been recognized for several years, new medications targeting this connection have started to surface only recently.

At the recent International Headache Congress meeting several trials were reported involving these newer medications. A trial of the COX-2 inhibitor rofecoxib (Vioxx) by itself proved beneficial for most headache patients in an open (non-comparative) trial. Similarly, the leukotriene antagonist montelukast (Singulair®), normally used for asthma, proved very effective in small trials involving teenagers with migraine. Other research in which both montelukast and rofecoxib were combined for the prevention of migraine offered very promising results, with the drug combination well-tolerated over a prolonged period.

Women and Migraines

- 20 million women in the U.S. suffer from headaches; 9 million of these suffer from migraines.
- Over a quarter of women are affected by migraines during their life.
- The prevalence of migraine is 2-3 times higher in women.
- Women with headache report higher levels of pain, longer duration of headaches, and more associated symptoms, such as nausea and vomiting. Visual symptoms, however, are less common in women.
- Over half of women with migraine report an association between their headaches and their menstrual cycle.
- The frequency and severity of migraine is increased commonly with the use of oral contraceptive pills and during the menopause.

National Women's Health Information Center, <4woman.gov/faq/migraine.htm>

Botulinum Toxin

Some migraine therapies that seem to work only superficially at first glance may actually have more far-reaching effects. One example of this is the lidocaine patch, which has been shown effective against acute migraine in a recent study by Dr. Seymour Diamond. Dr. Diamond's research suggests that lidocaine goes beyond its local anesthetic effect and may work against migraine via its action on the trigeminal vascular system.

The concept of "There's more here than meets the eye" can also be applied to the use of botulinum toxin (Botox) in headache management. The utility of botulinum toxin injections in migraine therapy was discovered serendipitously by plastic surgeon Dr. William Binder when he was using the technique to reduce facial wrinkles. These early findings led to a number of clinical trials to assess the potential efficacy of botulinum toxin injections in preventing the migraine, tension-type headache, and cluster headache.

How botulinum toxin works to prevent migraine and other headaches remains poorly understood. Many people associate botulinum toxin with the highly fatal form of food poisoning. To offer reassurance, the toxin that causes food poisoning is a more complex molecule, whereas the two forms of botulinum toxin used in medicine are merely selected portions of this more complex molecule. These medicinally active portions have the effect of reducing muscle spasticity.

Two forms of botulinum toxin are currently available—type A, whose trade name is Botox®, and type B, trade name Myobloc®. To date there have been no studies with Myobloc in headache. Since the two types do not work in exactly the same way, clinical trials will be needed with Myobloc to determine whether it is beneficial in headache treatment.

In one of the first trials of Botox in patients with true migraine headache, 51% of patients had complete remission of their headaches; an effect lasting approximately four months on average. Several multi-center trials in the U.S., including the first large-scale trial reported by Dr. Stephen Silberstein of the Jefferson Headache Center, have demonstrated the efficacy of Botox versus placebo.

The results of European studies led by German researcher Dr. Hartmut Gobel have provided the best level of scientific evidence to date that Botox therapy offers migraine prevention comparable to well-established migraine medications. In addition, a trial of Botox in tension-type headache was shown to be highly effective in a small pilot trial. Follow-up studies are being analyzed to evaluate the effectiveness and safety of Botox for these headaches.

Physicians using Botox in day-to-day practice report varying results, some even better than those reported in clinical trials. Administration techniques may play a part in this, with variations in the injection sites and the use of repetitive injections over several months to target specific areas on an individual patient.

Some researchers believe that botulinum toxin affects the branches of the trigeminal nerve, not just at the level of the nerve-muscle junction, but deeper in the brain, affecting the sensitization near the root of the migraine process. Like lidocaine, Botox may alter the release of neurotransmitter substances that appear to play a role in the mechanism of migraine and other headaches. These same chemical processes may be acted upon by the anti-epileptic drugs, by other modifying means within the nerve cell. Even the newer anti-inflammatory agents may play a role in modifying the release of substances that induce neurogenic inflammation in migraine or help to block the chemical mediators involved in their release.

As this and other headache publications have stated many times, abortive therapy for migraine has come a long way, but better preventive measures are needed. Perhaps some of these new methods, approaching the migraine problem from several different angles, will allow preventive therapy to catch up.

Used with permission from the National Headache Foundation <www.headaches.org>.

Osteopathic Approach to the Treatment of Headaches

by Rick Lin, D.O.

Introduction

In today's society, 90 percent of the population suffers from headache. Despite the use of pharmacotherapy, a significant portion of headache patients find little or no relief. Because of that, many patients explore the possibility of alternative treatment. Osteopathic manipulation provides several advantages over straight pharmacotherapy in the treatment of headache patients. An osteopathic physician has a distinct advantage over allopathic counterparts in treatment of the headache patient because of the superior palpatory skills required to detect the craniosacral changes on a headache patient. In this case report, we will discuss a headache case as presented in the Osteopathic Manipulative Medicine Clinic, and some relevant review of literature.

Chief Complaint

The patient is a 32-year-old white female presenting with cervical muscular tightness accompanied by throbbing occipital headaches that radiate over the top of the cranium into the frontal area.

History of Present Illness

The patient reports that she has had chronic episodes of headache occurring every four months. Each episode lasts two to three days. The patient denies nausea, vomiting, and vertigo, but reports that prior to each episode she experiences a visual aura. The patient has a history of migraine headaches that have resolved.

Personal History

The patient is a divorced nurse. She denies tobacco use, but admits to occasional social drinking.

Past History and Family History

The patient's past medical history includes seasonal allergies, bunion removal, tonsillectomy, and bilateral tubal ligation. She denies allergies to any medications. The patient denies a family history of cancer and reports she had one first degree relative with a heart attack at 40 years of age. The patient's only current medication is Ortho Tricyclen.

Physical Examination

Cervical

Paracervical musculature tension bilateral
RLSL C2-C5
Myofascial dysfunction in the cranium
Lumbar, Thoracic, Pelvis and Sacrum
No dysfunction or tissue texture changes found

Diagnosis

Cranial somatic dysfunction
C2-C5 RLSL
Cervicothoracic junction somatic dysfunction

Treatment Plan

CV4 technique
Venous Sinous Release
Condylar Decompression
Soft tissue to areas of paracervical tension
HVLA to C3
Indirect Spinal Manipulation of C2-C5
Direct supine HVLA to Cervicothoracic junction

Review of the Literature

A chronological literature review reveals the diverse nature of the theories surrounding the generation and presentation of headache pain. In addition, research into the mechanism of the efficacy of manipulation often generates the need for further research.

The first article to be discussed was published in 1976. In this article, headache pain is a symptom of improper pressure and fascial tension on the meninges. The result is the most common type of headache that a family practice physician will be called upon to treat. This is the tension vascular headache, an expression of the incessant tension placed on individuals in our fast paced society. The article continues on to focus on the importance of diaphragmatic dysfunction in the creation of facilitated segments often found in headache patients. The author contends that lymphatic and venous congestion are in large part responsible for this viscerosomatic response. According to this article, tension in the vascular system, or vasoconstriction, results in a back pressure on the proper venous and lymphatic drainage. The resulting congestion disrupts the proper clearing of metabolites, carbon dioxide, and acidic molecules. All of these components generate the viscerosomatic response responsible for the well-known facilitated segment. After the facilitated segment has been

generated, it contributes to the perpetuation of the vascular tension that initiated the venous and lymphatic congestion to begin with. The critical point relayed by the article is the importance of treating the body's various diaphragms in headache patients. The author emphasizes the benefit received by treating the thoracoabdominal and urogenital pelvic diaphragms. In treating these, a more healthy and well balanced state of fluid circulation can be achieved.

The next article was published later in the same year. It discusses the division of headache into various categories as follow: vascular headaches, tension headaches, sinusitis headaches, and allergic headaches. The author first approaches headache broadly as one of the most common kinds of pain known to mankind. He states that it has been estimated that up to 90% of the population is affected by headaches. More specifically, he discusses the origin and treatment of the four categories of headaches as mentioned above.

The vascular headache includes the well-known migraine and more rare cluster headaches. During osteopathic evaluation, the article states that one should pay special attention to the upper thoracic and whole cervical areas. These are the areas overlying the main sympathetic outflow tracts to the head. Since the sympathetic system is chiefly responsible for vasomotor tone, it is assumed that it will play an important part in generating vascular headaches. By detecting and treating upper thoracic and cervical dysfunctions, the regulation of sympathetic outflow may be achieved. The parasympathetic system must not be forgotten as it is generates the vagally mediated migraine symptoms of nausea and vomiting. The author contends that craniosacral imbalances produce the parasympathetic component. Thus, craniosacral manipulation must be included in the treatment of migraine and cluster headaches.

In treating the common tension headache, the osteopathic physician should focus on the suboccipital area as the chief area of concern. Muscular contractions in this area are thought to be the culprit in etiology of tension headaches. Unfortunately, merely treating the suboccipital muscles themselves may overlook the distal structural imbalance that generated the contraction. Thus, the physician must evaluate the entire musculoskeletal system carefully for a source of chronic tension headache.

Sinusitis headaches are characterized by a pattern of pain that follows the distribution of the occipital nerve. It begins in the atlanto-occipital area and moves along the top of the cranium to the superorbital areas. The resulting pain seems to be located in the frontal sinuses. Along with the treatment of the atlanto-occipital area, the article promotes the treatment of venous and lymphatic systems by balancing of rib cage mechanics and the balancing of sympathetic outflow by treating the upper thoracic and cervical areas.

In the treatment of allergic headaches, the author again emphasizes the importance of well-regulated sympathetic outflow and proper venous and lymphatic circulation. Additionally, he notes that he has often found areas of dysfunction in the thoracolumbar area in patients with allergic headache. He proposes that such dysfunction has the effect of impeding the appropriate sympathetic outflow to the adrenals. If chronic, this state can result in a low-grade exhaustion or hypoadrenalism. If true, this would necessitate the proper investigation and treatment by the physician whenever he approached this type of headache. The article concludes by re-emphasizing that the role of osteopathic manipulative therapy in headache should be central.

The next article, published in 1979, states that although there is no objective way to measure pain, the researchers attempted to evaluate the effects of osteopathic manipulative procedures on muscle tension headaches in a group of patients. The patients selected had a history of chronic muscle tension headaches recurring over months to years. The researchers decided to objectify headache symptoms by using EMG to measure the contraction of frontalis muscles in the subjects. They set out to discover if osteopathic manipulation on subjects with headaches in progress would effect reductions in EMG levels of the frontalis muscle. Subjects in the study were assigned to three groups. The first group received palpatory examination for restricted movement in the axial skeleton combined with osteopathic manipulation involving soft tissue procedures over the entire axial skeleton and HVLA procedures to release restriction. The subjects in the second group received palpatory examination for restricted movement in the axial skeleton without any manipulative procedures. The members of the third group were told to rest in the supine position for ten minutes. In order to eliminate experimenter effect, the same physician was used to administer all palpatory examination and manipulative procedures. EMG measurements of the frontalis muscle contraction before and after treatment for all three groups were recorded. Results of this study showed that although EMG levels did not differ significantly for any of the treatment groups, only the subjects from Group 1 reported subjective post treatment reductions in headache pain. The authors went on to comment that EMG levels in the frontalis muscle most likely did not correspond to ratings of headache severity. They proposed that some intervening process and not frontalis muscle contraction itself was accountable for the presence of absence of subjective headache pain. They further commented that the pain in muscle contraction headache is mediated by cortical interpretation of sensory data and resultant changes in autonomic reactivity. Furthermore, the cortex receives and interprets sensory data, while the limbic system regulates the degree of autonomic system activation. On the basis of this model, the researches proposed that osteopathic manipulative procedures produce a cortical response that leads to a limbic reduction in autonomic reactivity and, therefore, a reduction in subjective headache pain.

An article published in 1983 once again investigated the role of EMG measurements and headache pain in addition to other related theories. The author begins the article by once again reviewing the major types of headaches. He comments that EMG level readings of frontalis muscle contraction cannot be used to distinguish between classic migraine and muscle contraction or tension headaches since they demonstrate no qualitative differences. Furthermore, he points out that objectively, no compelling biologic difference exists between the two maladies. He advances the idea that different manifestations of recurring headache represent a spectrum of clinical presentation with tension headaches at one end and classic and common migraine at the other.

Although the author also devotes a significant portion of the article to discussing differential diagnosis of headache pain and pharmacologic treatment, for the purposes of our paper we will focus on the section dedicated to current research and its repercussions on osteopathic manipulative therapy. In this section, the author cites several studies with topics that relate to headache pain and osteopathic manipulative theory. The first bit of research the author refers to discusses the use of trigger point treatment for headache therapy. He states that numerous trigger zones are located along the soft tissue of the neck as well as the temporomandibular joint area. These points refer pain to the face and cranium when palpated during a headache episode. These hypersensitive trigger points correspond to the familiar Jones trigger points. These trigger points and their treatment are well known to any osteopathic physician. Another study the author used concerned EMG level measurements in cervical and temporal muscles of headache patients. The study compared the contraction levels in both muscles for control, migraine, and cervical sympathetic syndrome patients. The results of the study showed that mean amplitude of action potentials increased in the cervical region in the headache groups when compared to the control group. This information confirms the usefulness of cervical muscle relaxation via soft tissue techniques. Next, the author mentions a study that investigated the use of high velocity, low amplitude techniques in tension headache patients. HVLA was found to have significant beneficial effects on tension headache patients when used on the axial skeleton. On average, such therapy was found to reduce pain by fifty percent. Lastly, the author presents several questions that are designed to help direct further research into our understanding of migraine.

Discussion

Despite the use of pharmacotherapy, a significant portion of headache patients find little or no relief. The treatment of such patients should be complemented by the use of osteopathic manipulative therapy. Indeed, the osteopathic physician should not wait for pharmacotherapy to fail before using his knowledge of manipulative medicine in order to relieve his patients' pain. Osteopathic manipulative provides several advantages over straight pharmacotherapy in the treatment of headache patients. By using OMT, the physician is better able to address the restoration of neuromuscular balance that is upset during headache pain. Pharmacotherapy, although often helpful, many times does not fully address the root cause behind a symptom. When applying OMT, a physician considers and addresses the anatomical components that have generated the condition. More specifically, the use of OMT offers the physician the ability to treat both sympathetic and parasympathetic aspects of migraines. Overall, a physician with a sound background in osteopathic principles should have a better understanding of pathophysiology and anatomical dysfunction. This knowledge can be applied to patient education as well. Thus, a patient can leave a treatment session with a clearer idea of how the symptoms were generated. The other obvious advantage offered by manipulative therapy is the chance to build a stronger relationship with the patient. By gently and effectively applying OMT to headache sufferers, physicians will build an aspect of trust into their physician-patient relationship. OMT can be used as a means for showing empathic concern for the patient. Lastly, manipulation has the very attractive advantage of being cost effective.

By reviewing the literature, a methodical approach to OMT in headache patients can be synthesized. A sound approach will include aspects of both craniosacral therapy as well as more broad musculoskeletal therapy. The importance of either aspect should not be ignored for the sake of convenience. Particularly in the initial evaluation of a patient, the musculoskeletal system must be thoroughly examined for any distal structural imbalances that could be generating or contributing to the patient's symptoms. After a thorough initial assessment, taken in light of a detailed medical history, the physician should prioritize the importance that each somatic dysfunction has in relation to the generation of headache pain. After prioritization, the physician will select the techniques that will offer the patient the most benefit.

In the literature, several comments were made regarding the efficiency of high velocity, low amplitude techniques versus soft tissue techniques. The results of studies reported that patients given HVLA techniques often had significant initial relief. However, they also reported that the pain would recur a few hours after treatment. Overall, the best treatment results for HVLA were found in tension headache sufferers. The benefit of soft tissue techniques is that they minimize treatment induced joint stress and have a more powerful effect on the fascial distortions causing the headache. All of these things should be considered when the physician is selecting the appropriate treatment techniques. For most patients, a well balanced approach to treatment including treatment of craniosacral and musculoskeletal dysfunctions should be implemented. The treatment of the subject of this case report provides a good example of such an approach. In the treatment plan, one will find a prominent use of the appropriate craniosacral techniques, followed by the use of soft tissue, indirect techniques and also carefully selected HVLA techniques.

Conclusion

Despite the prevalence of headache in the population, the effective treatment of such symptoms may remain elusive for many physicians. Many doctors do not have any idea how to approach headache treatment beyond writing a prescription. The osteopathically-trained physician is at a distinct advantage when treating this malady. Using superior palpatory skills in the evaluation, the osteopathic physician will have special insight into the etiology of headache. This knowledge will lead to more effective treatment, time and again. Osteopathic physicians should seek to remain updated on current theories regarding headache treatment in order to best serve their patients. It is suggested that by the knowledge of osteopathic principles, physicians will succeed in reducing or eliminating headache symptomatology where medical therapy alone may often fail.

References

1. Freitag, Fred D.O., "Osteopathic Manipulative Treatment of Migraine." Osteopathic Annals: 11:6, June 1983; pp. 254-258.

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Hardcore Headaches

Headaches affect millions upon millions of people worldwide. In fact, because migraine and headache disorders generate such a substantial disability burden, the World Health Organization (WHO) has recommended that they be classified amongst major public health disorders.

In it's landmark "Headache Disorders and Public Health" report issued in 2000, the WHO noted that it is essential to raise awareness of headache disorders through an education campaign. Furthermore, such a campaign "must alter complacent perceptions of headache disorders as minor, trivial and undeserving of treatment to realizations that a common, ubiquitous and disabling group of neurobiological disorders are under-recognized, undertreated and commonly mismanaged." The report notes that nearly all migraine sufferers and 60% of those with tension-type headache experience reductions in social activities and work capacity.

The Three Most Common Types of Headaches

Migraine headaches affect about 28 million Americans. Symptoms occur in various combinations that include throbbing pain, sensitivity to light and sound, nausea and visual disturbances. Migraine attacks may be triggered by lack of food or sleep, hormonal irregularities in women, and exposure to light. Anxiety and stress can also be triggers. Migraine is more frequent in women and is a genetic disorder. [2]

Migraine can cause significant disability and annually costs the American taxpayer approximately $13 billion in missed work or reduced productivity. Although it is estimated that one in four households in the U.S. have someone affected by migraines, many employers and insurers do not consider migraines to be a legitimate medical problem. [2]

Cluster headaches are named for their repeated occurrence in clusters. They begin as a pain around one eye that spreads to the side of the face, resulting in excruciating pain. Cluster headaches usually start between the ages of 20 and 40. Unlike migraines, they occur more frequently in men and do not run in families. Clusters can strike several times a day or night for several weeks or months then mysteriously disappear. A their worst, chronic cluster headaches can last continuously for years.[1]

Tension headaches produce mild to moderate pain that feels like pressure is being applied to the head or neck. Ninety percent of all headaches are classified as tension/muscle contraction headaches. However, chronic muscle-contraction headaches can last for weeks, months, and sometimes years, and the pain is steady. Muscle-contraction headaches can sometimes be accompanied by nausea, vomiting, and blurred vision.[3]

1 "Headache: Hope Through Research," National Institute of Neurological Disorders and Stroke (NINDS), <ninds.nih.gov/health_and_medical/pubs/headache_htr.htm>; 2 "Migraine Update", 3 "Pain – Hope Through Research," NINDS.

Headaches in Children

- Headache can be a common problem in children. In fact, the frequency of headache increases as children enter adolescence and encounter stress associated with puberty and secondary school.
- Migraine headaches often begin in childhood or adolescence.
- As many as half of all school children experience some type of headache.
- Childhood headache can be a sign of depression.
- Children with migraine often have nausea and excessive vomiting. Some children have periodic vomiting, but no headaches – the so-called abdominal migraine; these children usually develop headaches when they are older.

"Headache: Hope Through Research," NINDS, <ninds.nih.gov/health_and_medical/pubs/headache_htr.htm>

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2. Hoyt, W. Hadley D.O., Shaffer, Fredric Ph. D., Bard, Dean B. S.E, Benesler, J. S. B. S., "Osteopathic manipulation in the treatment of muscle-contraction headache." Journal AOA: Volume 78, January 1979; pp. 49-52.

3. Stiles, Edward D.O. F.A.A.O., "Osteopathic Evaluation of Headaches." Osteopathic Medicine: October 1976; pp. 49-50.

4. TePoorten, Bernard A. D.O., "Headache: A Manipulative Approach." Osteopathic Annals: March 1976; pp. 118-120.

This article was written in 2000 by Rick Lin during clinical rotation in the Department of OMM at the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine. Dr. Lin has since received his D.O. degree and is currently in residency training at St. Paul Medical Center, Dallas.

The Complete Headache Chart

TYPE	SYMPTOMS	PRECIPITATING FACTORS	TREATMENT	PREVENTION
Hangover	Migraine-like symptoms of throbbing pain and nausea, not localized to one side.	Alcohol, which causes dilation and irritation of the blood vessels of the brain and surrounding tissue.	Liquids (including broth). Consumption of fructose (honey, tomato juice are good sources) to help burn alcohol.	Drink alcohol only in moderation.
Caffeine Withdrawal	Throbbing headache caused by rebound dilation of the blood vessels, occurring multiple days after consumption of large quantities of caffeine.	Caffeine.	In extreme cases, treat by terminating caffeine consumption.	Avoiding excess use of caffeine.
Exertion	Generalized head pain of short duration (minutes to 1 hour) during or following physical exertion (running, jumping, or sexual intercourse), or passive exertion (sneezing, coughing, moving one's bowels, etc.).	10% caused by organic diseases (aneurysms, tumors, or blood-vessel malformation). 90% are related to migraine or cluster headaches.	Cause must be accurately determined. Most commonly treated with aspirin, indomethacin, or propranolol. Extensive testing is necessary to determine the headache cause. Surgery to correct organic disease is occasionally indicated.	Alternative forms of exercise. Avoid jarring exercises.
Post-traumatic	Localized or generalized pain, can mimic migraine or tension-type headache symptoms. Headaches usually occur on daily basis and are frequently resistant to treatment.	Pain can occur after relatively minor traumas. Cause of pain is often difficult to diagnose.	Possible treatment by use of propranolol, anti-inflammatory drugs, or biofeedback.	Standard precautions against trauma.
Hunger	Pain strikes just before mealtime. Caused by muscle tension, low blood sugar, rebound dilation of the blood vessels, oversleeping or missing a meal.	Strenuous dieting or skipping meals.	Regular, nourishing meals containing adequate protein and complex carbohydrates.	Same as treatment.
Temporomandibular Joint (TMJ)	A muscle-contraction type of pain, sometimes accompanied by a painful "clicking" sound on opening the jaw. Infrequent cause of headache.	Caused by malocclusion (poor bite), stress, and jaw clenching.	Relaxation, biofeedback, use of bite plate. In extreme cases, correction of malocclusion.	Same as treatment.
Tic Douloureux	Short, jablike pain in trigger areas found in the face around the mouth or jaw. Frequency and longevity of pain varies. Relatively rare disease of the neural impulses; more common in women after age 55.	Cause unknown. Pain from chewing, cold air, touching face. If under age 55, may result from neurological disease, such as MS.	Anticonvulsants and muscle relaxants. Neurosurgery.	None.
Fever	Generalized head pain that develops with fever. Caused by swelling of the blood vessels of the head.	Caused by infection.	Aspirin, NSAIDs, acetaminophen, antibiotics.	None.
Arthritis	Pain at the back of head or neck. Intensifies on movement. Caused by inflammation of the blood vessels of the head or bony changes in the structures of the neck.	Cause of pain is unknown.	Anti-inflammatory drugs, muscle relaxants.	None.
Eyestrain	Usually frontal, bilateral pain, directly related to eye strain. Rare cause of headache.	Muscle imbalance. Uncorrected vision, astigmatism.	Correction of vision.	Same as treatment.
Temporal Arteritis	A boring, burning, or jabbing pain caused by inflammation of the temporal arteries. Pain, often around ear, on chewing. Weight loss, eyesight problems. Rarely affects people under 50.	Cause is unknown. May be due to immune disorder.	Steroids after diagnosis. Confirmed by biopsy.	None.
Tumor	Pain progressively worsens, projectile vomiting, possible visual disturbances speech or personality changes; problems with equilibrium, gait, or coordination; seizures. Extremely rare condition.	Cause of tumor is usually unknown.	If discovered early, treat with surgery of newer radiological methods.	None.
Tension	Dull, non-throbbing pain, frequently bilateral, associated with tightness of scalp or neck. Degree of severity remains constant.	Emotional stress. Hidden depression.	Rest, aspirin, acetaminophen, ibuprofen, naproxen sodium, combinations of analgesics with caffeine, ice packs, muscle relaxants. Temporary use of stronger prescription analgesics. Antidepressants, biofeedback, psychotherapy.	Avoidance of stress. Use of biofeedback, relaxation techniques or antidepressant medication.
Migraine without Aura	Severe, one-sided throbbing pain, often accompanied by nausea, vomiting, cold hands, sensitivity to sound and light.	Certain foods, birth control pills or menopausal hormones, excessive hunger, changes in altitude, weather, lights, excessive smoking, emotional stress. Hereditary component.	Ice packs, isometheptene mucate, combination products containing caffeine, ergotamine, DHE injectable and nasal spray, 5-HT agonists; analgesics or medications which constrict the blood vessels. For prolonged attacks steroids may be helpful.	Biofeedback, beta-blockers, anti-convulsant (divalproex sodium). Calcium blockers and NSAIDs may prevent or treat.

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TYPE	SYMPTOMS	PRECIPITATING FACTORS	TREATMENT	PREVENTION
Migraine with Aura	Similar to migraine without aura, except warning symptoms develop. May include visual disturbances, numbness in arm or leg. Warning symptoms subside within one-half hour, followed by severe pain.	Same as migraine without aura.	At earliest onset of symptoms, treat using biofeedback, dihydroergotamine or a 5-HT agonist, ergotamine. Once pain begins, treatment is identical to migraine without aura.	Prevent with same techniques as migraine without aura.
Cluster	Excruciating pain in vicinity of eye. Tearing, nose congestion, flushing of face. Pain frequently develops during sleep and may last for several hours. Attacks occur every day for weeks/month, then disappear for up to a year. 90% of cluster patients are male, most ages 20-50.	Alcoholic beverages, excessive smoking.	Oxygen, ergotamine, sumatriptan or intranasal application of local anesthetic agent.	Use of steroids, ergotamine, methysergide, calcium channel blockers and lithium.
Menstrual	Migraine-type pain that occurs shortly before, during, or immediately after menstruation or at mid-cycle (at time of ovulation).	Variances in estrogen levels.	Same treatment as migraine.	Small doses of vasoconstrictors and/or anti-inflammatory drugs before and during menstrual period may prevent headaches. Hysterectomy does not cure menstrual headaches.
Hypertension	Generalized or "hairband" type pain, most severe in the morning. Diminishes throughout day.	Severe hypertension: over 200 systolic and 110 diastolic.	Treat with appropriate blood pressure medication.	To prevent, keep blood pressure under control.
Aneurysm	Symptoms may mimic frequent migraine or cluster headaches, caused by balloon-like weakness or bulge in blood-vessel wall. May rupture (stroke) or allow blood to leak slowly resulting in a sudden, unbearable headache, double vision, rigid neck. Individual rapidly becomes unconscious.	Congenital tendency. Extreme hypertension.	If aneurysm is discovered early, treat with surgery.	To prevent, keep blood pressure under control.
Sinus	Gnawing pain over nasal area, often increasing in severity throughout day. Caused by acute infection, usually with fever, producing blockage of sinus ducts and preventing normal drainage. Sinus headaches are rare. Migraine and cluster headaches are often misdiagnosed as sinus in origin.	Infection, nasal polyps, anatomical deformities, such as a deviated septum, that block the sinus ducts.	Treat with antibiotics, decongestants, surgical drainage if necessary.	None.
Allergies	Generalized headache. Nasal congestion, watery eyes.	Seasonal allergens, such as pollen, molds. Allergies to food are not usually a factor.	Topical, nasal cortisone related sprays or desensitization injections, antihistamine medications.	None.

U.S. Headache Consortium Develops Landmark Evidence-Based "Headache Guidelines"

In 2000, after intense collaboration and study, evidence-based practice parameters for headache for primary care physicians were developed by the U.S. Headache Consortium. Coordinated by the American Academy of Neurology (AAN), consortium participants included the American Osteopathic Association, AAN, American Academy of Family Physicians, American Headache Society, American College of Emergency Physicians, American College of Physicians, American Society of Internal Medicine, and the National Headache Foundation. The goals of the guidelines are to reduce attacks, improve response to medication, and restore patients' ability to function.

Broken into five parts, the guidelines address strategies for: 1) preventing migraine; 2) understanding its causes; 3) patient involvement in a treatment plan; 4) following progress; and 5) measuring success.

The "Headache Guidelines" are available from the AOA Web site at <www.aoa-net.org>.

WHO'S IN THE NEWS?

Patrick Hanford, D.O. and George Smith, D.O. Receive Fellow Awards

The American College of Osteopathic Family Physicians held its annual Conclave of Fellows Awards Banquet on October 24 at the Mariott Hotel and Marina in San Diego, California. Granted fellowship awards were TOMA members Patrick J. Hanford, D.O., and George N. Smith, D.O.

Dr. Hanford, a family physician in Lubbock, Texas, is a member of the TOMA Board of Trustees and chair of the Ethics Committee and is very active in TOMA District 10. He also serves as Treasurer on the Texas Medical Foundation Board of Trustees, is a diplomat of the National Board of Examiners for Osteopathic Physicians and Surgeons, and is a past president of the Texas Society of the American College of Osteopathic Family Physicians. Dr. Hanford is a 1983 graduate of the University of North Texas Health Science Center/Texas College of Osteopathic Medicine, Fort Worth, Texas.

Dr. Smith is a family physician in West, Texas. He serves as a member of the Board of Directors of West Hospital Authority, West EMS and the Texas Medical Directors Association. A member of the TOMA House of Delegates for 17 years, he has chaired two midyear conventions as well as the 2001 annual convention, and is the founder and president of TOMA District 18.

Dr. Smith is a 1974 graduate of the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri.

From the Texas Medical Foundation

William Jones, D.O., a Georgetown family physician, received the Texas Medical Foundation's Philip R. Overton Award. The award is presented to physicians who have provided meritorious service in medical peer review. Dr. Jones has been a member of the TMF Board of Trustees since 1992. Monte Troutman, D.O., of Fort Worth, was re-elected to the TMF Board of Trustees for 2001-04. Jim Czewski, D.O., of Fort Worth, was elected as a new TMF board member. Patrick J. Hanford, D.O., of Lubbock, was elected TMF treasurer.

On December 11th, George Smith, D.O., of West, Texas, jogged through cold and rainy downtown Austin as an official 2002 Olympic Relay Touch-bearer. Dr. Smith was chosen from thousands whose names were submitted as Americans who donate their time and services to their comminuties through volunteer work.

Texas ACOFP and TOMA Welcome Jill Weir as New Texas ACOFP Executive Director

Jill Weir, CAE, has been hired as the Executive Director for the Texas Society of the American College of Osteopathic Family Physicians. She began her new position on October 15, 2001. In addition to working for Texas ACOFP, Jill is the Projects Coordinator for the Texas Osteopathic Medical Association. Currently, both positions are part-time.

Jill has been in the non-profit arena for over 12 years. She began her career with the Odessa Chamber of Commerce, moving to Austin in 1990 to work in its satellite office. In 1994, she began working for the Austin Convention and Visitors Bureau. She was hired in 1997 by the Texas Society of Association Executives (TSAE) as Director of Membership Development and Marketing, and was promoted to Vice President in 1998. Prior to leaving TSAE in December 2000, Jill served as their Interim President and CEO. She began her present duties as TOMA Projects Coordinator in January of 2001.

Jill lives in Austin with her husband, Daren, and their two daughters, Courtney and Amber.

TOMA board member Kenneth Bayles, D.O. (L), accepts the 2001 National Osteopathic Medicine Week Proclamation from Dallas Mayor, Ron Kirk.

Call for Award Nominations

The Distinguished Service Award is presented to an osteopathic physician in recognition of outstanding accomplishments in scientific, professional, osteopathic education, or service to the osteopathic profession in Texas or at the national level. The candidate must be a member of the Texas Osteopathic Medical Association; a longtime member of their district society; and a member of the American Osteopathic Association. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Meritorious Service Award is presented to an individual in recognition of outstanding accomplishments in scientific, philanthropic, or other fields of public service to the osteopathic profession in Texas. The candidate does not have to be an osteopathic physician.

The Community Service Award is presented to an osteopathic physician in recognition of outstanding service to their community through the promotion of and dedication to osteopathic medicine in their practice. The candidate must be a member in good standing of the Texas Osteopathic Medical Association, have provided excellent service to their local, regional, or state community, exceptional care to their patients, and demonstrated a commitment to the principles and philosophy of osteopathic medicine. The candidate should exemplify what the profession perceives to be the "typical" osteopathic physician who cares for patients and is an unsung, local hero. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Public Service Award, TOMA's newest award, may be presented to a maximum of two governmental officials whose works and accomplishments are outstanding in promoting the health care needs of the state of Texas, while recognizing the unique value of the osteopathic philosophy.

The Nomination Process

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available from Paula Yeamans at the TOMA State Office, and include pertinent biographical data about the individual as well as information about the person's accomplishments that make them deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. The nomination form should then be sent to Terry Boucher, the TOMA Executive Director, *no later than March 15, 2002*, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

Upon receipt of the nomination form, the TOMA Awards and Scholarship Committee will conduct a discreet but thorough investigation as to the accuracy of the information. After careful review, the committee chairman may nominate a candidate, if recommended by the committee, presenting necessary information to the Board of Trustees. An affirmative vote by three-fourths of the members of the Board of Trustees will be required to grant any award.

Award recipients will be notified by the Board of Trustees and will be requested to attend TOMA's annual convention, at which time the award will be presented by the TOMA President or Master of Ceremonies during the President' Banquet on Saturday night.

Please note that not more than one of each award will be granted in any one year, except for the Public Service Award. Additionally, these awards are not necessarily annual awards.

The TOMA Board of Trustees is currently accepting nominations for four awards:

Distinguished Service Award

Meritorious Service Award

Outstanding Community Service Award

Public Service Award

These awards represent the highest honor that TOMA can bestow in recognition of outstanding service and contributions to the osteopathic profession in Texas.

Community Hospital Celebrates One-Year Anniversary

Mr. Jimmy Brown (center), President and CEO, and Joseph LaManna, D.O., are joined by physicians and the community in ribbon cutting ceremony to mark one-year anniversary.

Dallas Southwest Medical Center, a 107-bed, not-for-profit hospital in the Oak Cliff Community of Dallas, Texas celebrated its one-year anniversary in October. The Oak Cliff Medical Foundation purchased the hospital from HCA in 2000. The Foundation is comprised of community residents, business people and medical professionals. In conjunction with the purchase, the Foundation hired Mr. Jimmy Brown as the Dallas Southwest's President/CEO. Mr. Brown brought solid credentials and hospital administration skills to the organization from his assignments in both the military and civilian healthcare environments.

In its first year as a stand-alone facility the hospital was able to achieve many outstanding accomplishments, some of which include:

- Securing a $400,000 grant from the Texas Department of Health to add two new operating rooms,
- Becoming a Disproportionate Share Hospital based on its high volume of charity care,
- Completing requirements for Trauma Level IV Emergency Room designation,
- Achieving re-accreditation from the Joint Commission on Accreditation of Healthcare Organization (JCAHO),
- Participating in or initiating extensive outreach to the medically underserved and financially needy patients in the community in which it resides.

The spirit in which the hospital operated its first year was the spirit in which it celebrated its anniversary; a spirit of duty and commitment to its community. The phased event was kicked off with a ribbon cutting ceremony attended by community leaders and concluded with a health fair that drew over 1700 people. The Dallas Southwest Medical Center is located at 2929 S. Hampton Road in Dallas, across from Kiest Park, 214-467-6601.

In Memoriam

William R. Boone, Sr., D.O.

Dr. William Boone, Sr., passed away September 30, 2001. He was 79. Funeral services were held October 6 at Restland Wildwood Chapel.

Dr. Boone was born in Arkansas. After graduation he was honored with a congressional appointment from Senator Joseph T. Robinson to the U.S. Merchant Marine Academy in New York,. He saw action in the Pacific as a Lieutenant Commander in the U.S. Navy. Dr. Boone received the Purple Heart for wounds received during the invasion on Saipan and was among the survivors of Iwo Jima. After service in the Korean War, he completed his D.O. degree in 1959 at the Kansas City College of Osteopathic Medicine, Kansas City, Missouri.

Board certified in family medicine, Dr. Boone had a long and successful career in southeast Dallas. After 37 years of practice, he retired in 1997.

Survivors include his sons, Dr. William R. Boone, Jr. and his wife, Kyoko Nakamizo, Paul Lee Boone, and his daughter, Becky Boone Guinn and her husband, John Guinn; and his grandsons Darryl Robert and William Garrett Guinn.

Marion E. Coy, D.O.

Marion E. Coy, D.O., died November 1 at his home in Joshua at the age of 91. A memorial service was held November 9, in the Atrium at the UNTHSC.

A 1938 graduate of Kirksville College of Osteopathic Medicine, Dr. Coy practiced family medicine and anesthesiology in Jackson, Tenn., for 34 years before moving to Fort Worth in 1972.

Dr. Coy joined TCOM in 1972 as its executive administrative dean and served as its first president while the college changed from a private medical school to a state institution. He led the college through its formative years, overseeing the education and graduation of its first two classes of osteopathic physicians. When TCOM became a state institution and was placed under the governance of the University of North Texas in 1975, he relinquished the presidency to UNT's president, C.C. Nolan. From 1975 until his retirement in 1983, Dr. Coy shared his expertise with student physicians as a professor of osteopathic philosophy, principles, and practice. He also received the school's highest honor, the TCOM Founders Medal, in 1981 and was named its first professor emeritus in 1982.

He was an active TOMA member, receiving a TOMA life membership. He was a former president of the American Osteopathic Association and the American Association of Osteopathic Examiners. He also served on the National Board of Medical Examiners in Osteopathic Medicine and Surgery for 20 years.

Dr. Coy is survived by Martha, his wife of 66 years, daughter Myra Martin, son Phillip Edmond Coy, daughter Rene Ann Sims, five grandchildren, two great-grandchildren. The family requests that memorial donations be made to the TCOM Foundation at the UNT Health Science Center in Fort Worth, Texas.

News from the University of North Texas Health Science Center at Fort Worth

UNT Health Science Center Provost Honored for Contributions to Osteopathic Medical Education

Benjamin L. Cohen, D.O., F.A.C.O.P., provost and senior vice president for health affairs at the University of North Texas Health Science Center, recently received the Dale Dodson Award from the American Association of Colleges of Osteopathic Medicine for his outstanding contributions to osteopathic medical education. The award was presented at a luncheon October 21, 2001, during the American Osteopathic Association's Annual Convention in San Diego, Calif. The luncheon was a joint event between the AACOM's Board of Governors and Council of Deans.

In nominating Dr. Cohen for the Dodson Award, Sandra Featherman, Ph.D., president of the University of New England, said, "Ben's intelligence and commitment to osteopathic medical education are each prodigious. Through his leadership role in encouraging the sharing of valuable information, he has helped the entire profession of osteopathic medical education move forward."

The Dodson Award is named after a former president of the American Osteopathic Association. The Dodson Award recognizes an outstanding leader from one of the osteopathic medical colleges who goes above and beyond the call of duty to advance osteopathic medicine.

Dr. Cohen joined the UNT Health Science Center in 1990 as vice president for academic affairs and dean of the Texas College of Osteopathic Medicine. During the past 11 years, he has played a key role in leading the academic team through the process of changing the status of the Texas College of Osteopathic Medicine from a medical school to an academic health science center. He also worked closely with the institution's leaders and the Higher Education Coordinating Board to add a master of public health degree and a physician assistant degree to the institution's programs.

Dr. Cohen has provided leadership in a number of other critical areas at the institution, including raising academic standards for incoming medical students and facilitating a significant growth in the number of full-time faculty at the institution. He also oversaw the development of the public health program and the School of Public Health.

Dr. Cohen has served as a medical educator since 1966 when he began his tenure as a clinical instructor in the Department of Pediatrics at the Des Moines College of Osteopathic Medicine. He has since held clinical teaching positions at the Kirksville College of Osteopathic Medicine, the Ohio State University College of Medicine and the Ohio University College of Osteopathic Medicine. He also served as a professor of pediatrics at the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine and as the Dean of that school from 1977 to 1985.

Dr. Cohen has been active in many leadership positions throughout the osteopathic profession and has served in leadership positions many times at AACOM, the most recent being as the Chair of the Council of Deans from 1998 to 2001.

UNTHSC Named Home to New Osteopathic Research Center

Dr. Scott T. Stoll, chair of the department of Osteopathic Manipulative Medicine at the Health Sciense Center, supervises a student doctor during an OMM class.

The University of North Texas Health Science Center will be the primary site for the new Osteopathic Research Center (ORC), a joint project of the American Association of Colleges of Osteopathic Medicine (AACOM), the American Osteopathic Foundation (AOF) and the American Osteopathic Association (AOA). The health science center learned of the decision at the annual AOA convention October 21-24 in San Diego.

"The UNT Health Science Center excelled in all aspects of the selection process, and they have faculty, facility, and financial resources available to support the ORC," says John B. Crosby, JD, AOA and AOF executive director. The health science center will receive approximately $1.1 million over four years to fund research projects.

Through the ORC, the health science center will collaborate with other colleges of osteopathic medicine to investigate the clinical efficacy of osteopathic manipulative medicine (OMM). Research prototypes planned include a study of OMM in moderately severe osteoarthritis as well as the effect of OMM on outcomes of pregnancy.

Scott T. Stoll, D.O., Ph.D., chair of the department of Osteopathic Manipulative Medicine and director of the Physical Medicine Institute, will direct the ORC.

Osteopathic research is nothing new to the health science center. The institution first offered pre-doctoral fellowships in OMM in the 1970s. In the early 1990s, the institution began providing additional training to physicians through post-doctoral fellowships in OMM. In 1998, philanthropic contributions allowed the program to expand, doubling the number of pre-doctoral fellows.

continued on next page

Currently, 12 pre-doctoral fellows are receiving training in the fundamentals of OMM research while working toward dual-degrees in medicine, public health, and/or biomedical sciences. Physicians also continue to receive residency training in neuro-muscular skeletal medicine and osteopathic manipulative treatment.

The fellowships are now supported through a $1.35 million grant from the National Center for Complementary and Alternative Medicine (NCCAM), a component of the National Institutes of Health.

"We have a tradition here of developing future leaders and researchers capable of successful and competitive clinical and basic science research in OMM," Stoll says. "The ORC will allow us to expand upon that tradition."

The ORC is another step toward establishing the clinical efficacy of manipulative medicine through scientific research. "The establishment of the Osteopathic Research Center is a milestone in the history of the osteopathic medical profession," said Douglas L. Wood, DO, AACOM president. "The Center will provide us with a unique opportunity to establish osteopathic manipulation as a therapeutic modality based on excellent research."

Other organizations that played an instrumental role in this decision include the American Osteopathic Healthcare Association/Association of Osteopathic Directors of Medical Education, American College of Osteopathic Family Physicians, and the American Academy of Osteopathy.

TEXAS FYI

Texas Attorneys Who Engineered Multibillion-Dollar Settlement Between Texas and Tobacco Companies Donate $8 Million to the University of Texas M.D. Anderson Cancer Center

The money will be placed in M.D. Anderson's newly established President's Excellence Fund, created to support promising and innovative research projects, and will be allotted over 10 years. M.D. Anderson administrators said the money will support research in immunology, cell biology, cancer genetics and the identification of genes that predispose people to some cancers, while the center's President John Mendelsohn said follow-up grants could boost the eventual value of the lawyers' gift to around $40 million.
Houston Chronicle, 11-7-01

Texas Has Delayed and Could Scrap the Expansion of the Texas Health Network

The health care system for poor Texans, which reportedly would have saved taxpayers $18 million over the next two-year budget cycle, is opposed by doctors and hospitals, citing low fees and burdensome paperwork, but is supported by the Texas Medical Association. Texas Health Network already operates in 37 counties and pays providers on a fee-for-service schedule while asking physicians to coordinate and manage a patient's care as an HMO would.
Austin American-Statesman, 10-31-01

Texas Attorney General John Cornyn Asks U.S. Supreme Court to Preserve a Provision of Texas' HMO Reform Law that Allows Patients to Seek an Independent Medical Opinion If Their Insurers Deny a Treatment or Test

A federal appeals court struck down the provision in a June 2000 ruling, while a different federal appeals court upheld the right to an independent review in a similar case in Illinois four months later. The Supreme Court has agreed to hear the Illinois case, with the outcome to determine the fate of the Texas provision. Cornyn said that, in more than 1,300 reviews in Texas since 1997, HMOs have prevailed 42 percent of the time.
Dallas Morning News, 11-11-01

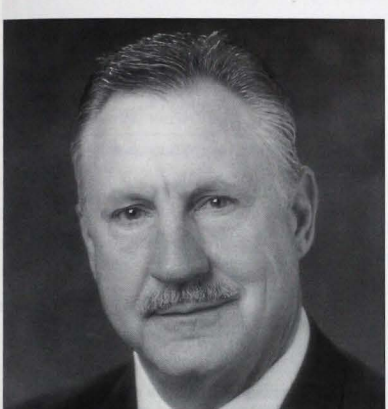
Uninsured Poor Families Will Pay More for Prescription Drugs Under Plan Approved by the University Health System Board of Managers

Beginning in March, co-pays will go up to $5 or $10 for a 30-day supply of drugs, while families earning less than 75 percent of the federal poverty rate still won't be required to pay for prescriptions. University Hospital pharmacists will fill children's prescriptions, even if the parents cannot pay the requested co-pay. The new rates will apply to patients in University Hospital's CareLink, a health care program for indigent residents of Bexar County.
San Antonio Express-News, 11-28-01

Prostate Cancer Expert at the University of Texas M. D. Anderson Cancer Center Named Director of the National Cancer Institute

Dr. Andrew C. von Eschenbach, who was rumored as a candidate for surgeon general last year, is expected to assume the NCI position in early 2002. Von Eschenbach is director of the Center for Genital and Urinary Cancers, special assistant for external affairs and a professor of urology at M.D. Anderson, as well as president-elect of the American Cancer Society.
Houston Chronicle, 12-6-01

Senator Mike Moncrief to Serve as Keynote Speaker at TOMA's 46th MidWinter Conference & Legislative Symposium



Texas State Senator Mike Moncrief will be the featured speaker at the Legislative Luncheon on Saturday, February 9, during TOMA's 46th MidWinter Conference & Legislative Symposium at the Renaissance Dallas North Hotel.

Senator Moncrief, a life-long resident of Fort Worth, is a successful businessman who has been involved in public service for over 25 years. He has represented District 12 in Fort Worth since the 72nd Legislature in 1991, and is currently a member of both the Senate Administration and Criminal Justice Committees.

During the recently concluded 77th Legislature, Senator Moncrief was appointed chair of the Senate Health and Human Services Committee. He was instrumental in the passage of legislation addressing Texas' nursing shortage, increasing access to healthcare through telemedicine and telepharmacy, improving the quality of long-term care and child care, and preventing medical insurance and dental fraud. Other bills by Sen. Moncrief allow businesses to claim a franchise tax credit for wages paid to the disabled, and prescription drug relief to low-income senior citizens and the disabled.

During the 76th Regular Session, he passed several major pieces of legislation including landmark bills relating to the Children's Health Insurance Program (CHIP), and protection of individuals needing home health care or placement in an assisted living facility. He also successfully authored legislation relating to newborn hearing screening, electronic campaign filing, and automobile rear safety belt requirements for children.

Prior to being chosen by the voters of District 12, he served as a Tarrant County Judge. Working with local leaders, he ensured construction of the first Fort Worth/Tarrant County jail, established a Restitution Enforcement Program, passed a bond program to restore the historic Tarrant County Courthouse and established the Tarrant County Mayor's Council and the Conference of Urban Counties. He also served as State Representative in the 62nd Legislature, where he won passage of major drug legislation and was voted "Legislator of the Year" by his fellow members.

Senator Moncrief is the recipient of numerous honors and awards, which include "Legislator of the Year" from the Texas Assisted Living Association; "Legislator of the Year" from the Texas Association of Obstetricians & Gynecologists; Public Service Award from the Texas Speech-Language-Hearing Association; "Pillar of Hope" Award from the Texas Association Against Sexual Assault and Texas Council of Family Violence; Golden Bootie Award from the Children Hospital Association; Governmental Award from the Texas Mental Health Liaison Group; and the Texas Hospital Advocacy Tribute from the Texas Hospital Association.

46th MidWinter Conference & Legislative Symposium
EARLY REGISTRATION FORM

PLEASE PRINT or TYPE

Name:_____

Name for Badge (if different from above):_____

Address:_____

City:_____ State:_____ Zip:_____

Business Phone: (____) _____

Home Phone: (____) _____

FAX: (____) _____

Spouse/Guest Name:_____

D.O. College:_____

Graduation Year:_____ AOA#:_____

Specialty:_____ TOMA District:_____

REGISTRATION FEES

	Postmarked by Jan. 25, 2002	Postmarked after Jan. 25, 2002
TOMA Member	$250 (includes one luncheon ticket)	$325 (includes one luncheon ticket)
Non-Member	$325 (includes one luncheon ticket)	$400 (includes one luncheon ticket)
Students	$0 (lectures only)	$0 (lectures only)

Please include _____ additional tickets for the Legislative Luncheon on Saturday, February 9, 2002 at $30 each.

REGISTRATION TOTALS

Registration Fee(s) $_____
Additional Luncheon Ticket(s) $_____
TOTAL $_____

REGISTRATION PAYMENT

Check enclosed in the amount of $_____

OR

Credit Card Payment in the amount of $_____

Check One:
☐ VISA ☐ MasterCard ☐ AmExpress

Credit Card #_____

Expiration Date_____

Name on Card:_____

Signature:_____

REFUND POLICY

- **Refund requests postmarked on or before January 25, 2002 will receive a refund less 25% administration fee.**
- **All refund requests MUST be made in writing.**
- **No refund will be given after January 25, 2002.**

Return completed form, *with payment in full,* to:
TOMA
Attention: MidWinter 2002 Registration
1415 Lavaca Street
Austin, Texas 78701-1634

Fax *ONLY* if paying by credit card
512-708-1415

Hotel Information

TOMA's 46th MidWinter Conference & Legislative Symposium will be held at the Renaissance Dallas North Hotel in Dallas, Texas, 4099 Valley View Lane (LBJ Freeway & Midway Road).

Please call the hotel directly to make reservations at 972-385-9000. **Reservations must be made no later than JANUARY 17, 2002** to receive the discounted group rate of $109 per night– single/double/triple.

Be sure to ask for the "Texas Osteopathic Medical Association Conference Room Rate" to receive the discounted rate.

A CHANGE OF HEART
Practicing Preventive Healthcare

Texas Osteopathic Medical Association
46th MidWinter Conference & Legislative Symposium
FEBRUARY 8 – 10, 2002 PROGRAM SCHEDULE
Joseph M. Perks, D.O., Program Chair • 17.75 Catagory 1-A CME Hours Available

Friday, February 8

8:00am – 5:00pm	Committee Meetings
3:30pm – 7:00pm	Registration Open
3:30pm – 7:00pm	Exhibit Hall Open
5:00pm – 6:00pm	Reception with Exhibitors
6:00pm – 7:00pm	Risk Reduction for Patients with Coronary and Vascular Disease *A. H. O-Yurvati, D.O.*
7:00pm – 9:00pm	OMT for the Cardiovascular System *Russ Gamber, D.O.* *Eric Gish, D.O.*

Saturday, February 9

7:30am – 4:30pm	Registration Open
7:30am – 4:00pm	Exhibit Hall Open
7:30am – 8:30am	Breakfast with Exhibitors
8:30am – 9:30am	Challenge of Treating Tobacco Dependence: Translating Research into Practice *Tres Radford, M.D.*
Sponsored by:	M.D. Anderson Cancer Center Tobacco Outreach Education Program
9:30am – 10:30am	Management of Migraine Headaches in the Primary Care Practice *Frederick G. Freitag, D.O.*
Sponsored by:	Pharmacia
10:30am – 11:00am	Break with Exhibitors

Saturday continued

11:00am – 12:00pm	Treating Diabetes – New Insulin Medications *Royce Keilers, D.O.*
Sponsored by:	Aventis Pharmaceuticals
12:00pm – 1:30pm	Legislative Luncheon *Senator Mike Moncrief*
1:30pm – 2:30pm	Primary Prevention – National Cholesterol Education Program *Michael Clearfield, D.O.*
Sponsored by:	Pfizer
2:30pm – 3:30pm	Ace Inhibitor Risk Reduction – The HOPE Study *Charles A. Reasner, II, M.D.*
Sponsored by:	Wyeth-Ayerst
3:30pm – 4:00pm	Break with Exhibitors
4:00pm – 5:00pm	Medical Ethics *Monte Mitchell, D.O.*

This course designated by the Texas Osteopathic Medical Association for one (1) hour of education in medical ethics and/or professional responsibility.

5:00pm – 6:00pm	Obesity and Nutrition Speaker – TBA
Sponsored by:	Roche Pharmaceuticals

Sunday, February 10

8:00am – 1:00pm	Risk Management Program – HIPAA: Practical Steps for Physician Compliance *Barbara Odom-Wesley, Ph.D., RRA*
	"Don't Make Me Sue You" *Jane Mueller*
Sponsored by:	TMLT Dean, Jacobson Financial Services, LLC

This course designated by the Texas Osteopathic Medical Association for one (1) hour of education in medical ethics and/or professional responsibility.

??? QUESTIONS??? Contact Jill Weir, CAE, TOMA Projects Coordinator
512-708-8662 or 800-444-8662

Self's Tips & Tidings

By Don Self

Quick Pay Discounts

There is no rule anywhere that says you have to charge all patients the same. Have you noticed the senior citizen discounts at the movies, early bird dinners, etc.? Yes, you can give discounts but you must be careful not to discriminate. For instance, a "cash" discount would discriminate against insurance companies. A "quick pay" discount does not, because it extends to everyone that will pay in full on the day of service. I have never seen an insurance carrier that allows us to fax them a claim and they, in turn, wire transfer the money to our bank account the same day. So, when telling a patient that we will give them a discount, say "We will give you a quick pay discount for payment in FULL today or on the date of service." If you have to wait on insurance, the quick-pay discount does not apply.

How much of a discount should you offer to the patient? I've seen it range from as little as 15% to as much as 25%. The actual percentage you give is up to you.

Nursing Home Progress Notes

Recently, I received a letter from an osteopathic family physician in Oklahoma, stating that he was being audited on some of his nursing home visits and he had requested the records from the nursing home to show the visits. He emphasized that he needed these records to prove that he had, in fact, seen the patients. His problem was that the nursing home, misguided as they were, believed they could not release the copies of the patient charts to him, even though they had received a demand letter from CMS (formerly called HCFA). This left him in a completely unnecessary bind. This was unnecessary because he should have had a copy of every progress note in his own office, for every visit he had made. Leaving the responsibility for maintaining the charts and progress notes to the nursing home (or hospital, for that matter) is highly dangerous. If the nursing home (or hospital) does not safeguard this information, you (the physician) can be left out on the end of a limb with CMS (or any other auditor) holding a chain saw. If you're not going to keep every progress note in your office, at least get copies for your own protection. The burden of proof in an audit is on you – not the nursing home.

Charging Different Fees

There are some who believe it is illegal to charge different fees for the same procedure, based on the type of insurance or method of payment. That is not true, regardless of how many times it has been repeated.

There are all kinds of businesses that charge differently for the same product. As an example, when you go to the theater to see a movie, they have one price for children under 12 and a different price for those over 65 – yet both take up a seat. The pricing on airplanes is also different, even though you may be in a seat identical to the person next to you. Hotels have different prices for the same rooms, yet we believe physicians are limited? Some people seem to think that a person's income level should also dictate how much the patient is charged and they like to make it sound like it's a moral issue here since healthcare is a necessity. You don't see that in grocery stores and eating is a necessity. I've been in enough stores to know that everyone pays the same for the can of Del Monte green beans, regardless if they make $125,000 a year or $20,000 a year. So – while we generally recommend you have one fee schedule for everyone to make it easier on your staff – remember – there is no regulation or law that says you have to.

A mechanic was removing a cylinder head from the motor of a Harley, when he spotted a world-famous heart surgeon in his shop. The heart surgeon was waiting for the service manager to come take a look at his bike. The mechanic shouted across the garage, "Hey, Doc, can I ask you a question?" The famous surgeon, a bit surprised, walked over to the mechanic working on the motorcycle. The mechanic straightened up, wiped his hands on a rag and asked, "So, Doc, look at this engine. I also can open hearts, take valves out, fix'em, put in new parts and when I finish this will work just like a new one. So how come I get a pittance and you get the really big money, when you and I are doing basically the same work?" The surgeon paused, smiled and leaned over, and whispered to the mechanic, "Try doing it with the engine running!"

Pre-Op Care In 2002

In years past, by following the CPT guidelines published by the AMA, a physician was allowed to bill for and collect for hospital admits the day prior to a major procedure or even the day of a procedure. The CPT definition of "surgical package services" or "global fees" did not include the normal pre-op associated with a surgery. That "loophole" has been closed in the 2002 edition (but you can still continue the old way till January 1st).

Here is the new language:

"The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/-metatarsal/digital block or topical anesthesia;
- Subsequent to the decision for surgery, one E/M encounter on the

date immediately prior to or on the date of procedure (including history and physical);

- Immediate post-operative care, including dictating operative notes, talking with the family and other physicians;
- Evaluating the patient in the post-anesthesia recovery area;
- Typical postoperative follow-up care."

This is much more similar to Medicare's Global Surgery Package than they have been in the past.

Lesions & Repairs

A common misconception is that multiple lesion excisions should be added together and reported as a single excision. Adding together the lengths and reporting the total as a single item refers to the repair (closure) codes: "if multiple wounds are repaired within the same classification, the sum of the lengths is added together and reported as a single item".

If two benign skin lesions are removed using a single excision, then only one excision of lesion code would be reported. As only one excision was performed, it would not be appropriate to report two separate excision codes. The excision of lesion code should accurately reflect the maximum diameter of the two lesions that were excised.

Billing for Suture Removal

Imagine that one of your patients shows up in your office to have sutures removed that were put in at the hospital ER. How you bill or whether you bill depends on one thing: Did you put the sutures in? If so, then the repair code you used when you placed them covers the removal. If you did not suture the patient, then you should charge for an office visit only. Yes, there is a complicated way to bill for the repair code with a 55 modifier to denote post-operative services, but that's a pain and usually causes more work than it's worth. You can also send the patient back to the ER to have them removed, which you may want to do in the case of some patients whom you would rather not see.

Being Non-Par With Medicare Doesn't Protect You

Occasionally, I'll receive an e-mail from a doctor saying that he/she is non-participating with Medicare, so therefore they are exempt from all Medicare rules, regulations and laws. There is nothing further from the truth. In fact, non-par physicians have just as many rules concerning them. A non-par physician is still subject to the rules placed upon them by the Congress of the United States. Included in those are restrictions on how much they may charge, when they HAVE to accept assignment, how much they can collect from the patient, etc. So – if you do not accept assignment on Medicare claims – you are considered to be a non-par physician and you should check into the regulations for which you are responsible.

Patient Signatures ... A Very Good Idea

I now recommend that you have every patient sign the superbill at every encounter. Yes, this will take an extra 20 seconds, but it provides you with a measure of protection that proves without any doubt that the patient was present.

Don Self, CSS, BFMA
DON SELF & ASSOC., INC.
305 Senter Avenue
Whitehouse, TX 75791
903-839-7045
FAX: 903 839-7069
donself@donself.com
www.donself.com

HHS Announces Medicare Premium and Deductible Rates for 2002

On October 19, 2001, the Department of Health and Human Services (HHS) announced legally mandated increases in the Medicare premium, deductible and coinsurance amounts to be paid by beneficiaries in 2002.

For Medicare Part A, which pays for hospital, skilled nursing, hospice care and some home health care, the beneficiary deductible will increase to $812, up 2.5 percent from $792 in 2001. The premium for Medicare Part B, which helps pay for physician services, ambulatory care and other services, will rise to $54 per month, up 8 percent from $50 per month in 2001.

The Medicare statute requires that the deductibles and premium be updated annually in accordance with statutory formulas. Medicare law sets the Part B premium at the amount needed to cover 25 percent of estimated program costs for aged enrollees; general revenue tax dollars cover the other 75 percent of the costs. The Part A deductible applies only to those enrolled in the original fee-for-service Medicare program. Beneficiaries who choose to enroll in private Medicare+Choice plans may not be affected by the Part A increase, and may receive additional benefits with different cost-sharing arrangements.

TRICARE News and Related Military Issues

Vaccine Safety

by Sgt. 1st Class Kathleen T. Rhem, USA
American Forces Press Service

Military allergy and immunization specialists have worked hard to educate healthcare providers on vaccine safety. But in light of rising bioterrorism concerns, they've ratcheted up their efforts.

Army Dr. (Col.) Renata Engler is the medical director of the Vaccine Healthcare Center Network, which recently opened its first center here at Walter Reed Army Medical Center. She explained that vaccines are tools to protect DoD's members, but they also need to be afforded the same care, respect and safety precautions given other prescription medicines.

DoD and the Centers for Disease Control and Prevention in Atlanta became partners this summer to provide a network of clearinghouses for information on vaccine safety and procedures throughout DoD.

The new initiative was in response to "the growing challenges that have arisen in the context of immunization healthcare," Engler said, particularly concerning the public controversies surrounding immunization safety in general as well as the DoD Anthrax Vaccine Immunization Program specifically.

"Knowledgeable resources had to be developed to support the providers and the small outlying immunization clinics who are dealing with the challenges and to support special, complex patient issues that local medical facilities might not be resourced to handle," she said.

Engler said her work has come into a whole new light in the aftermath of Sept.ember11 – the contamination of the mail with anthrax has made the threat of bioterrorism clear to Americans.

She said her organization has been involved in developing plans for possible new or changing vaccination programs for service members.

Any possible use of smallpox vaccine is of particular concern, since America's stockpiles of vaccine for this deadly, disfiguring disease are old and were made with outdated technology, experts have said. Engler and her staff are consulting with various agencies to work up contingency plans in case experts decide there's a need to vaccinate Department of Defense as well as emergency response personnel against smallpox, she said.

"There are some concerns about adverse events related to that vaccine," Engler said. "We've gotten busier faster than we wanted to in response to new bioterrorism threats that are arising." But this is why the organization was created in the first place.

"The Vaccine Healthcare Center is really a resource to address the need for outreach education in this rapidly changing world of immunization challenges," Engler said. "We need to do everything we can to give the right shot to the right person at the right time in the right way."

She said service members 20 years ago received "a handful" of vaccines, but now routinely take more than 50 shots during their careers. And another 30 vaccines are at various stages of the developmental pipeline and may be introduced into the immunization requirements over the next five years.

Adverse reactions and drug reactions occur in 1 percent to 2 percent of people with any drug, Engler said. That small percentage, she noted, can mean big problems in a large enough population.

"That's 20,000 to 40,000 people in a population of 2 million," she said. "Improving our understanding of rare adverse events would enhance vaccine safety surveillance and lead to higher quality immunization healthcare delivery overall."

The Vaccine Healthcare Center Initiative began in September and is scheduled to expand to include several regional centers in the future. Several more are set to open in regional DoD medical centers in the United States in 2002, leading up to a total of 15 regional centers by 2006, Engler said.

"These vaccine healthcare centers would work as a network to share information, not just internally but with the Food and Drug Administration, CDC, and the Vaccine Adverse Event Reporting System, too, as questions arise surrounding a vaccine," she said.

Opportunities Unlimited

PHYSICIANS WANTED

DYNAMIC, CARING, THOUGHTFUL, ENERGETIC are words that could be used to describe you. Wanted: Family Practice D.O. that enjoys working with Patients, Pain, WC. No Medicare and very little Medicaid. Present practice has enough patients to need an additional Doctor plus we are in the process of building a new building. We welcome the right D.O. full time, part time, or a flexible schedule. This situation is a win-win for the right D.O. who enjoys their work and pay. Please call 915-938-5478 and leave a message at the ranch. (05)

DALLAS – Physician needed at walk-in GP clinic. Flexible hours or part-time. 214-330-7777. (11)

WE ARE LOOKING FOR A BOARD CERTIFIED PHYSICIAN IN FAMILY OR INTERNAL MEDICINE to join our group in El Paso, Texas. Applicants with H-1 Visa welcome. Please contact Lillian Rodriguez at <Lilly1610@prodigy.net>, 915-591-2704, or FAX CV to 915-598-3946. (14)

OSTEOPATHIC DOCTORS NEEDED FOR SMALL TEXAS COMMUNITIES, for clinic work and emergency room, either full- or part-time. For more information call Jerry or Sean at 800-460-8159 or FAX CV to 800-666-1377. (16)

DALLAS/FORT WORTH – Physician opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call and no emergencies. Please call Lisa Gross at 888-525-4642 or 972-255-5533 or FAX CV to 214-441-2813. (25)

POSITIONS WANTED

BOARD CERTIFIED FAMILY PHYSI-CIAN WITH 20 YEARS PRACTICE & TEACHING, skilled in OMT, good surgical skills, broad knowledge of herbs, public speaking, graduate in counseling. Seeks position in consultation, administration or teaching & patient contacts in or near Metroplex. Please contact Randall Hayes, D.O., at 817-535-1585. (10)

BOARD CERTIFIED FP for outpatient full time, part time or locum tenens, prefer 60 miles radius of Dallas/Fort Worth area. $65.00 per hour. Excellent references will be furnished. Call Eric M. Concors, D.O., at 214-365-9013. Leave message. (13)

PRACTICE FOR SALE/RENT

CHECK OUT THIS GREAT OPPOR-TUNITY: Moderate to large broadbase family practice for sale, Fort Worth suburban area, 20 years. Available for immediate take over. Patient base OMT, Pediatric & Senior Care. No Medicaid. Please contact Dr. Hayes at 817-535-1585. (04)

FOR SALE – FAMILY PRACTICE, Austin, Texas. Net $200,000/no hospital. Will finance. Will work with new associate/owner during transition period. Contact TOMA at 800-444-8662. (09)

"SWEET EQUITY" PRACTICE STARTUP south of DFW. Salary, benefits, small town, home town environment. New building. Call Dr. Rod Phelps, 866-476-3639. (15)

FOR SALE – Family Practice, Dallas, Texas. No hospital. Will work with new owner during transition period. Established practice 40 years-plus. Call TOMA 800-444-8662. (23)

MISCELLANEOUS

VIDEO PATH WELCH ALLYN VIX-10 COLONSCOPE with foot pedal and video screen. Approximately one-year-old unit with little use. Paid $20,000, asking $10,000; might trade for exam tables, phone system with 10 lines or X-ray. Call 915-646-1195, Charlie or Lawrence. (01)

CREATE A SUBSTANTIAL INCOME with our simple wellness and preventive health care business. Call 1-888-253-4360 for recorded information or visit www.MyRexallBiz.com. (06)

FOR SALE – ANTIQUE OSTEO-PATHIC TREATMENT TABLE, good condition, $4,000 or best offer; antique electric spinolator table, fair-good condition, $4,000 or best offer. 903-583-8328, for pictures e-mail:<mkassio@hotmail.com>. (12)

FOR SALE – Two McManus tables, excellent condition. Metroplex area. Contact Cheryl Bean at 817-731-0801. (30)

CLASSIFIED ADVERTISING RATES & INFORMATION

Call Trisha at the TOMA Offices • 512-708-8662 or 800-444-8662

2002 UPDATE
FOR YOUR INFORMATION

IMPORTANT NUMBERS

American Osteopathic Association	800-621-1773 or 312-202-8000
Washington Office	800-962-9008 or 202-414-0140
American Osteopathic Healthcare Association	301-968-2642
Dean, Jacobson Financial Services, LLC – Malpractice, Disability and other insurance programs	800-321-0246
Medicare Provider Services (Trail Blazer Health Enterprises)	Toll Free 877-392-9865
Medicaid-NHIC	512-514-3038
Texas Medical Foundation	512-329-6610
Toll Free	800-725-9216
TRICARE-General inquiry	800-406-2833
Texas Osteopathic Medical Association	800-444-8662 or 512-708-8662
TOMA Physician Health and Rehabilitation Program-Jeff McDonald, J.D.	800-896-0680
TOMA Med-Search	800-687-5302
UNTHSC-Texas College of Osteopathic Medicine	817-735-2000
Dallas Metro	817-429-9120

TEXAS STATE AGENCIES

Texas Department of	
Health	512-458-7111
Insurance	512-463-6464
HMO Complaints	800-252-3439
Protective and Regulatory Services	512-438-4800
Public Safety	
Controlled Substance Division	512-424-2188
Triplicate Prescription Section	512-424-2189
Texas Health and Human Services Commission	512-424-6603
Texas Hospital Association	800-252-9403
Texas Poison Control Center Network	800-764-7661
Texas State Board of Medical Examiners	512-305-7010
FAX	512-305-7006
Verification	512-305-7030
Permits	512-305-7020
Formal Complaints	800-201-9353
Consumer Disciplinary Hotline	800-201-9353
Texas State Board of Pharmacy	512-305-8000
Texas Workers Compensation Commission	512-448-7900
Medical Review Division	512-707-5852

FEDERAL AGENCIES

Drug Enforcement Administration	
Registration Office (DEA number)	214-366-6982
For state narcotics number	512-424-2000 ext. 2150
Diversion policy and related questions	214-640-0849

CANCER INFORMATION

Cancer Information Services	800-422-6237

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