P1346

A COMPARATIVE STUDY WITH TRIGGER POINT DRY NEEDLING UNDER ULTRASOUND GUIDANCE AND BLIND TECHNIQUE. A NEW APPROACH FOR MYOFASCIAL PAIN SYNDROME MANAGEMENT

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Background: Most pain syndromes in clinical practice have myofascial nature, caused by the myofascial trigger points (MTrP) formation. We use dry needling of muscle trigger point under ultrasound guidance for MTrP inactivation.

Materials and methods: The study included two groups with myofascial pain at different locations. 133 patients were randomly assigned to either dry needle trigger point therapy under ultrasound guidance (91 patients) or to dry needle trigger point therapy using clinical (palpatory) established landmarks (42 patients). Ultrasound scanning with a linear transducer 5-10MHz frequency using sonoelastography was carried out to identify the myofascial trigger point. In first group after the visual identification of trigger point, dry needling using acupuncture needles (28gage) was inserted to elicit the LTR effect. Visual analogue scale data (0 to 10) were measured before, immediately after and 24 hours after the intervention. The

Results: The pain relief effect (more than 50% of VAS decrease) was registered in all patients of two groups. In the study the trigger point dry needling of muscle trigger point under ultrasound control was performed.

Conclusion: Ultrasound guidance significantly increases the pain relief effect, increases level of eliciting LTR (local twitch response), significantly decreases average number of needled trigger points and average number of treatment sessions. There were registered significant correlations between eliciting LTR during needling and the pain relief effect. Using sonoelastography increases the level of trigger point detection but in this study it is not statistically significant.

P1347

UTILITY OF LEVADEX™ WHEN EARLY INTERVENTION IS IMPRACTICAL

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Background: Well-controlled studies have demonstrated substantial reductions in triptan efficacy with delayed migraine treatment, and surveys have revealed some patients reluctance to treat migraines early, leading to treatment failure and dissatisfaction.

Methods: This post-hoc analysis of a randomized, double-blind, placebo-controlled phase 3 study compared 2-hour pain-relief (PR) and pain-free (PF) rates among patients treating migraine within 1 hour, 1-4 hours, 4-8 hours, or >8 hours of its start.

Results: Of 903 patients randomized, 771 treating a single attack were included in the efficacy analysis. Two-hour PF and PF rates were: 66% and 38% (inhaled DHE) and 41% and 13% (placebo) when treated within 1 hour of migraine start; 60% and 28% (inhaled DHE) and 35% and 10% (placebo) when treated within 1-4 hours; 53% and 22% (inhaled DHE) and 30% and 8% (placebo) when treated within 4-8 hours; and 49% and 19% (inhaled DHE) and 24% and 9% (placebo) when treated >8 hours after start.

Conclusions: This analysis demonstrates the efficacy of orally inhaled DHE in moderate/severe acute migraine, even when administered >8 hours after migraine start. Inhaled DHE may help many migraineurs who are unable to treat migraine early.