DEBATE: THE USE OF PLACEBO IS ESSENTIAL IN HEADACHE TRIALS: NO (AT LEAST AS PRESENTLY APPLIED)

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Two somewhat separate questions are posed for this session—"essential" and "very important". Actually, it may be more accurate to state that 4 questions need consideration during this debate, as responses need to vary as a function of acute versus prophylactic applications of medication.

Double blind, placebo controlled trials are considered the gold standard in medicine. Many definitions of standard exist; but, for the sake of argument, let us consider the following: "A set of specifications that are adopted within an industry to allow compatibility between products". Placebo rates are notoriously variable, particularly so for acute trials, and can be influenced by a host of factors (e.g. instructional set, packaging, mode of delivery, prescribing agent, treatment setting, etc.). Further, when asked about condition assignment (which is rarely done), both patients and providers can often detect which drug is "real" and which is placebo. This occurs in part because the side effects from an active drug are quite different from the side effects of a placebo and patients/providers notice this. One approach to help ensure blinding is to include "active" placebos in randomized controlled trials. An "active" placebo is one that produces side effects similar to the drug under investigation, but lacks the ingredient assumed to produce the desired clinical effect. Until we come close to establishing standards and methods to enhance the likelihood of obtaining somewhat similar placebo effects, I concede to my debate partner that placebo trials will remain important, but not always essential, at least as regards evaluations of acute medications for aborting headache.

Turning to trials examining prophylaxis, the answers to both questions become much closer to being "no", at least with respect to our existing tried and true medications. As new approaches are pursued, some will need to incorporate placebo comparisons, but the trials should soon shift to examining the incremental utility of new treatments versus established treatments.

The talk closes with a number of additional considerations and suggestions for future research endeavors on this topic. These include efforts to *maximize* the placebo effect (not minimize it), study of ways to match patients to treatments, and markedly limit placebo comparisons for more severe forms of headache, such as cluster.