INFORMATION SHEETS FOR CLINICIANS
Headache Management System for Adults

Medication overuse headache

What should I say to the patient? What should I do?

When does it happen?

In patients with migraine or tension-type headache, regular frequent use of acute treatment can result in exacerbation of the pre-existing primary headache (medication overuse headache (MOH)

Majority of patients improve on withdrawal of the overused medication.

All medications used to treat an acute headache can result in MOH.

Triptans, opioids and combination analgesics are likely to result in development of MOH more rapidly (ie when taken on 10 days or more per month) as compared to simple analgesics such as paracetamol (ie when taken on 15 days or more per month)

MOH occurs primarily in individuals with migraine or tension type headache and is generally of the same phenotype.

Overuse of triptans has been shown to cause MOH faster and with fewer doses compared with analgesics. One study suggested the average interval between the first intake and daily MOH was 1.7 years for triptans, 2.7 years for ergots and 4.8 years for analgesics.

What should I do?

Specifically ask about usage of both prescription medications and of treatments taken over the counter.

Specifically ask how many days in a month the patient takes medication for treating the acute headache and preferably correlate this with a headache diary.

Be aware that in patients with a history of migraine or tension type headaches pain killer medication taken regularly for non-headache pain, such as joint or back pain, can result in medication overuse headaches.

Be aware that the association between analgesic overuse and chronic pain is strongest for chronic migraine (odds ratio of 10.3).

Be aware that the prevalence of comorbid psychiatric disorders, including depression and anxiety, is greatly increased in patients with MOH.

Be aware that in patients with MOH with pre-existing episodic tension type headache 67.7% have comorbid psychiatric disorders while in those with pre-existing migraine these were present in 53.7%.

Be aware that depression and anxiety themselves also be risk factor for MOH.

Be aware that migraine is comorbid with depression and anxiety and these may be risk factors for developing MOH.

Be aware that dependence related behaviour is noted in up to 60–70% patients suffering from MOH and relapses are common

Managing and avoiding MOH

An important aspect in the management of MOH is to increase awareness of the condition amongst health care providers as well as the general population.

Patients must be advised that restricting their acute headache medications to no more than 2 days in a week minimises the potential of developing MOH.

Educational intervention is crucial and results in improvement in headache.

Comparison of advice alone with a structured detoxification program in patients with MOH suggests that are similarly effective.

The use of rescue medications, including steroids, does not improve outcomes.

Patients should be encouraged to seek preventive treatments for migraine as this can prevent the conversion from episodic to chronic migraine thereby reducing the risk of development of MOH.