

Headache Toolbox

Chronic Migraine: Medication Overuse Headache

Please note: this advice also applies to other headaches, not just migraines

The diagnosis of *chronic migraine* implies that a patient has a history of migraine headaches and that he/she now is experiencing headache at least 15 days out of the month. Chronic migraine is common, afflicting about 1 in 50 citizens. Effective management of chronic migraine involves prescription of a daily preventive medicine intended to decrease headache frequency; aggressive acute treatment of such headaches that occur despite the preventative medication and, last but not least, identification and treatment of any conditions that may be contributing to the chronic headaches. The conditions that most commonly aggravate chronic migraine are impaired sleep, a disorder of mood (typically depression, anxiety, or both), hormonal influences (pregnancy, recent childbirth, oral contraceptive use), and *analgesic overuse*.

An *analgesic* is any medication intended for the relief of pain, whether it be humble acetaminophen (Tylenol) or a potent opioid (“narcotic”). Patients with chronic headache understandably tend to take analgesics frequently in an effort to reduce their pain and so enable themselves to carry out their routine activities. Unfortunately, virtually all of the medications—prescription or over-the-counter (OTC)—widely taken by migraineurs for the treatment of acute headache can *promote* headache when used too often over a period of weeks to months; some of the most common culprits are acetaminophen (eg, Tylenol), compounds containing acetaminophen plus caffeine (eg, Excedrin, Goodys, BC powders), butalbital-containing compounds (eg, Esgic, Fioricet, Fiorinal), and hydrocodone (eg, Lorcet, Lortab, Vicodin). Even the triptans (eg, sumatriptan: Imitrex) may cause medication overuse headache (MOH).

In seeking to avoid MOH, how much is too much? In other words, how long can one take a given analgesic at a given frequency and in a given dose before MOH becomes a real possibility? Put yet another way, how does the patient with chronic migraine know whether the analgesic he/she frequently takes is helping or contributing to the very problem (headache) that provoked its use in the first place? The most realistic answer is: it depends. The potential for developing MOH is likely a function of the individual patient’s unique biology and, perhaps even more important, the particular drug in question. Some investigators have reported that of all the drugs commonly used for acute migraine treatment, it is the triptans that have the highest potential for producing MOH. At the other end of the spectrum, the nonsteroidal anti-inflammatory drugs (NSAIDs) are believed to have the lowest potential for producing this complication. The OTC agents are the “sneakiest” among this group. The fact that they *are* effective therapies when used appropriately and are so readily available and relatively cheap lures many migraineurs into steadily increasing their use of a given product, so becoming hopelessly stuck in the desolate swamp of MOH.

How do you know if you may have a component of MOH? The following checklist may help.

1. Are you using a given analgesic more than 3 days per week on a chronic basis (ie, every week for a period of weeks to months)?
2. On the days you use the analgesic, are you taking multiple doses?
3. Have you found that effectiveness of the analgesic seems to be steadily decreasing even

though you have been increasing your usage of the drug?

4. Are you being awakened from sleep by headache, or do you have a headache when you awaken in the mornings?

If your chronic migraine does contain a component of MOH, cutting back on your use of the offending agent unfortunately may not lead to rapid improvement. Weeks—possibly months—may be required for your body to recover biologically from the effects of the medication overuse, and the clinical improvement accompanying that recovery similarly may be delayed. Even so, *stick with it!* Once established, it may well be that MOH must be removed from the picture if you are to enjoy any significant and lasting improvement in your headache disorder.

In summary, your strategy for defeating chronic migraine typically should include the following:

1. Prescription of an effective preventative medicine
2. Aggressive treatment of acute headaches or headache intensifications
3. Treatment of chronically disrupted sleep, if that problem exists

4. Effective treatment of co-existing anxiety and/or depression, if present
5. Avoidance of analgesic overuse
6. Treatment of analgesic overuse, if present
7. Faithful use of a simple headache diary

Finally, if you find it impossible to cut back on your use of a medication that is likely to be contributing to your chronic migraine, do not be hesitant to discuss this with your physician. Nothing is to be gained by keeping the information to yourself, and to do so risks the strong possibility that your chronic migraine will worsen progressively and possibly become yet more resistant to any treatment attempted. There are various techniques available to assist patients in reducing their use of a given analgesic, and at times hospitalization may be required to facilitate that process. In attempting to control your chronic migraine, your physician is your consultant, adviser, and advocate. . .not your adversary. Working *together*, chances are good that you will enjoy a significant reduction in your headache burden.

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