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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Medication Overuse Headache

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Silberstein:
This is Dr. Stephen Silberstein, the Director of the Jefferson Headache Center, talking about medication overuse headache.

Medication overuse is not addiction. It's motivated by a desire to relieve pain and to function. Suffering patients will deviate from drug limits to find release. The important difference is the following: how often it's used versus how much is used. So if somebody were to take a lot of medicine, one day a month, that's not as important as taking a little bit of medicine every day.

How do we define medication overuse? If the overuse for more than 3 months have more than 1 drug, or 1 drug or more taken for the acute treatment of headache. The risk factor is what for? Increased headache frequency. The more you take, the worse you get. Medication overuse is not the same as medication overuse headache. Medication overuse headache is patients who have medication overuse, who develop a new type or worsening of their pre-existing headache occurring 15 days or more per month.

Let's look at the classification of medication overuse. Ergots, triptans, opioids, or butalbital analgesics taken on a regular basis 10 or more days per month. So if you took it for 1 week in a row, 10 days, that's not the same. Other analgesics like opioids greater than equal to 15 days per month. And let's say you're taking butalbital and triptans and opioids; if you're not taking each of them 10 days a month, but the total is more than 15, all acute drug exposure is greater than 15 days a month. That's it. And triptans are more likely to increase migraine frequency, but not gepants.

Now, this is an interesting slide. Opioids and barbiturates are associated with migraine progression to chronic daily headache. So look at the bottom scale, it's the monthly barbiturate or monthly opioid use, and then there are 3 lines above the monthly headache days at baseline. And as you can see, the greater the number of baseline days, the greater the probability of going to chronic daily headache or chronic migraine. And a change is greater for barbiturates than opioids, so the curve goes up. So this is one thing you need to understand.

The second thing is look at the triptans. Same thing, but nonsteroidals are paradoxical. With low daily headache, if you take a nonsteroidal, it works as a preventative. But if you have 10 to 14 headache days a month, and you start to increase nonsteroidals, your headache frequency goes up. This is a paradox which you need to let your patients know about; a little bit as good, a lot is bad.

Medication overuse is very common. It's estimated that 1% of the population have it in European headache centers and 5 to 10% of patients overuse. The one study was almost 4.5% of 3,000 consecutive patients in U.S. specialty clinics. Majority of the patients we see with chronic daily headache habit, it's estimated in the United States population 30 to 80% of chronic migraine patients overuse acute medicines, and chronic daily headache is 7 times more likely to develop with than without medication overuse.

Remember, preventative medication without withdrawal may be effective. We used to say detox first, treat later; we don't need that. The

full benefit of preventive drugs may take 6 months. The combination preventative medicine may be necessary. Remember, chronic migraine medication overuse are relapsing remitting disorders. Long-term prevention is often necessary. And relapse does not always mean tachyphylaxis; it may mean that if the patient does terrible again, they're taking their acute medicines much too much. Set realistic expectations. Mild daily headache with fewer exacerbations may be all you need, or headache free. And there's some patients who are medically intractable and do not improve, and that's another story. Thank you.

Announcer:
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