Identifying and treating individuals with chronic migraine and Medication Overuse Headache (MOH)

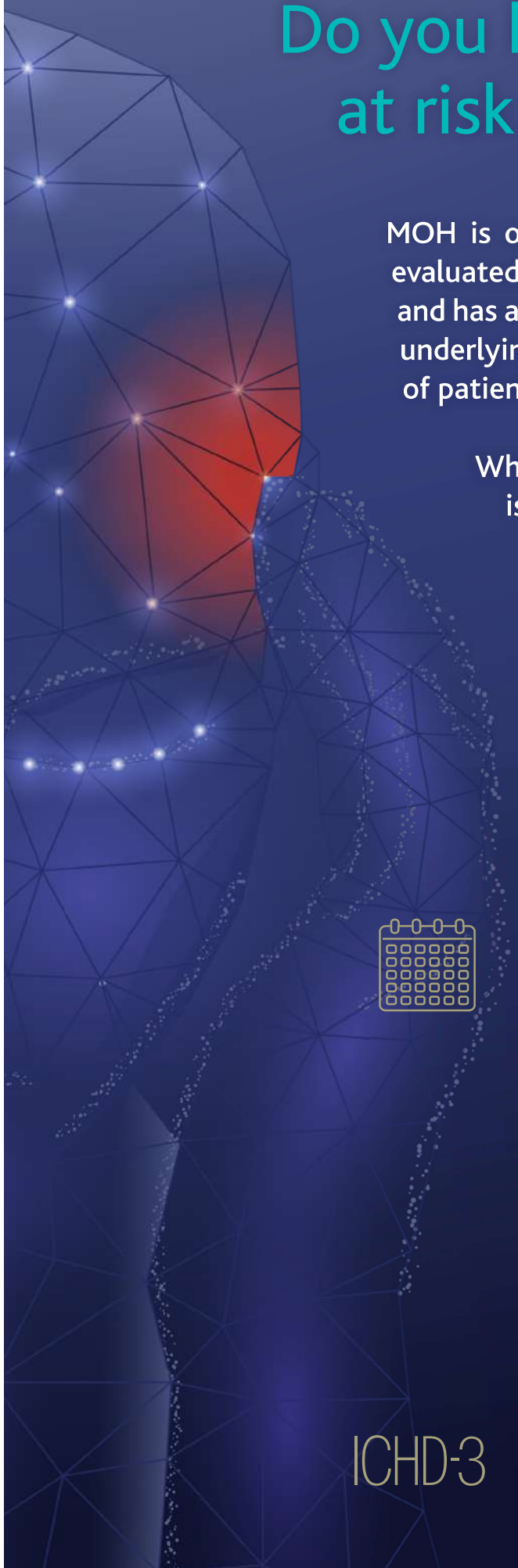
A practical guide

Lundbeck

Do you have patients at risk of MOH?

MOH is one of the most common headache types evaluated in headache clinics or tertiary care centres and has a global prevalence of 1–2%.[1] Migraine is the underlying headache disorder in approximately 80% of patients with MOH.[2]

While MOH can be challenging to manage, it is also extremely rewarding when positive outcomes are achieved for patients.



What is MOH?

Headache occurring ≥15 days/month in a patient with a pre-existing primary headache disorder and developing as a consequence of regular use of the following for >3 months:[3]

- **≥10 days/month** ergotamines, triptans, combination analgesics, opioids, or multiple medications not individually overused
- **≥15 days/month** aspirin, paracetamol, or non-steroidal anti-inflammatory drugs

ICHD-3

Not better accounted for by another ICHD-3 diagnosis

Talking to your patients about MOH

- Use **clear, diplomatic** and **non-judgmental language** and demeanor

- Take a **clear history** of medication use and **headache frequency**
- Ask **open-ended questions** and query further based on the individual's responses

- Take time to **explain what MOH is** and that it is defined by the amount of medication taken each month for migraine relief[3]
- One approach is to point out that the individual has been experiencing so many headache days that their level of medication use is not surprising.* However, the number of days of medication use puts them at risk of making their headache worse:[3,4]
  - **Simple analgesics:** Common medications such as aspirin, paracetamol, non-steroidal anti-inflammatory medicines such as ibuprofen and naproxen (≥15 days/month for >3 months)[3]
  - **Combination analgesics:** Formulations that contain a combination of two or more classes of analgesics (≥10 days/ month for >3 months)[3]
  - **Triptans and ergotamines:** ≥10 days/month for >3 months[3]
  - **Opioids:** Tramadol, morphine, oxycodone, codeine, and hydrocodone ≥10 days/month for >3 months. Note that use <10 days/month may also create issues and that they are not recommended for acute treatment of migraine.[1*] Prospective studies indicate that patients overusing opioids have the highest relapse rate after withdrawal treatment.[3]

*Recommendations based upon expert opinion

Identifying patients with, or at risk, of MOH

The following questions may assist with the diagnosis of MOH:

How many headache days are you having each month on average?	**Diagnostic criteria:** Headache occurs on ≥15 or more days per month.[3] **Helpful tip:** Ask the patient to keep a headache diary to obtain an accurate account of the number of headaches they are experiencing in a month.
How many 'crystal clear' days do you have each month?	**Helpful tip:** 'Crystal clear days' are those where the patient has no headache or headache -related symptoms.*
How many days are you taking medication for your headache?	**Diagnostic criteria:** Regular use for >3 months of: simple analgesics on ≥15 days/month OR ergotamines, triptans, opioids or combination-analgesics on ≥10 days/month.[3]
What medications do you take on these days? How many days do you take each of these medications?	**Diagnostic criteria:** Asking about number of days of use of multiple medications can help identify individuals with MOH attributed to multiple drug classes not individually overused.[3]
What brought you here to see me today?	**Helpful tip:** Worsening headaches may be an indicator that the patient is at risk of MOH.*
Are you taking pain relievers for any conditions other than headache?	**Helpful tip:** Intake of pain medications for non-headache conditions can contribute to MOH in individuals with pre-existing headache disorders.[3]

*Recommendations based upon expert opinion

Communicating how MOH is treated

Several strategies for the treatment of MOH are available.[2–4] Explaining these strategies can be highly motivating for the patient and may foster treatment engagement. Strategies may be applied individually or in combination – and should be tailored to the individual – to manage MOH.[2]

- **Reduction or withdrawal of overused medications:**
  - As there may initially be a short period of worsening headache,[5] individuals should be counseled that they may require some time off work or studies.*
  - Simple analgesics can be used as rescue treatment while withdrawing higher-risk analgesic classes[2]
  - Explaining that almost three quarters of patients have a 50% or greater improvement in their headache after stopping the overused medications[5] may assist with patient motivation
  - In some circumstances bridging therapy for relief of withdrawal headache and symptoms can be used, if required[2]
  - Simple analgesics and/or triptans can usually be withdrawn successfully in the outpatient setting. Patients with more complicated MOH, characterised by opioid overuse, significant psychiatric comorbidities and/or previous history of relapses, may require inpatient management.[4]

- **Initiation of migraine-preventive therapy to treat the primary headache disorder[3,4]**
  - Recent evidence suggests that withdrawal combined with preventive treatment from the start of withdrawal may improve compliance with withdrawal and potentially increase MOH remission rates and reversion to episodic migraine status.[6]

Reassure the patient that they will be supported during the process and follow-up will be provided to avoid relapse.

*Recommendations based upon expert opinion

Summary of key points to communicate

- Medication overuse headache is the term now used for 'rebound headache'[3]
- There are different risks for different types of pain medication[5]
- Withdrawal or reduction of overused medication will usually improve the headache pattern in MOH[2,3]
  - Almost three quarters of patients have a 50% or greater improvement in their headache after stopping the overused medications[5]
- Simple analgesics can be used as rescue treatment while withdrawing higher-risk analgesic classes[2]
- Initiating preventive treatment at the start of the withdrawal process may improve compliance with withdrawal and increase MOH remission rates and reversion to episodic migraine status[6]

*Recommendations based upon expert opinion

References 1. Kristoffersen ES, Lundqvist C. *Ther Adv Drug Saf* 2014; 5:87–99. **2.** Diener H-C *et al*. *Eur J Neurol* 2020; 27:1102–16. **3.** Headache Classification Committee of the International Headache Society. International Classification of Headache Disorders, 3rd edition. *Cephalalgia* 2018; 38:1–211. **4.** Sun-Edelstein C *et al*. *CNS Drugs* 2021; 35:545–65. **5.** Diener H-C, Limmroth V. *Lancet Neurol* 2004; 3:475–83. **6.** Carlsen LN *et al*. *JAMA Neurol* 2020; 77:1069–78.

Lundbeck Australia Ltd, ABN 86 070 094 290,
Ground Floor, 1 Innovation Road,
North Ryde NSW 2113.
Ph: +61 2 8669 1000, Fax: +61 2 8669 1090,
Medical Information: 1300 721 277.

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