Urgent need for research into the best treatment for medication overuse headaches

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There is a critical need to review current treatment strategies for the increasingly common problem of medication overuse headaches (MOH), according to a series of international papers in the November issue of *Cephalalgia*.

"MOH is associated with severe disability, unmet treatment need and little clinical data to support current management strategies" says neurology expert Professor David W Dodick from the Mayo Clinic College of Medicine, Arizona, USA.

His overview also highlights the need for greater research into the condition - in particular the role that migraine medication can play in the withdrawal process. It is accompanied by papers on how the condition is tackled in Canada, Denmark, Germany, India, Moldova, Japan, Spain and Taiwan.

MOH, previously known as rebound headache, drug-induced headache or drug-misuse headache, is a headache that occurs at least 15 days a month when patients overuse medication.

"Tolerance to the analgesic effect of the acute medication develops over time, consumption may increase and patients may show withdrawal symptoms when they stop the overused mediation" explains Professor Dodick. "We estimate that the condition affects one in every 100 adults and one in every 200 adolescents worldwide, which is a considerable number.

"For example, in the USA 60 per cent of people with chronic daily headaches attending headache clinics have MOH. Data from a physician study suggests that it may be the third most frequent type of headache after migraines and tension-type headaches. And a Norwegian study found that people were seven times more likely to suffer from chronic headaches if they used analgesics daily or almost daily for more than a month."

Despite being very common, there are no standardised treatment guidelines for MOH, partly due to the small number of controlled clinical trials that have addressed the treatment of this condition.

However, recent research suggests that the traditional approach of not providing new treatment strategies until patients have been through detoxification may not be the best clinical option.

"Data from recent trials indicate that treatments developed to prevent migraine may prove effective if they are used in patients with MOH before the overused medicine is withdrawn" says Professor Dodick.

"This points to the need for clinical trials to re-evaluate current strategies and find the best way forward."

The international papers that accompany Dr Dodick's overview show that MOH is a common problem, but the incidence, causes and treatment vary from country to country.

-- Just under a quarter of the MOH cases seen at Taipei Veterans General Hospital in Taiwan are caused by people overusing cold cure preparations. Dr Shuu-Jiun Wang points out that 100 brands are currently available in Taiwan and he and his colleagues frequently see patients who have taken the whole 60ml bottle rather than the 10ml recommended dose. The problem is more common in people with lower

education levels. Other common causes of MOH, which affect one in 100 Taiwanese people, include analgesics, with or without caffeine.

-- Dr Zaza Katsarava from the University of Essen in Germany reports that new rules that enable healthcare plans to sign contracts with headache centres to provide day care centre withdrawal programmes have reduced MOH relapse rates in the country. He says that studies lasting from three to five years have indicated that relapse rates range from 34 to 48 per cent.

-- Medication overuse is a major clinical problem and a significant source of headache-related disability in Canada, according to Professor Werner J Becker from the University of Calgary. He believes that it will take a concerted effort by the public, health professionals and healthcare funders to provide better prevention and treatment for MOH. But he points out: "It can at times be difficult for patients to find a physician who will expend the time, energy and skill to help them escape from the prison of medication overuse."

-- MOH is a serious problem in Spain, especially among middle-aged women, says Professor Julio Pascual from the University Hospital at Salamanca. He advocates an active detection and treatment approach, pointing out that in his experience this can lead to long-term improvements in more than half of MOH cases. However he adds that patients with primary headache can often be biologically, and possibly genetically, predisposed to developing chronic daily headaches regardless of analgesic use, making the drugs the consequence, not the cause of daily headaches.

-- Dr Rigmor Jensen from the University of Copenhagen, Denmark, says that MOH has become a greater problem in Scandinavia over the last decade and is now the third most prevalent form of headache after tension type headaches and migraine. "A long-standing tradition of

restrictive use of painkillers is changing and in general the use of simple analgesics and combination drugs has steadily increased in Denmark" she says.

-- The drugs that cause MOH may vary from country to country says Dr Rie Kanki from Kitasato University in Kanagawa, Japan, as their market availability may differ and people's attitudes can be greatly affected by cultural attitudes. For example codeine and barbiturates, which are used in combination analgesics in the USA and Europe, are not available in Japan. Dr Kanki says that patient education is essential and that the growing number of headache specialists in Japan is making it easier to seek expert advice.

-- People living in Moldova often face psychological, cultural and religious barriers to drug use, according to Dr Ion Moldovanu from the State Medical and Pharmaceutical University in Chisinau. He reports that a clinical study of chronic migraine patients found that the two-thirds who did not have MOH expressed significantly greater phobias about the effects of drugs. Because of this they used fewer drugs than the third of patients who did have MOH.

-- Limited clinical data suggests that MOH is not as prevalent in India as it is in Europe and the US, reports Dr K Ravishankar from the Lilavati Hospital and Research Centre in Mumbai. He suggests this could be because people tend to use pain balms, delay medication and use alternative medicine. However, he says that more population-based studies are needed in the country, where access to healthcare is difficult and costly and headaches are not a priority compared with AIDS, Malaria and TB.

"It is clear from the papers in this issue of Cephalalgia that MOH is a common universal problem and that many countries face unique challenges due to the drugs that are available, patient and physician

attitudes and the different health care delivery systems" says Dr Dodick, who will take over as Editor-in-Chief of *Cephalalgia* in January 2009.

"However, the overwhelming consensus is that MOH is a growing problem that has a major negative impact on health-related quality of life. It is important to identify patients with a high frequency of headaches, who are at high risk of MOH, as early as possible and initiate measures to reduce the consumption of acute pain medication.

"This is an important series of papers as it illustrates the global public health burden imposed by MOH and identifies the unique underlying factors that contribute to MOH in different countries, as well as country-specific barriers to treatment.

"The expert authors have also highlighted the need for systematic and concerted research efforts to better understand the mechanisms and most effective treatment strategies for MOH, stressing that this is a major priority in the field of headache medicine."

Citation: How clinicians can detect, prevent and treat medication overuse headache. Dodick et al. Cephalalgia. 28.11, p1207-1217 (November 2008). Country papers: Canada (Becker et al, p1218-1220). Germany (Katsarava et al, p1221-1222). India (Ravishankar et al, p1223-1226). Japan (Kanki et al, p1227-1228). Moldova (Moldovanu et al, p1229-1233). Spain (Pascual et al, p1234-1236). Scandinavia (Jensen et al. p1240-1242). Taiwan (Wang et al. p1218-1220)

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