key points

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Medication overuse headache (MOH) affects 1-2% of the population worldwide. It occurs as a complication of the management of primary headache disorders, primarily migraine and tension type headache (TTH). MOH does not occur in cluster headache unless there is associated migraine.

MOH is defined as headache occurring on 15 or more days per month, that has evolved in association with the frequent use of acute medication over a period of more than 3 months. Normally, it has a chronic migraine pattern i.e. 15 or more headache days per month of which 8 or more fulfil the criteria for migraine. Importantly, not all patients with chronic migraine who frequently use acute treatment have MOH; some have poorly controlled migraine.

Any medication used for the acute treatment of headache can cause MOH. In the case of triptans, combination analgesics and opioids, use on 10 or more days per month is considered sufficient to cause MOH, whereas for simple analgesics (aspirin, ibuprofen and paracetamol) the threshold is 15 days per month. A good rule of thumb is to limit acute treatment to 2 days per week in patients with migraine and TTH. This rule does not apply to patients with cluster headache where the safe limit of triptan use is 2 doses per day for injectable sumatriptan and 3 doses per day for nasal zolmitriptan.

The diagnosis of MOH is based on a thorough history which can be aided by the use of headache diaries. Typically, episodic migraine has gradually become chronic migraine in association with increasing acute medication use. Patients often underestimate the number of headache days by concentrating on significant headache days and it is important to ask how many completely clear days there are. It is important to enquire about over the counter medication and where the patient keeps their medication. Medication kept in multiple locations may be an indicator of overuse. The number of days per month on which acute medication is used is more important than the total amount of medication taken.

The three treatment options for MOH are: abrupt withdrawal alone, abrupt withdrawal with prophylaxis, or prophylaxis without withdrawal. Opioids should be withdrawn gradually. Abrupt withdrawal is often associated with transient worsening of headache frequency and intensity and patients should be warned to expect this. Referral to a neurology or specialist headache clinic should be considered if: appropriate management of MOH has not been successful, advice is required about management of the underlying primary headache disorder, or there is concern that there may be an underlying sinister cause.