

Health status after detoxification in medication overuse headache

The problem of drug overuse in the population of headache patients has strongly been brought to the fore by the recent introduction of medication overuse headache (MOH) in the 2nd edition of the International Classification of Headache Disorders (ICHD-II). We have moved from an *ex-post* diagnosis of MOH, definable after the drug withdrawal, as reported in the 1988 Headache Classification, to a 2004 IHS diagnosis *ex-ante*, definable during the overuse period and recognising additional sources of abuse, such as triptans, opioids and combination drugs containing analgesics/AINS, butalbital and/or caffeine. The outcome of this qualitative leap in classification is evident. If MOH was considered, at first, a topic rarely discussed, something to talk about reluctantly, as if to hide a defeat, today it has become a subject worthy of a scientific journal's front page [1]. The epidemiology of this headache form shows that 4% of the population overuse drugs for migraine and that 1% of the population present with MOH [1]. However, the MOH picture has progressively changed due to the widespread use of triptans as a first-line migraine treatment. In view of a progressive divergence from both ergotamine and barbiturates during the last ten years, we have observed an increase of a more or less aware self-medication, with OTC analgesics,

AINS drugs, COXIB-2 and triptans. Fortunately, in Europe we have never seen consistent occurrences of opioids use/abuse for the treatment of acute headache.

Among the unsolved problems, such as MOH's roots, whether mainly in chronic migraine, chronic tension headache or chronic daily headache, or the length of the delay between overuse stabilisation and MOH insurgence, or the different relapse length (class-dependent?), we must include another important question: what is the extent of drug-induced organ damage? An additional issue worth debating is how inadequate information concerning the risk of drug abuse could influence the behaviour of patients prone to drug abuse in the self-management of the recommended drugs and doses for a headache attack [2]. Our action priorities must converge on the explosive mix of these last two points, on how superficial and imprecise medical information given to the patient can facilitate a silent and unintentional gradual increase in drug overuse, and to what extent it generates organ damage. MOH must therefore be regarded as a real problem which concerns public health, as it can be the origin of a variety of organ damage, including silent cerebrovascular ischaemic micro-damage [3], patent renal or gastric injuries and the recent matter of cardiovascular dam-

age, just to cite the most frequent ones. Furthermore, once these clinical problems appear in the emergency medicine or primary care area, they are not always linked to the previous situation of drug abuse. The global state of health of a patient with MOH or prior MOH concerning organ damage, must be considered at risk. The frequent relapses that MOH patients experience during their life span demonstrate that this is a subpopulation of chronic headache patients with a real multi-factorial terrain.

Given the fact that MOH rehabilitation procedures need to be performed in an in-hospital environment, to accomplish the highest patient compliance, several issues remain unsolved. Why do about a quarter of MOH patients present repeated, regular relapses?

Moreover, what does the not uncommon observation of spontaneous detoxification, observable in about 5% of MOH, mean? Is it due only to a brief period of abuse or to a minimum daily number of drug intakes? Does the re-prophylaxis criteria have to occur in a very early phase, after the detoxification period, immediately following the devastating 72-hour rebound headache, or in a late period after the wash-out, weeks later, when the natural core crises reappear?

The absence of an average protocol for intravenous poly-therapy to rehabilitate MOH patients and to

cross the rebound headache needs to be codified by an expert panel, even if it is evident to all of us how this represents a politically difficult and extremely treacherous path.

Among the final considerations, the reassurance of the MOH patient about a long, painful and possibly unsuccessful detoxification, embodies the key phase for the success of this important therapeutic rehabilitation procedure [4]. The physician could then be puzzled by the sudden change of the MOH patient's mood; from the discouragement of the pre-wash-out and the deepest despair during a rebound crisis that seems never ending, to the euphoria of no longer having the headache and the fear of its reappearance. This is a real test not only for the patient but, in terms of empathy, for the physician as well. Although the results of MOH detoxification procedures are generally held to be excellent and lead to a clear amelioration of the health status of MOH patients, the unforeseen relapse represents the real challenge to a continuous and efficacious collaboration between the physician and the patient. However, an occasional wash-out period is always preferable to dangerous daily drug abuse, a phenomenon fuelled by indefensible shortcuts, which today seems to be relentlessly expanding.

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References

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