Rebound Headache
(Medication Overuse Headaches)

In 1984, Dr. Joel Saper and I published the world's first paper that suggested that certain headache medications, if taken too frequently, would actually cause headaches to become worse, in severity, frequency and inability to treat them. The medication, which we studied, was ergotamine tartrate sold under the brand names Cafergot® and Wigraine®.

Soon after that time, there was an avalanche of other studies from around the world showing the same kind of worsening of headaches could occur with the too frequent use of pain killers, decongestants and most recently triptan drugs (such as Imitrex®. The term "Rebound Headaches" was coined to describe this syndrome. Earlier this century, the term was changed to "Medication Overuse Headache Syndrome" (MOHs). This is very different from where you take one medication, it is helpful for many hours but then the pain comes back. We call that reoccurrence.

MOHs develops over time, usually months if not years or even decades. It is a real syndrome and can make headaches worsen and fail to respond to good preventative and abortive treatments.

The most common medications, which can cause MOHs, are combination analgesics including over-the-counter medications such as Excedrin®. Prescription combination analgesics include butalbital-containing preparations, such as Fioricet® and Fiorinal®. While the combination products are the worse, all pain medications can cause rebound or MOHs. The last products in this category are the decongestants such as pseudoephedrine. The simple rule is that these above-mentioned medications should never be used more than two days per week and if they are, they must be reduced to increase the patient's chances of getting better.

The last medication category is triptans. There is a growing consensus among headache specialists that medications such as Imitrex® can also cause MOHs, but not as readily as the previously-mentioned drugs. We think that you must use triptans more than three days a week and use them longer to develop MOH. It is also easier to reduced the triptans than the first category.

I've personally noticed a pattern that the newer headache specialists claim that all symptomatic medications, including ibuprofen, naproxen and even nausea medication can cause MOHs. At this juncture there is no scientific evidence to support that. It is also my personal opinion that these newer headache specialists assume that a person is experiencing MOHs anytime they have difficult to treat headaches and they are talking these medications frequently. They can then blame the patient for their inability to help them. Most of us seasoned headache specialists, however, think that over-using rebounding medications is only the culprit some of the time. The International Headache Society defines MOHs, as severe headache problem that gets better naturally within 90 days of stopping the medications which were assumed to be causing rebound. Many of

these patients have stopped their “rebound medications” for much longer period of time and have seen no improvement, thus you can not assume that the medications had anything to do with the difficult nature of their headaches.

Treatment of MOH at Pacific Rim Headache Center

There is a compassionate way to treat MOH and to do it as an out patient. Here are my steps.

1) First start the patient on a new preventative program. For the first two weeks, while the new program is being established, the patient makes no heroic attempts to cut back on the rebounding mediations.
2) Starting with week three, a subtle tapering program is instituted for reducing the number of days the rebounding mediations is taken.
3) During the tapering of the rebounding medication, the headaches can get really severe. To help the patient, an aggressive short-term preventative program is started. This program can be any of the following, tailored made for the patient:
    a. Daily DHE-45 Injections (in the office or at home) or,
    b. Daily long-acting triptans such as Frova® of Amerge® or,
    c. Daily methergine (a potent headache prevention medication) or,
    d. Daily steroids such as prednisone for up to three weeks and/or,
    e. Psychological support.
    f. Other CAM (complimentary) treatments can also be used such as acupuncture, massage, biofeedback and physical therapy.

Most patients are able to get off the offending medications and do well. Some must be hospitalized. I often recommend special headache hospital program such as the Michigan Headpain and Neurologic Institute.

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