Chronische hoofdpijn
diagnose en
medicamenteuze behandeling

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Hasselt, 17 oktober 2011

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Ghent University Hospital
Chronic (Daily) Headache

A syndrome with multiple etiologies (such as e.g. parkinsonism)

Frequent Headache
≥15 days/month

Yes

No

Episodic Headache

Chronic Headache
≥4 hours in duration

Yes

No

Short-Duration Chronic Daily Headache

Chronic Daily Headache
Daily or near daily headache lasting ≥4 hours
Headache Classification

Headache ≠ continuum

→ discrete entities

→ classification

1988    ICHD-I

hierarchical
diagnostic criteria
universal

2004    ICHD-II
Primary headaches (4 categories: 1-4)
Secondary headaches (8 categories: 5-12)
Cranial neuralgias (1 category: 13)
Not classifiable elsewhere (1 category: 14)
Up to 4 digits (hierarchical)

Example

chronic cluster headache

3. Cluster headache and other trigeminal autonomic cephalalgias

3.1.2 Chronic cluster headache
Chronic (Daily) Headache
short duration (<4hrs)

In Flanders mean diagnostic delay of 44 months!

> Cluster headache

Acta Neurol Belg 2009;109:10-17
Cluster headache

Graph showing pain intensity over time with peaks at 00:00, 6:00, 12:00, and 18:00.
A. At least 5 attacks fulfilling criteria B - D
B. Severe or very severe unilateral orbital, supraorbital and/or temporal pain lasting 15 - 180 min if untreated
C. Headache is accompanied by ≥1 of the following:
   1. ipsilateral conjunctival injection and/or lacrimation
   2. ipsilateral nasal congestion and/or rhinorrhoea
   3. ipsilateral eyelid oedema
   4. ipsilateral forehead and facial sweating
   5. ipsilateral miosis and/or ptosis
   6. a sense of restlessness or agitation
D. Attacks have a frequency from 1/2 d to 8/d
What happens to patients with cluster headache?

<table>
<thead>
<tr>
<th>Specialist</th>
<th>Seen by</th>
<th>Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>46%</td>
<td>Tooth extraction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Splint</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Braces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Filing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maxillo-facial surgery</td>
</tr>
<tr>
<td>ENT</td>
<td>32%</td>
<td>Sinus washout</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nasal septal surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antibiotics</td>
</tr>
<tr>
<td>Optician</td>
<td>26%</td>
<td>Spectacles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Eye exercises</td>
</tr>
<tr>
<td>Ophthalmologists</td>
<td>23%</td>
<td>None!</td>
</tr>
</tbody>
</table>

Chronic (Daily) Headache
long duration (>4 hrs)
1. Headache of sudden onset

   → 21-46 % secondary headache

   → 10-30 % SAH

2. Headache associated with neurological SS

   → 44-55 % secondary headache in ER

3. Headache onset after 50 years of age

   → 2-3 times more secondary headache

Headache 2011;51(2):346-52
Secondary Chronic (Daily) Headache
long duration (>4 hrs)

1. Cervicogenic headache
2. Post-traumatic headache
3. Medication-overuse headache
Primary Chronic (Daily) Headache
long duration (>4 hrs)

4-5%

Chronic daily headache disorders

Chronic tension-type headache
New daily persistent headache
Hemicrania continua
Chronic migraine

2-3%  rare  rare  2%

± MOH

Chronic migraine: recognition as a distinct disorder

2004: ICHD-II recognises chronic migraine

- Classified as a complication of migraine
- \( \geq 15 \) migraine days/month for \( \geq 3 \) months

ICHD-II criteria not practical in the clinical setting

Proposed revisions endorsed in ICHD-IIR (2006) as an appendix to ICHD-II

- \( \geq 15 \) headache days/month, with
- \( \geq 8 \) migraine days/month for \( \geq 3 \) months

Modifiable risk factors CM

- Comorbidities (depression, obesity, ...)
- Attack frequency
- Snoring & OSAS
- Medication overuse
- Stressful life events
- Other pain syndromes
- Caffein overuse

Curr Opinion Neurol 22;269276
“Only two pharmacological treatments have been shown to be effective in placebo-controlled randomized trials: topiramate and local injection of botulinum toxin...

Many other substances have been investigated in chronic daily headache. All trials were underpowered and, therefore, recommendations concerning possible efficacy are not possible.”

Tension-type headache

amitriptyline (Redomex®)

start low – go slow
dose range 10-100 mg
Medication-overuse HA

~ chronic tension-type headache
~ chronic migraine
(near) daily headache - morning headache
refractory preventative treatment
no class I evidence: ‘withdrawal’
Medication overuse

ICHD-II medication overuse definition

Ergotamines OR triptans ≥10 days/month

Opioids OR combination analgesics ≥10 days/month

Simple analgesics ≥15 days/month

Intake of any combination of ergotamine, triptans, analgesics, and/or opioids on ≥10 days/month
Combinatiepreparaten...

<table>
<thead>
<tr>
<th>60 Geulens</th>
<th></th>
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<tbody>
<tr>
<td>ERGOTAMINE TARTR.</td>
<td>1 mg</td>
</tr>
<tr>
<td>ACETYLSALICYL ACID.</td>
<td>CRIST. 250 mg</td>
</tr>
<tr>
<td>PARACETAMOL</td>
<td>250 mg</td>
</tr>
<tr>
<td>CODEINE PHOSPHATE</td>
<td>20 mg</td>
</tr>
<tr>
<td>COFFEINE</td>
<td>50 mg</td>
</tr>
<tr>
<td>ALUCOL ND</td>
<td>100 mg</td>
</tr>
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</table>
Self-medication of regular headache: a community pharmacy-based survey

E. Mehuys, **K. Paemeleire***, T. Christiaens, L. Van Bortel, L. De Bolle, I. Van Tongelen, J.P. Remon, K. Boussery

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Department of Neurology
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Results

44 % study population (n=528) no physician Dx headache → 225 of them (42.6%) ID-M positive!

Only 12% with migraine Dx used prophylactic migraine medication, and 25% used triptans

About 24% (n=292) overused acute medication
  > combination analgesic overuse
  > simple analgesic overuse

Only 14.5% was ever advised to limit intake frequency of acute headache treatments
### Table 2 Revised criteria for medication overuse headache

**Appendix 8.2 Medication overuse headache**

**Diagnostic criteria:**
- A. Headache present on \( \geq 15 \) days/month
- B. Regular overuse for \( >3 \) months of one or more acute/symptomatic treatment drugs as defined under sub forms of 8.2.
  1. Ergotamine, triptans, opioids, or combination analgesic medications on \( \geq 10 \) days/month on a regular basis for \( >3 \) months
  2. Simple analgesics or any combination of ergotamine, triptans, analgesics opioids on \( \geq 15 \) days/month on a regular basis for \( >3 \) months without overuse of any single class alone
- C. Headache has developed or markedly worsened during medication overuse
Withdrawal procedure
The procedures for withdrawal in patients with MOH vary substantially, and no study has compared abrupt withdrawal treatment with tapered withdrawal in prospective randomised trials. Most headache specialists are in favour of abrupt discontinuation of pain medication because this is thought to be associated with fast resolution of the drug-induced pain-coping behaviour. However, tapered withdrawal might be recommended for opioids, barbiturates and, in particular, benzodiazepines to reduce withdrawal symptoms.
Immediate head headache following withdrawal of acute medications
Long-term outcomes
preventive treatment - abrupt withdrawal acute medications

Cephalalgia 2009;29(2):221-32
How is withdrawal achieved?

- Simple advice
- Out-patient Neurology
- In-patient Neurology
- Psychiatry
- ...

UNIVERSITEIT GENT
Short-term effectiveness of simple advice as a withdrawal strategy in simple and complicated medication overuse headache.

Exclusion criteria: … severe psychiatric illnesses
… overuse of opioids and/or barbiturates

Complicated MOH: … a current diagnosis of mood disorder, anxiety disorder, eating disorder, or substance addiction

Eur J Neurol 2011;18:396-401
What is the Role of Dependence-Related Behavior in MOH?

“These data support the proposition of separating 2 sets of MOH patients:

- the first one in which the illness is mainly due to the worsening of the headache course
- the second one in which behavioral issues are a major determinant of the illness. Detection of a psychological dependence component in a sub-group of MOH patients should have direct relevance to disease management.”

Medication overuse ≠ abuse

Headache 2010;50:1597-611
Objectives in managing MOH

1. Stopping overused medication
2. Managing withdrawal symptoms
3. Underlying primary headache
4. Preventing relapse