BRIEF REPORT

The International Classification of Headache Disorders, 2nd Edition (ICHD-II)—revision of criteria for 8.2 *Medication-overuse headache*

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☐*Classification, headache disorders, medication-overuse headache*

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Introduction

The ICHD-II criteria for 8.2 *Medication-overuse headache* have been revised based on constructive criticism at the International Headache Research Seminar in Copenhagen in March 2004. The major changes are: (i) elimination of the headache characteristics; and (ii) a new subform (8.2.6 *Medication-overuse headache attributed to combination of acute medications*) that takes into account patients overusing medications of different classes but not any single class.

The revised section is below.

8. Headache attributed to a substance or its withdrawal

8.2 Medication-overuse headache (MOH)
- 8.2.1 Ergotamine-overuse headache
- 8.2.2 Triptan-overuse headache
- 8.2.3 Analgesic-overuse headache
- 8.2.4 Opioid-overuse headache
- 8.2.5 Combination analgesic-overuse headache
- 8.2.6 Medication-overuse headache attributed to combination of acute medications
- 8.2.7 Headache attributed to other medication overuse
- 8.2.8 Probable medication-overuse headache

General comment

Definite or probable? In the particular case of 8.2 *Medication-overuse headache*, a period of 2 months after cessation of overuse is stipulated in which improvement (resolution of headache, or reversion to its previous pattern) must occur if the diagnosis is to be definite. Prior to cessation, or pending improvement within 2 months after cessation, the diagnosis 8.2.8 *Probable medication-overuse headache* should be applied. If such improvement does not then occur within 2 months, this diagnosis must be discarded.

8.2 Medication-overuse headache (MOH)

Previously used terms

Rebound headache, drug-induced headache, medication-misuse headache.

Diagnostic criteria

A Headache[1] present on ≥15 days/month fulfilling criteria C and D.

[1]The headache associated with medication overuse is variable and often has a peculiar pattern with characteristics shifting, even within the same day, from migraine-like to those of tension-type headache.

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B Regular overuse[2] for >3 months of one or more drugs that can be taken for acute and/or symptomatic treatment of headache.[3]
C Headache has developed or markedly worsened during medication overuse.
D Headache resolves or reverts to its previous pattern within 2 months after discontinuation of overused medication.

Comments
MOH is an interaction between a therapeutic agent used excessively and a susceptible patient. The best example is overuse of symptomatic headache drugs causing headache in the headache-prone patient. By far the most common cause of migraine-like headache occurring on ≥15 days per month and of a mixed picture of migraine-like and tension-type-like headaches on ≥15 days per month is overuse of symptomatic antimigraine drugs and/or analgesics. Chronic tension-type headache is less often associated with medication overuse but, especially amongst patients seen in headache centres, episodic tension-type headache has commonly become a chronic headache through overuse of analgesics.

Patients with a pre-existing primary headache who develop a new type of headache or whose migraine or tension-type headache is made markedly worse during medication overuse should be given both the diagnosis of the pre-existing headache and the diagnosis of 8.2 *Medication-overuse headache*.

The diagnosis of MOH is clinically extremely important because patients rarely respond to preventative medications whilst overusing acute medications.

8.2.1 Ergotamine-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Ergotamine intake on ≥10 days/month on a regular basis for >3 months.

[2]Overuse is defined in terms of duration and treatment days per week. What is crucial is that treatment occurs both frequently and regularly, i.e. on 2 or more days each week. Bunching of treatment days with long periods without medication intake, practised by some patients, is much less likely to cause medication-overuse headache and does not fulfil criterion B.
[3]MOH can occur in headache-prone patients when acute headache medications are taken for other indications.

Comment
Bioavailability of ergots is so variable that a minimum dose cannot be defined.

8.2.2 Triptan-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Triptan intake (any formulation) on ≥10 days/month on a regular basis for >3 months.

Comment
Triptan overuse may increase migraine frequency to that of chronic migraine. Evidence suggests that this occurs sooner with triptan overuse than with ergotamine overuse.

8.2.3 Analgesic-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Intake of simple analgesics on ≥15 days/month[4] on a regular basis for >3 months.

8.2.4 Opioid-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Opioid intake on ≥ 10 days/month on a regular basis for >3 months.

Comment
Prospective studies indicate that patients overusing opioids have the highest relapse rate after withdrawal treatment.

8.2.5 Combination analgesic-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Intake of combination analgesic medications[5] on ≥10 days/month on a regular basis for >3 months.

[4]Expert opinion rather than formal evidence suggests that use on ≥15 days/month rather than ≥10 days/month is needed to induce analgesic-overuse headache.
[5]Combinations typically implicated are those containing simple analgesics combined with opioids, butalbital and/or caffeine.

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8.2.6 Medication-overuse headache attributed to combination of acute medications

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Intake of any combination of ergotamine, triptans, analgesics and/or opioids on ≥10 days/month on a regular basis for >3 months without overuse of any single class alone.[6]

8.2.7 Headache attributed to other medication overuse

Diagnostic criteria

A Headache fulfilling criteria A, C and D for 8.2 *Medication-overuse headache*.
B Regular overuse[7] for >3 months of a medication other than those described above.

8.2.8 Probable medication-overuse headache

Diagnostic criteria

A Headache fulfilling criteria A and C for 8.2 *Medication-overuse headache*.
B Medication overuse fulfilling criterion B for any one of the subforms 8.2.1–8.2.7.
C One or other of the following:

1 Overused medication has not yet been withdrawn.
2 Medication overuse has ceased within the last 2 months but headache has not so far resolved or reverted to its previous pattern.

Comments
Codable subforms of 8.2.8 *Probable medication-overuse headache* are 8.2.8.1 *Probable ergotamine-overuse headache*, 8.2.8.2 *Probable triptan-overuse headache*, 8.2.8.3 *Probable analgesic-overuse headache*, 8.2.8.4 *Probable opioid-overuse headache*, 8.2.8.5 *Probable combination analgesic-overuse headache*, 8.2.8.6 *Headache probably attributed to overuse of acute medication combinations* and 8.2.8.7 *Headache probably attributed to other medication overuse*.

Many patients fulfilling the criteria for 8.2.8 *Probable medication-overuse headache* also fulfil criteria for either 1.6.5 *Probable chronic migraine* or 2.4.3 *Probable chronic tension-type headache*. They should be coded for both until causation is established after withdrawal of the overused medication. Patients with 1.6.5 *Probable chronic migraine* should additionally be coded for the antecedent migraine subtype (usually 1.1 *Migraine without aura*).

[6]The specific subform(s) 8.2.1–8.2.5 should be diagnosed if criterion B is fulfilled in respect of any one or more single class(es) of these medications.
[7]The definition of overuse in terms of treatment days per week is likely to vary with the nature of the medication.

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