REBOUND HEADACHES

VIVIAN FRITZ, *MB MCh, FCP (SA), PhD, FRCP, FCNeurol (SA)*
Professor Emeritus, *University of the Witwatersrand, Johannesburg*

In the 1988 International Headache Society (IHS) classification drug-induced headache is defined as:

- headache appearing at least 15 days a month
- headache induced by the regular intake of analgesics, ergot alkaloids
- headache disappearing after withdrawal of substance.

The term drug-induced headache has now been changed to medication-overuse headache in the new IHS classification. In the new classification it is required that the headache should worsen or increase in frequency during symptomatic medication overuse.

Chronic headaches with medication overuse occurs in about 1% of the general population. This association is common until middle age and declines thereafter. It peaks at 40 - 49 years in women and at 50 - 59 years in men.

The association between analgesic overuse and headache is stronger in migraine than in non-migrainous headache sufferers. Tension-type headaches also have a very strong association with analgesic overuse. The concept that medication used to manage headache can become a cause of headache if overused has been difficult to appreciate.

Clinical features

According to most estimates, approximately 90% of the population suffer from headaches, most commonly tension-type headache. The pain is mild to moderate, non-throbbing, steady and aching, spreading to both sides of the head and lasting hours to days. The vast majority of the population self-medicate these headaches with over-the-counter products. Less than 20% of patients with headaches seek medical attention and usually only after over-the-counter medications have failed.

The chronic, daily headaches caused by analgesics are usually the result of the medication causing an increase in frequency of the headache. Often the headache becomes continuous for days and frequently for weeks. Any patient with a history of tension-type or migraine headache can transform into a chronic, daily headache sufferer if he/she overuses certain medications. Medications regarded as safe are in fact the most likely culprits. Among these are aspirin, sinus relief medications, acetaminophen, sedatives for sleep, codeine and related narcotic preparations, and over-the-counter combination headache remedies.

While small amounts of these medications per week may be safe and effective for intermittent or periodic headaches, at some point the continued medication use leads to the development of a low-grade headache that will just not go away. Taking larger and more frequent doses of the offending immediate-relief medication is not recommended. This only exposes the patient to a higher level of the medication's toxicity and also perpetuates the situation, worsening it and sometimes making it continue indefinitely. The patients eventually 'live' on the medication for months on end because they continue to find short-term relief, even though the headache inevitably returns.

Often the headache occurs in the middle of the night while the patient is sleeping – the patient awakens with persistent headache because he/she has missed the next scheduled dose.

Causation: the role of drugs and the role of secondary headaches

There is no established threshold for the quantity, frequency or duration of medication required for the development of drug-induced rebound headache. Affected patients typically take headache-relieving medication daily or near daily, but the sustained use of these medications more than 3 days a week is probably sufficient to develop drug-induced rebound headache.

All symptomatic medication including tryptans has the potential to cause drug-induced rebound headaches. Only after a careful evaluation for secondary headaches should drug-induced rebound headaches be suspected in patients with medication overuse. The physician should remain alert to the signs of secondary headache in patients who self-medicate.

Treatment

The treatment is only effective after recognition of the problem, and recognition is half the battle won. This kind of patient should be referred to a clinician experienced in difficult headache problems.

Usually discontinuing the medication will lead to the development of more easily controlled headaches with the use of carefully administered headache-abortive medications. Sometimes detoxification is required in patients taking large doses of sedative hypnotics, sedative combination headache pills or narcotics. These patients may need to be admitted to hospital to recover under supervision. Detoxification for the first several weeks is often plagued by increasing headache frequency which is a rebound phenomenon of sorts and therefore this should never be attempted by the patient without medical supervision. However, if the patient perseveres the headache will disappear and resume its previous intermittent nature. Preventive medication when prescribed then becomes more effective.

After withdrawal or detoxification has been completed, the symptomatic medication should never be used for more than 2 days a week. Non-steroidal anti-inflammatory drugs are frequently useful in this kind of patient and tryptans can be used for migraine flares. It is important to prevent these patients from using combination analgesics, caffeine-containing compounds and narcotics. Lifestyle management is a useful way of treating this type of patient. There is a role for anti-epileptic drugs, particularly valproic acid or sodium valproate, gabapentin and/or topiramate.

CERVICAL HEADACHE – MANUAL PHYSIOTHERAPY CAN HELP

FRANNE MALLEN, *BSc Physiotherapy, OMT, Advanced OMT, Advanced Diploma in Physiotherapy*

Physiotherapist, *Pinegowrie, Johannesburg*

Some physiotherapists have postgraduate qualifications in orthopaedic manual therapy, where they are specifically trained in manual techniques, evaluations and appropriate therapeutic exercise. This type of therapist, working in conjunction with the patient's GP, a neurologist, an ENT specialist, maxillofacial surgeon, dietician, optometrist, homeopath, or clinical psychologist, can offer successful treatment and ongoing management of cervical headaches.

Therapy for headaches of cervical origin can relieve, pre-empt and often cure the headache. Physiotherapists work on the motion segments of atlanto-occipital joint C1/2 C2/3 specifically and have an