Migraine Trigger Guide:

Medication Adaptation

**Explanation**

Migraine medications are designed to help. But they can easily be misused. Many medications are not designed for long-term or prolonged use, and if not used as directed, can cause significant issues to internal organs or have other undesired side effects.

Medication Adaptation Headaches (MAH) — also known as medication overuse headaches (MOH) or rebound headaches — refer to when medication is taken too frequently, and headache or migraine may “rebound” after the medication wears off. Patients may develop a dependency on the medication and/or complications that can lead to daily headache or migraine attacks.

MAH is estimated to be responsible at least 30% of chronic daily headache and is common, affecting around 0.7-1.7% of the general population.¹

**Trigger causes**

Medication Adaptation Headache creeps up gradually, often over the course of years.

As the migraine condition gradually worsens or becomes less responsive to medication, the medication frequency or dose begins to increase. This increase continues, and so the downward spiral continues until suddenly you are trapped in a cycle of increasing headache, migraine attacks and medication.

**How do you know if this is an issue?**

If you’re taking medication to treat headache symptoms regularly on more than two or three days a week over three months, then you are at risk of developing MAH.

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Characteristics of MAH:

- the frequency of attacks increases over time, without you being aware
- you often wake up in the early morning with an attack, even though this was not a feature of the original headache type
- some of the attacks may become nondescript — lacking features specific to migraine or tension-type headache
- you get a headache more easily with stress or exertion
- greater doses of the medications are needed to alleviate the attack
- attacks occur within a predictable period after the last dose of medication, which often has reduced efficacy

How much medication is too much?

The International Headache Society (IHS) criteria guidelines state that MAH can be associated with the use of:

- simple analgesics (i.e. aspirin, ibuprofen) for 15 days or more per month, for more than 3 months
- combination medications for 10 days or more per month, for more than 3 months
- opioids for 10 days or more per month, for more than 3 months
- ergotamine and triptans for more than 10 days per month, for more than 3 months

Habitual and regular use (i.e. two or three times per week) is much more likely to cause MAH than taking medication in clusters of several treatment days separated by prolonged treatment-free intervals.

Caffeine is an ingredient in some headache medications. It may help improve headaches initially, but daily intake of caffeine-containing medications, or caffeine-containing beverages, can result in greater attack frequency and severity. Stopping caffeine abruptly may actually make attacks worse, and some patients require professional help to overcome caffeine dependency.

Options to try

Treating MAH requires discontinuing or tapering off the overused medication.

This should be conducted under the supervision of your doctor, who should provide the necessary education and reassurance, help alleviate withdrawal symptoms, and transition treatment into a more sustainable and effective management plan.
Watch-outs

MAH patients account for up to 80% of patients attending specialist headache clinics. For doctors, a high index of suspicion of MAH is appropriate for a patient presenting with frequent headache — and with good cause.

This suspicion is for our own good. To break out of MAH is often difficult because sometimes you may need to get worse before you can get better.

But it’s worth the effort. 80% of patients will improve with a 50% or more decrease in frequency and severity by addressing MAH.

Failure to address MAH will likely reduce the potential efficacy of any preventive intervention. This was first pointed out in research more than 30 years ago. Many studies since then have demonstrated similar results.

If this isn’t enough to motivate a change, consider the risk of liver, kidney and gastrointestinal disorders which can result from the overuse of acute treatments.

More information on how to rate your MAH trigger

There are treatments for migraine that are designed for daily and monthly use. These are preventive migraine medications (also called prophylactic treatments) — for example, topiramate and CGRP-related medications.

If you are taking a preventive migraine treatment, this does not count towards your MAH trigger. Consider only your acute migraine treatments such as analgesics, NSAIDs, opioids, ergotamine and triptans, etc.

More reasons to manage this trigger

MAH is subtle and can be devastating. It traps its victims. Many people with migraine who have had MAH have experienced it for over 10 years with a significant economic and personal cost.

Resources

- Watch Dr. Alan Rapoport (2016) and Dr. Larry Charleston IV (2017) and Dr. Richard Lipton (2018) interviews at the Migraine World Summit for in-depth discussions on this topic.

- Further reading on treatment approaches for MAH, weaning strategies and success rates http://www.blog.migrainepal.com/blog/2015/9/1/medication-overuse-headaches
If you suspect you have MAH (i.e. have daily headache and/or migraine) and take acute/abortive medications more than 2-3 times a week for longer than 3 months, then it is strongly advised you see your doctor to discuss prevention.

Professional medical assistance is needed.

This is not one of those triggers you can manage without the supervision of a doctor. If you do have MAH and are not getting professional treatment, then your frequent attacks are less likely to respond to other efforts you take to improve your condition.

MAH can be successfully addressed.