



Research Article

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MEDICATION OVERUSE HEADACHE: HOW MUCH ARE WE AWARE? İLAÇ AŞIRI KULLANIMI BAŞ AĞRISI: NE KADAR FARKINDAYIZ?

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Öz

Amaç: İlaç aşırı kullanımı baş ağrısı (İAKB), migren ve gerilim tipi baş ağrılarını izleyerek en sık 3. baş ağrısı tipi olması ve iyatrojenik kökeni önemlidir. Amacımız, baş ağrısı ile başvuran hastalar içerisinde İAKB sıklığı, ağrı şiddeti ve eşlik eden psikiyatrik bozukluklarla ilişkisini değerlendirmektir.

Materyal ve Metot: İlaç aşırı kullanımı baş ağrısı olanlar ve İAKB olmayan olarak 2 hasta grubu oluşturuldu. Hastaların cinsiyeti, yaşı, baş ağrısı süresi, aylık baş ağrısı atak sıklığı, aylık analjezik kullanımı ve tipi, anksiyete ve depresyon varlığı ve ağrı şiddeti açısından değerlendirildi.

Bulgular: İlaç aşırı kullanımı baş ağrısı hastalarının 38'sinde (%69,10) migren, 17'sinde (%30,90) gerilim tipi baş ağrısı hikayesi vardı. Hastalarda en sık kullanılan analjezik olarak 37 hastada (%67,28) olmak üzere parastemol + non-steroid antiinflatuar saptandı. İlaç aşırı kullanımı baş ağrısı olan hastaların 33'ünde depresyon (%60) 12 'sinde (%21,82) anksiyete gözlemlendi. İlaç aşırı kullanımı olmayan 164 hastanın 30'unda (%18,29) depresyon ve 42'sinde (%25,60) anksiyete gözlemlendi. Yaş, cinsiyet, baş ağrısı süresi ve tipi her iki grup arasında anlamlı bir farklılık görülmedi. Baş ağrısı atak sıklığı (aylık), depresyon varlığı ve ağrı şiddeti İAKB grubunda anlamlı olarak daha fazla idi.

Sonuç: Bu hastalığın bilinmesi, öncelikle gelişmesinin önlenmesi açısından, eğer gelişti ise de erkenden tanınarak tedavisinin yapılması açısından önem taşımaktadır. Özellikle birinci basamak poliklinikleri başvuran hastaların aşırı analjezik kullanımı açısından farkındalığının sağlanmasının, İAKB görülme sıklığını azaltacağını düşünmekteyiz.

Anahtar Kelimeler: İlaç aşırı kullanımı baş ağrısı, analjezikler, depresyon, anksiyete.

Abstract

Objectives: Medication overuse headache (MOH) is the third most common type of headache following migraine and tension-type headaches, and its iatrogenic origin is important. Our aim is to evaluate the frequency of MOH, the severity of pain and its relation with comorbid psychiatric disorders among patients presenting with headaches.

Materials and Methods: Two patient groups were formed: those with MOH and those without MOH. Patients' gender, age, headache duration, monthly headache attack frequency, monthly analgesic use and type, presence of anxiety and depression, and pain severity were evaluated.

Results: 38 (69.10%) of the MOH patients had a history of migraine, and 17 (30.90%) of them had a tension headache. Paracetamol + non-steroidal anti-inflammatory was the most commonly used analgesic in 37 patients (67.28%). Depression was observed in 33 (60%) of the patients with MOH, and anxiety was observed in 12 (21.82%). Depression was observed in 30 (18.29%) and anxiety in 42 (25.60%) of the 164 patients who did not use medication excessively. There was no significant difference in age, gender, headache duration and type between the two groups. The frequency of attacks (monthly), presence of depression and pain severity were significantly higher in the MOH group.

Conclusion: Knowing this disease is important primarily in terms of preventing its development and if it has developed, early diagnosis and treatment. We think that raising awareness of patients who apply to primary care polyclinics in terms of excessive analgesic use will decrease the incidence of MOH.

Keywords: Medication overuse headache, analgesics, depression, anxiety.

Introduction

The observation that analgesics used to treat headaches themselves can cause headaches is a paradox that has caused considerable confusion among both physicians and patients.¹ According to the latest International Classification of Headache Diseases (ICHD-3), the definition of medication overuse headache (MOH) includes people with primary headache who have more than 15 days of headache per month and the use of analgesic drugs (10 or more per month or 15 or more per month depending on the treatment used) for the treatment of acute or symptomatic headache for at least three months (Table 1).²

Medication overuse headache is the third most common type of headache following migraine and tension-type headaches, and its iatrogenic origin is important. Westergaard ML et al. reported that up to 70% of people with chronic daily headaches have a medication overuse headache.³ Medication overuse headache most often develops in people with migraine or less commonly tension headache and rarely in cluster headaches.^{4,5}

Especially anxiety and depression are common psychiatric disorders in MOH patients. This is either because chronic headache causes psychiatric disorders or vice versa.⁶⁻⁸

Our aim is to evaluate the MOH prevalence, pain severity and its relation with accompanying psychiatric disorders among the patients who applied to Harran University Faculty of Medicine Neurology and Family Medicine Polyclinic.

Materials and Methods

It is a prospective study in which patients who applied to Harran University Faculty of Medicine Neurology and Family Medicine outpatient clinic with the complaint of headache between July 2017 and September 2017 were included. Informed consent forms were received from both the headache patients and the healthy control group participating in this study. Ethics committee approval of the study was obtained from the Ethics Committee of Harran University Faculty of Medicine (approval number: E.24671). The diagnosis of headache was made according to the International Headache 2018 (ICD 8.2, 8.2.1-6) criteria (Table 1).² Two patient groups were formed: those with medication overuse headache and those without MOH. Patients' gender, age, headache duration, monthly headache attack frequency, monthly analgesic use and type, presence of anxiety and depression, and pain severity were evaluated. This information was obtained by the researcher by interviewing the patient and healthy control group. Those who use antidepressants or anxiolytics, those with chronic diseases and pregnant women have been excluded.

The Hospital Anxiety and Depression Scale (HADS) was used for psychiatric evaluations of the patients. The Hospital Anxiety and Depression Scale consists of 14 items. Seven of these items measure anxiety symptoms and the other seven questions measure depression symptoms. Validity and reliability analyzes of the scale with the study of adaptation to Turkish were conducted by Aydemir et al.⁹ The Visual Analogue Scale (VAS) was used to evaluate the severity of pain. According to VAS, pain intensity is usually graded as "no pain" 0 points and "worst pain imaginable" 10 points (10 cm scale).

Results

Medication overuse headache was detected in 55 (25.11%) of 219 patients who applied with the complaint of headache between July 2017 and September 2017. The mean age of the patients was 36.01 ± 9.74 in the group without MOH and 35.88 ± 10.10 in the group with MOH. 46 (83.64%) of MOH patients were female, and 9 (16.36%) were male. 38 (69.10%) of the MOH patients had a history of migraine, and 17 (30.90%) of them had a tension headache. Paracetamol + non-steroidal anti-inflammatory use was detected in 37 patients (67.28%), NSAID and ergotamine in 12 (21.82%) and 6 patients (10.90%). There was no significant difference in age, gender, headache duration and type between the two groups. The frequency of attacks (monthly), presence of depression and pain severity were significantly higher in the MOH group (Table 2-3). Depression was observed in 33 (60%) of the patients with MOH, and anxiety was observed in 12 (21.82%). Depression was observed in 30 (18.29%) and anxiety in 42 (25.60%) of the 164 patients who did not use medication excessively (Table 2, Table 3)

Table 1. Medication overuse headache definition according to 2018 ICHD-3 diagnostic criteria

A. Having a headache of 15 days or more per month in a patient with a previous primary headache.
B. Regularly taking one or more drugs for the acute and/or symptomatic treatment of headache for more than three months.
C. Regular intake of one or more paracetamol, aspirin and non-steroidal anti-inflammatory drugs ≥ 15 days/month AND / OR ergotamine, triptans and opioids ≥ 10 days/month

Table 2. Clinical and Demographic Characteristics of Patients

	Patients without MOH (n=164)	Patients with MOH (n=55)	<i>p</i>
Age	36.01 ± 9.74	35.88 ± 10.10	0.897
Gender			
Woman	125(%76.22)	46 (%83.64)	0.461
Male	39 (%23.78)	9 (%16.36)	
Headache duration (months)	45.87 ± 39.32	51.41 ± 39.84	0.277
Headache type			
Migraine	123 (%75)	38 (%69.10)	0.497
TTH	41 (%25)	17 (%30.90)	
Headache frequency (months)	7.78 ± 4.98	16.81 ± 5.90	<0.001
Analgesic usage frequency (months)	4.01 ± 1.67	15.96 ± 4.99	<0.001

MOH: Medication overuse headache, TTH: Tension-type headache

Table 3. Relationship of MOH with anxiety, depression and pain severity

	Patients without MOH (n=164)	Patients with MOH (n=55)	<i>p</i>
Depression	42 (%25.60)	33 (%60)	0.356
Anxiety	30 (%18.29)	12 (%21.82)	<0.001
VAS	7.06 ± 1.88	7.94 ± 1.52	0.002

MOH: Medication overuse headache, VAS: Visual Analog Scale

Discussion

Medication overuse headache is seen at a rate of approximately 1-1.5% in the society and constitutes 30-50% of patients who apply to headache clinics.^{10,11} Ertaş M. et al. reported that the incidence of MOH was 2.20% in adult women and 0.60% in men in our country.¹² The priority in treatment should be to educate MOH awareness of both patients and physicians, including primary care physicians, and to try to prevent MOH from developing by following the risky patient group more closely. The risk of developing MOH is higher in women, people with a diagnosis of primary headache, especially those with a genetic predisposition, more than ten headaches per month, severe chronic disorders, low socio-economic status and concomitant psychiatric diseases.¹²⁻¹⁴ Knowing these risk factors will enable physicians to follow for modifiable factors and increase the awareness to prevent the development of MOH and the treatment process.

It is the simplest and most correct approach to explain to patients that they will experience more pain with excessive use of analgesics and keep the training of physicians on this subject, including primary care physicians. Effective treatment of MOH is the discontinuation of excessive use of analgesics and consuming plenty of fluids. In addition, appropriate prophylactic treatment should be initiated at this time.¹⁵

Medication overuse has been reported as drugs that cause headache; acetylsalicylic acid, acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs), ergot derivatives, triptans, and opioids. The most commonly used analgesics are NSAIDs.¹⁶

Chronic headaches and psychiatric disorders affect each other bilaterally. Psychiatric disorders may lead to the development of MOH, and they may also affect the success of treatment negatively in the case of accompanying this patient group.⁶⁻⁸ In a study in which patients were followed for one year, it was reported that the rate of relapse was higher in patients with accompanying psychiatric disorders.¹⁷ It has also been reported that depression and anxiety are more common in patients with MOH.^{18,19} In addition, short-term psychodynamic psychotherapy is recommended to be applied together with prophylactic treatment.²⁰ Both excessive use of analgesics and monitoring of comorbid psychiatric conditions in patients with primary headache are important in terms of preventing the development of MOH.

In our study, in accordance with the literature, depression was significantly higher in the group with MOH. Although the incidence of anxiety was higher in the group with MOH, it was not statistically significant.

A high VAS score has been reported to be a predictive value for MOH.²¹ VAS scores of patients with MOH have been reported to show a significant improvement after treatment.²² In our study, the mean VAS score of the group with MOH was significantly higher than the group without MOH.

The limitation of our study was that our patient group was small, and the prognosis of the MOH group after treatment was not evaluated.

Knowing this disease is important primarily in terms of preventing its development and if it has developed, early diagnosis and treatment. Early initiation of treatment for accompanying psychiatric symptoms is important for the success of MOH treatment. The financial burden of MOH on individuals and countries is gradually increasing. We think that raising awareness of patients who apply to primary care polyclinics in terms of excessive analgesic use will decrease the incidence of MOH.

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