The study found that students in the MoodGYM group had a CES-D score of 18 at baseline and 13 at a 20-week follow-up, whereas those in the control group scored 19 at baseline and 16 at 20 weeks. Although no tests of statistical significance were reported for this outcome, the MoodGYM group appears to have had a decrease in CES-D score out of the depressive range.\(^3\)

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What is the best treatment for medication-induced rebound headaches?

Evidence-Based Answer

For patients with medication overuse headaches, abrupt withdrawal of the suspected offending agent with rescue medications or using a preventive medication (angiotensin II blockers, beta-blockers, antiepileptic drugs, or tricyclic antidepressants) at the time of withdrawal may decrease headache frequency (SOR: B, RCT).

A multicenter, open-label RCT of 56 patients evaluated treatment options for medication overuse headaches over a 12-month period.\(^1\) Patients were randomized into 3 groups: abrupt withdrawal with rescue medication (amitriptyline 10–25 mg, diclofenac 50 mg, naproxen 500 mg, or metoclopramide 20 mg up to 2 days/week), preventive treatment (angiotensin II blockers, beta-blockers, antiepileptic drugs, or tricyclic antidepressants, dosages not provided), and a control group that received no advice or medication.

Compared with baseline, preventive treatment (n=17) reduced headache days per month at 3 months (–7.2 days; 95% CI –2.7 to –12), 5 months (–7.3 days; 95% CI, –2.7 to –12), and 12 months (–10.3 days; 95% CI, –5.8 to –15). Abrupt withdrawal (n=20) also resulted in a decrease in headache days per month at 3 months (–4.2 days; 95% CI, –3.3 to –7.4), 5 months (–4.8 days; 95% CI, –1.3 to –8.2), and 12 months (–5.1 days; 95% CI, 0.9 to –9.3). The control group (n=19) did not have a reduction in headache days compared with baseline (3 months: –1.6 days; 95% CI –5.1 to 1.8; 5 months: –2.1 days; 95% CI, –5.2 to 0.8).\(^1\)

In a 4-year follow-up study, 83% of the original study participants (N=50) were reevaluated.\(^2\) While two-thirds of the patients maintained at least a 50% reduction in headache frequency, there was no correlation with the type of early intervention.

The 2011 European Federation of Neurological Societies (EFNS) Headache Panel expert guidelines for management of medication overuse headaches recommended the abrupt withdrawal of the offending medication.\(^3\) Tapered withdrawal was recommended for opioids, benzodiazepines, and similar addictive medications. The guideline stated that no studies had directly compared abrupt versus tapered withdrawal, so recommendations were based on limited evidence.

Trials reviewed by the guideline indicated topiramate decreased chronic migraine headache frequency per month compared with placebo (–3.5 vs –0.2; P<.05), although 75% of the topiramate group reported adverse effects. Other small open-label trials reviewed by the guideline suggested preventive treatment with topiramate and valproic acid might benefit. Results with oral corticosteroids were conflicting, with benefit reported from prednisone and prednisolone in a large open-label trial and a small proof-of-concept study, but the only double-blinded RCT (N=97) investigating the use of oral prednisolone during the first 6 days after medication withdrawal showed no significant benefit. Other nonplacebo-controlled studies reviewed suggested amitriptyline (10–50 mg), naproxen (500 mg), or sumatriptan (subcutaneous injection) might be effective for withdrawal headache symptoms.\(^3\)

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