▪ Headache Medicine 2026, Supplement ▪ p-ISSN 2178-7468, e-ISSN 2763-6178

Headache Medicine

ID: 421

Multimodal approach in the reversal of Medication Overuse Headache (MOH): a case report

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Introduction
Medication overuse headache (MOH) constitutes a major cause of pain chronification in patients with recurrent primary headaches. The abuse of analgesics and abortive medications generates central sensitization and a rebound effect, perpetuating dependence and refractory attacks. Early recognition, detoxification, and adequate prophylaxis are essential for clinical control and functional recovery. Furthermore, this study reports the management of the case, aiming to provide evidence regarding the efficacy of this approach in managing this therapeutic challenge.

Case presentation
A 35-year-old male patient with a history of migraine since adolescence presented with an increase in attack frequency and initiated frequent self-medication. Despite the prior use of amitriptyline and valproate, he progressed over the last two years to daily headache (more than 20 days/month), meeting the criteria for chronic migraine and MOH (ICHD-3; 8.2). He daily consumed a combination of dipyrone (up to 4g/day), ibuprofen 600mg, and about 15 to 20 triptan tablets per month. He developed a pattern of rebound headache: waking up in the early morning with a burning and oppressive holocranial pain (VAS=9), which partially subsided only with further doses of analgesics. The clinical picture was associated with nausea, gastralgia due to anti-inflammatory abuse, insomnia, irritability, and work absenteeism. Detoxification was instituted with the abrupt discontinuation of analgesics and triptans. As transitional therapy for the withdrawal syndrome, Prednisone 40 mg/day was used for five days, associated with intravenous metoclopramide if necessary, initiation of Topiramate (titrated up to 100 mg/day), and greater occipital nerve block with 2% lidocaine. The patient received strict guidance regarding the limit for rescue medication use (up to 2/week). After six months, the frequency was reduced to four days of pain per month (VAS=3), with attacks restricted to the original episodic migraine, an excellent response to the triptan alone, and restoration of functionality.

Discussion
The case illustrates the link between MOH and the worsening of headache pain, as well as the rationale behind detoxification. The rebound effect of medication abuse favors central sensitization and compromises prophylaxis, contributing to frequent and refractory attacks, as observed in this case. The combination of a corticosteroid and anesthetic infiltration mitigated the withdrawal and enabled the action of topiramate. This management counteracted drug tolerance and restored the pain threshold. The positive evolution, with symptom relief and discontinuation of the overused medications, suggests the success of the management strategy.

Conclusion
MOH mimics therapeutic refractoriness. The abrupt detoxification strategy, supported by transitional care and patient education, proved effective in reversing the chronic pattern of the reported case, reinforcing the need for targeted and multidisciplinary management.

Keywords:
Chronic headache
Medication overuse headache
Detoxification
ICHD-3

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