ABSTRACT

Transformed migraine (TM) is a type of chronic daily headache characterized by daily or almost daily headaches (ie, >15 days/month) with an average duration of more than 4 hours per day if left untreated. Patients with TM have a history of episodic migraine initially, which progresses into CDH. These patients exhibit mixed features of migraine and chronic tension-type headache. Transformed migraine is often caused by analgesic overuse.1,2 Silberstein et al provided formalized criteria for diagnosing TM, although its inclusion in the International Headache Society diagnostic criteria is under discussion and evaluation.3

Clearly, TM is a serious condition, but the extent of disability has not been formally quantified in these patients, in part due to differences in classification criteria, small samples of patients, and short follow-up periods. Several investigators have evaluated the quality of life for TM patients and, not surprisingly, found it to be significantly reduced compared with healthy subjects. The decrease in quality of life was greatest for those with analgesic overuse.4 Lipton defines disability in headache as the consequences of the illnesses on ability to function at work, home, school, or recreation. Stewart et al developed the Migraine disability Assessment (MIDAS) questionnaire to quantify disability. It is a 5-question survey of various activities during the patient's last 3 months. It has shown good internal consistency, test-retest reliability, and validity compared with diary data.5 6

This study assessed the disability in a cohort of TM patients with medication overuse in an inpatient withdrawal program. D'Amico et al developed an Italian

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W I T H D R A W A L T H E R A P Y F O L L O W E D B Y PROPHYLAXIS FOR TRANSFORMED MIGRAINE

Based on a presentation by Licia Grazzi, MD

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*Based on a presentation by Dr Grazzi at the 54th Annual Meeting of the American Academy of Neurology.
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form of the MIDAS questionnaire in 1999 at the C. Besta National Neurological Institute in Milan, Italy. It has also shown good test-retest reliability and internal consistency.9

This study observed patients at 12 months’ follow-up after an inpatient withdrawal program of 8 to 10 days. It is an abrupt withdrawal followed by infusion of saline, steroids, and neuroleptics, as well as antiemetics or benzodiazepines. Sumatriptan (sc) was given on request. Patients were also educated about their headaches and the role of medication overuse, and prophylactic therapy was started. The type of prophylactic therapy depended on each patient's characteristics (presence or not of obesity, hypertension, depression) and any comorbidity. The categories of medications considered were beta-blockers, pizotifen, flunarizine, and antiepileptic. Antidepressants were also prescribed as necessary.

A total of 75 patients with TM were included in the study. The female-to-male ratio was 4:1 and the cohort's mean age was 46.2 ± 12.4 years. The mean duration of illness was 25.9 ± 12.8 years. This is important because the ability to successfully treat CDH is greater if the CDH has occurred for only 1 year.

Patients completed the Italian version of the MIDAS questionnaire, and then underwent the inpatient withdrawal program. Follow-up MIDAS measurements were made at 6 months and 12 months post-withdrawal; diary cards were also evaluated at these time points.

The results of the study are shown in the Table. Significant reductions in headache days per month were observed at both follow-up time points, as were significant reductions in analgesic use per month. The MIDAS disability score was reduced at both 6 months and 12 months, but the decrease was significant only at 6 months. Tribl et al, in a study to assess predictive factors for long-term outcome after drug withdrawal in CDH, showed that one third of CDH patients will develop recurrent drug use up to 5 years post-withdrawal.10 Most of the relapses occurred within the first 2 years. In this study, the MIDAS score was reduced by 64% at 1 year, suggesting that the addition of preventive therapy may assist in reducing the chances of relapse. In fact, only 8% to 10% of the study cohort had relapsed by 9 months, underscoring the importance of patient education on analgesic overuse.

Table. MIDAS Disability Score

<table>
<thead>
<tr>
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<th>Baseline</th>
<th>6 months</th>
<th>12 months</th>
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<tbody>
<tr>
<td>Days of HA/ month</td>
<td>30</td>
<td>8 ± 7.7*</td>
<td>11.9 ± 13.2*</td>
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<tr>
<td>Analgesic days/ month</td>
<td>49.9 ± 30.5</td>
<td>8.4 ± 14.2*</td>
<td>12.6 ± 19.2*</td>
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<tr>
<td>Mean MIDAS score</td>
<td>71 ± 58.8</td>
<td>24.8 ± 28.8*</td>
<td>35.0 ± 41.6*</td>
</tr>
</tbody>
</table>

* P < .001. HA = headache; MIDAS = Migraine Disability Assessment.
REFERENCES