

Exit strategy in heavy Indomethacin intoxication in Medication Overuse Headache

Open Access

Abstract

Published 09/04/2024

Copyright

© Copyright 2024

Bellamio et al. This is an open access abstract distributed under the terms of the Creative Commons Attribution License CC-BY 4.0., which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Distributed under

Creative Commons CC-BY 4.0

Matteo Bellamio ¹, Alberto Terrin ², Chiara Da Ronch ³, Rocco Quatralo ², Ernesto Gastaldo ¹

¹. UOS Neurofisiologia Clinica, Intraoperatoria e di Area Critica, Azienda ULSS 3 Serenissima, Ospedale dell'Angelo, Mestre, ITA ². UOC Neurologia, Azienda ULSS 3 Serenissima, Ospedale dell'Angelo, Mestre, ITA ³. AIRDA, AIRDA Associazione Interdisciplinare per la Ricerca e la Didattica sull'Autogenicità, Ponzano Veneto (TV), ITA

Corresponding author: Matteo Bellamio, matteo.bellamio@aulss3.veneto.it

Categories: Neurology, Pain Management

Keywords: medication overuse headache

How to cite this abstract

Bellamio M, Terrin A, Da Ronch C, et al. (September 04, 2024) Exit strategy in heavy Indomethacin intoxication in Medication Overuse Headache. Cureus 16(9): a1297

Abstract

Introduction. Medication overuse headache (MOH) is a secondary type of headache due to the overuse of painkillers by a person with an underlying headache, (mainly migraine or tension-type headache). MOH presents 15 or more headache days per month and it is associated with high disability and reductions in the quality of life. Treatments of MOH include the initiation of preventive therapies but, the withdrawal of the overused medication is essential to the success¹.

Indomethacin is one of the most effective drugs used in primary and also in secondary headache but it is also one of the drugs most often used by patients with MOH².

We present the case of a 44-years-old man with no relevant medical history, who suffered from migraine without aura since he was a child and from MOH with a very high daily intake of indomethacin (800-900 mg) for at least 5 years. All previous migraine preventive therapies had failed or had been not well tolerated (including monoclonal antibody, without national prescription plan).

Methods. Hospitalization was arranged to carry out some general tests and to propose a multidisciplinary therapeutic and psychological detoxification approach.

Baseline blood tests investigations were surprisingly normal (including liver and kidney function); EKG and cardiovascular status were also regular. We instituted a treatment with high doses of corticosteroids (intravenous methylprednisolone up to 500 mg a day) in association with benzodiazepines (intravenous diazepam 10 mg three times a day) for 7 days (subsequently tapered over 15 days). We had also planned to start antidepressant therapy and a psychiatric evaluation to better manage the drug dependency.

Results. Already from the second day our patient halved the use of indomethacin and by the fifth day he was free from the consumption of painkillers. At the 3-month follow-up evaluation the patient presented an episodic form of migraine without aura sensitive to acute treatment with triptans; no indication for preventive medications. Further evaluations will be planned in order to possibly start second-line therapy.

Conclusions. There are no unique therapeutic lines available for the approach to patients suffering from MOH; in our Headache Center we had never had to deal with a patient with such a high daily consumption of indomethacin with a serious risk of severe systemic intoxication.

In our previous experience, the most effective exit-strategies was the use of high-dose steroids (usually methylprednisolone 125-250 mg a day) for short period (up to 3-5 days) combined with oral benzodiazepines or the initiation of anti-CGRP pathway monoclonal antibody for migraine patients in association to an adequate psychological support plan. In this case we modified our previous scheme and therefore tailor-made an appropriate path for this patient with more than satisfactory results.

References.

1. Ashina S, Terwindt GM, Steiner TJ, Lee MJ, Porreca F, Tassorelli C, Schwedt TJ, Jensen RH, Diener HC, Lipton RB. Medication overuse headache. *Nat Rev Dis Primers*. 2023 Feb 2;9(1):5.

2. Villar-Martínez MD, Moreno-Ajona D, Chan C, Goadsby PJ. Indomethacin-responsive headaches-A narrative review. *Headache*. 2021 May;61(5):700-714.

