PREVENTIVE TREATMENT OF CHRONIC MIGRAINE

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The International Classification of Headache Disorders 3-beta defines chronic migraine as follows:

Description:
Headache occurring on 15 or more days per month for more than three months, which, on at least 8 days per month, has the features of migraine headache.

Diagnostic criteria:
A. Headache (tension-type-like and/or migraine-like) on ≥15 days per month for >3 months[2] and fulfilling criteria B and C
B. Occurring in a patient who has had at least five attacks fulfilling criteria B-D for 1.1 Migraine without aura and/or criteria B and C for 1.2 Migraine with aura
C. On ≥8 days per month for >3 months, fulfilling any of the following[3]:
    1. criteria C and D for 1.1 Migraine without aura
    2. criteria B and C for 1.2 Migraine with aura
    3. believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative
D. Not better accounted for by another ICHD-3 diagnosis.

They comment that "The reason for singling out chronic from episodic migraine is that it is impossible to distinguish the individual episodes of headache in patients with such frequent or continuous headaches. In fact, the characteristics of the headache may change not only from day to day but even within the same day. Such patients are extremely difficult to keep medication-free in order to observe the natural history of the headache. In this situation, attacks with or without aura are both counted, as well as tension-type-like headaches. The most common cause of symptoms suggestive of chronic migraine is medication overuse, as defined under 8.2 Medication-overuse headache. Around 50% of patients apparently with 1.3 Chronic migraine revert to an episodic migraine subtype after drug withdrawal; such patients are in a sense wrongly diagnosed as 1.3 Chronic migraine. Equally, many patients apparently overusing medication do not improve after drug withdrawal, and the diagnosis of 8.2 Medication-overuse headache may in a sense be inappropriate (assuming that chronicity induced by drug overuse is always reversible). For these reasons, and because of the general rule, patients meeting criteria for 1.3 Chronic migraine and for 8.2 Medication-overuse headache should be given both diagnoses. After drug withdrawal, migraine will either revert to the episodic subtype or remain chronic, and be re-diagnosed accordingly; in the latter case, the diagnosis of 8.2 Medication-overuse headache may be rescinded. In some countries, it is usual practice to diagnose 8.2 Medication-overuse headache only on discharge."

They also recommend that diagnosis "generally requires a headache diary to record information on pain and associated symptoms day-by-day for at least one month."

A number of treatments are FDA approved for preventive therapy of migraine, but only onabotulinum toxin is FDA approved for chronic migraine. There is evidence that topiramate is also beneficial, but it is not FDA approved for this subgroup of patients.

Expectations of treatment benefit should be modest in patients who have frequent headache, especially if those headaches are of longstanding. In most cases an appropriate goal is the reduction of headache frequency by 25 to 50%, or a reduced need for acute or abortive migraine medications.