Letters to the Editor

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This series is coordinated by Kenny Lin, MD, MPH, Associate Deputy Editor for *AFP* Online.

Pharmacologic Options for the Treatment of Chronic Daily Headache

Original article: Chronic Daily Headache: Diagnosis and Management

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TO THE EDITOR: I appreciated the excellent article on chronic daily headache. The goal of avoiding overuse of abortive therapy by employing prophylactic treatment when warranted was well described. I believe that two additional points would further enhance the discussion.

Butalbital is a commonly used abortive treatment with little evidence to support its use and growing evidence of risk. Despite being studied only for the treatment of tension headaches, butalbital is taken by 6% of patients with acute migraine headaches and 13% of patients with chronic migraine headaches.[1] Unfortunately, butalbital is the abortive medication most likely to lead to medication overuse headaches.[2] As a result, the American Academy of Neurology (AAN), the American Headache Society, and the American Board of Internal Medicine (in its Choosing Wisely campaign) recommend avoiding its use as a first-line agent for the treatment of headaches.[3]

The list of prophylactic medications in the article included tricyclic antidepressants and selective serotonin reuptake inhibitors but excluded venlafaxine (Effexor), a serotonin-norepinephrine reuptake inhibitor. Although the strength of evidence is limited, studies show that venlafaxine is comparable to some recommended medications, notably gabapentin (Neurontin) and tizanidine (Zanaflex).[4,5] In addition, as pointed out in the AAN guideline, venlafaxine appears to have equivalent benefit to tricyclic antidepressants but with fewer adverse effects.[6] The AAN gives venlafaxine a category B recommendation for prophylaxis of migraine headaches, the same as tricyclic antidepressants.

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IN REPLY: I agree with Dr. Arnold that butalbital should be avoided for acute treatment of headaches.

Regarding the use of venlafaxine for headache prophylaxis, the AAN guideline Dr. Arnold cites is for prophylaxis of episodic migraine, not for chronic daily headache, which by International Headache Society definition occurs for 15 days or more per month for at least three months.[1] It is unclear if medications that are effective for prophylaxis of episodic headaches, whether migraines or tension-type headaches, are

also effective for chronic daily headache. This is why the list of suggested medications in our article is more restrictive than the ones offered in the AAN guideline.[2]

The other studies Dr. Arnold mentions also excluded[3] or had unclear numbers of patients with chronic daily headache vs. episodic headaches.[4,5] In addition, all of the studies were sponsored by the same pharmaceutical company.[3-5] Although venlafaxine may have some effectiveness for prophylaxis of episodic migraines, I believe that more studies are needed before recommending its use over other available options for chronic daily headache prophylaxis.

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Correction

Missing words in haloperidol dosage. The article "Delirium in Older Persons: Evaluation and Management" (August 1, 2014, p. 150) had missing words in Table 8 (p. 156) regarding the dosage for haloperidol. The first row of the column "Dosage" should have indicated that 0.5 to 1.0 mg of haloperidol be given twice daily orally, with additional doses every four hours as needed, or intramuscularly every 30 to 60 minutes as needed. The online version of this article has been corrected. ■