MIPCA
MIGRAINE IN PRIMARY CARE ADVISORS

MIGRAINE ACTION

NUMBER 21, OCTOBER 2012

Updated guidelines on headache management for use by the pharmacist

Introduction

Headache is a major public health problem, with many patients remaining unrecognised, undiagnosed and poorly treated.[1] Many patients do not consult a GP for headache, and rely on over-the-counter medications from shops or pharmacists.[1] Guidance for the pharmacist on how to identify and manage headache sufferers would be welcome, and has the potential to improve the current unmet medical need.

Headaches are almost ubiquitous, the most common being episodic tension-type headache (TTH), migraine and chronic primary headache (a pattern of headaches occurring on ≥15 days per month and lasting for more than 4 hours on average, which are often linked to medication overuse).[2] The most frequently encountered of these chronic headaches are chronic migraine (where migraine attacks occur on a minimum of 8 days per month[3]) and chronic TTH.

MIPCA has developed evidence-based guidelines for the management of migraine (see Page 4)[4] and chronic headaches.[5] This newsletter describes updated headache guidelines developed by MIPCA and Migraine Action (MA) for pharmacists. The original guidelines were developed by MIPCA in 2006 in conjunction with a group of community pharmacists and pharmacy advisors.[6]

Overview: Pharmacist guidelines for headache management

Headache management guidelines contain seven principles of care that can be used for all headache subtypes, with treatment customised to the individual headache.[4,5] These principles are shown below, showing how they can be adapted for use by the pharmacist and their counter staff:

1. Screening: pharmacist and counter staff can respond to customer interest or elicit a headache history from those wishing to purchase analgesics.
2. Patient education and commitment: the pharmacy can contain posters and leaflets on headache, and the staff should be willing to discuss sources of further information with patients.
3. Differential diagnosis: a screening questionnaire is available that enables the pharmacist to diagnose the patient into the appropriate headache subgroup.
4. Assessment of illness severity: questions on the severity of the headache and associated symptoms, and limitations to daily activities allows the categorisation of migraine into mild-to-moderate or moderate-to-severe intensity.
5. Tailoring management to the needs of the individual patient: patients with TTH and mild-to-moderate migraine may be treated by the pharmacist with OTC medications. Those with moderate-to-severe migraine, chronic primary headache or possible sinister headache are best referred to the GP.
6. Proactive long-term follow up: patients should be encouraged to return to the pharmacy for review of illness severity and response to treatment.
7. A team approach to care: a partnership between the GP service and the pharmacist allows for efficient communication and facilitates the patient journey of care.

Screening, patient education and commitment

Headache sufferers need to be shown that the pharmacy can help them. Posters in the shop, leaflets located next to analgesics and advertisements in the local press may all be useful and encourage patients to speak to the pharmacist or the counter staff. Otherwise, a good starting point is to ask customers who want to buy analgesics if they need them for headache. Follow-up questions investigate the headache history, severity and use of medications.

Pharmacies should be able to provide advice in the form of leaflets, newsletters, and information on relevant websites and patient support organisations. Migraine Action (MA, the UK patient support group for headache, www.migraine.org.uk) and the Migraine Trust (www.migrainetrust.org) provide outputs designed for patients. The MIPCA website (www.mipca.org.uk) contains a wealth of information aimed at the healthcare professional.

Diagnosis

Pharmacists are generally not well informed on headache diagnosis. However, MIPCA and MA have developed a simple, eight-item, validated Diagnostic Screening Questionnaire (DSQ) for headache that differentiates between headache subtypes and is designed for use when the patient first consults for headache (Table 1).[7]

1. Has the pattern of your headaches been generally stable (i.e. no change or only small changes in frequency and severity) over the past few months?	Yes ☐ / No ☐
2. Have you had headaches for longer than 6 months?	Yes ☐ / No ☐
3. Are you aged between 5 and 50 years?	Yes ☐ / No ☐
4. Does the headache interfere to a noticeable extent with your normal daily life (work, education and social activities)?	Yes ☐ / No ☐
5. On average, how many days with headache do you have per month?	Less than 1 ☐ / 1 ☐ / 1–4 ☐ / 5–15 ☐ / 15–30 ☐ / Every day ☐
6. On average, how long do your headaches last, if left untreated?	Less than 15 minutes ☐ / 15 minutes to 1 hour ☐ / 1–2 hours ☐ / 2–4 hours ☐ / Over 4 hours ☐ / My headaches are always there ☐
7. On average, on how many days per week do you take analgesic medications?	Less than 1 ☐ / 1 ☐ / Up to 2 ☐ / 2 or more ☐ / Every day ☐
8. Do changes in your senses (sight, taste, smell or touch) occur in the period immediately before the headache starts?	Yes ☐ / No ☐

Table 1. The MIPCA / MA 8-item headache Diagnostic Screening Questionnaire (DSQ).[7]

Diagnostic algorithm

Possible sinister headache:	■ A 'no' answer to any of Questions 1, 2 or 3 indicates the possibility of secondary (or sinister) headaches.	
TTH:	■ 'Yes' to Questions 1–3. ■ 'No' answer to Question 4.	TTH is typified by a pattern of non-disabling headaches.
Migraine:	■ 'Yes' to Questions 1–3 ■ 'Yes' to Question 4 ■ '<1'; '1'; '1–4' and '5–15' days to Question 5 ■ '2–4 hours' and 'Over 4 hours' to Question 6 (those with headache duration ≤ 2 hours may have other types of episodic headache). ■ 'Yes' (migraine with aura) or 'No' (migraine without aura) to Question 8.	This provides the typical disabling, episodic pattern of headache, with or without aura, seen in migraine patients.
Chronic Primary Headache:	■ 'Yes' to Questions 1–3 ■ 'Yes' to Question 4 ■ '15–30 days'; and 'every day' to Question 5 ■ 'Over 4 hours' and 'My headaches are always there' to Question 6 (those with headache duration ≤ 4 hours may have other types of chronic headache).	This provides the typical disabling, chronic pattern of headache seen in patients with chronic primary headache.
Medication overuse headache (MOH):	Many patients with chronic primary headache overuse acute medications and have MOH, where the headache is directly related to the consumption of these drugs. ■ '<1'; '1'; 'up to 2' to Question 7 = no medication overuse ■ '2 or more' and 'every day' to Question 7 = with medication overuse.	

Decisions based on diagnosis

- Possible sinister headache: refer immediately to the GP.
- TTH: can be managed in the pharmacy.
- Migraine: patients with mild-to-moderate migraine can be managed in the pharmacy; those with moderate-to-severe migraine are best referred to the GP.
- Chronic primary headache, with or without MOH, and other chronic headaches: best referred to the GP.

Assessing migraine severity

The severity of migraine can be assessed using three questions:

1. On average, how intense are your migraines (none, mild, moderate, severe, excruciating)?
2. On average, how intense are your non-headache migraine symptoms (none, mild, moderate, severe, excruciating)?
3. How much do your migraines interfere with your normal daily activities (not at all, a little, a reasonable amount, a lot, unable to do any activities)?

Mild-to-moderate: symptoms mild or moderate; interference a little or reasonable.

Moderate-to-severe: symptoms severe or excruciating; interference a lot or unable to do any activities.

Treatment selection

From the outset, it needs to be established which drugs the person is taking for conditions other than headaches. They may be on pain killers for other pain states (e.g. joint pain), and these should be accounted for before selling a pain-killing drug.

TTH:

- Can usually be managed with OTC analgesics (e.g. paracetamol, aspirin and NSAIDs). If one analgesic has proved ineffective, another may be provided.

Migraine:

- May also be managed with paracetamol, aspirin, NSAIDs or combination analgesics. These treatments should be taken as soon as possible after the migraine attack starts, if possible even before the onset of the headache.
- There are now different formulations of analgesic medications, which may be appropriate for different types of migraine attacks. For example, some are rapidly absorbed and may be fast-acting (e.g. by adding a lysine group to the drug, as in Nurofen Migraine), and some may have a long duration of action (e.g. the NSAIDs). It is recommended that the pharmacist discusses the patient's migraine symptoms with them, so that he or she can provide them with optimal treatment.
- Imigran 50 mg tablets have been available for patients to purchase from the pharmacist without a doctor's prescription for several years now (i.e. P rather than POM status). Other triptans may follow suit in the next few years as they go off patent. Again, the pharmacist should discuss the patient's migraine symptoms with them before dispensing a triptan pharmacy prescription.
- However, patients who have previously failed on a range of analgesics and/or Imigran 50 mg should be referred to their GP.
- Lifestyle options (e.g. stress reduction and trigger avoidance), behavioural therapies (e.g. biofeedback and relaxation), physical therapies (e.g. cervical manipulation, acupuncture, massage and exercise) and complementary therapies (e.g. feverfew, magnesium, vitamin B2 and butterbur root extract) may also be effective and can be recommended to be taken as well as analgesics or Imigran 50 mg.
- In all cases, the frequent use (> 1 day per week) of codeine-containing analgesics is inadvisable, due to the associated risk of developing chronic headaches. Alternative treatments should be selected for such patients.
- Patients' co-morbidities and concurrent medications should be checked, as these may preclude certain medications, e.g. asthma sufferers should not be sold aspirin or NSAIDs.

Figure 1 shows the MIPCA algorithm for management of headache in the pharmacy.[6]

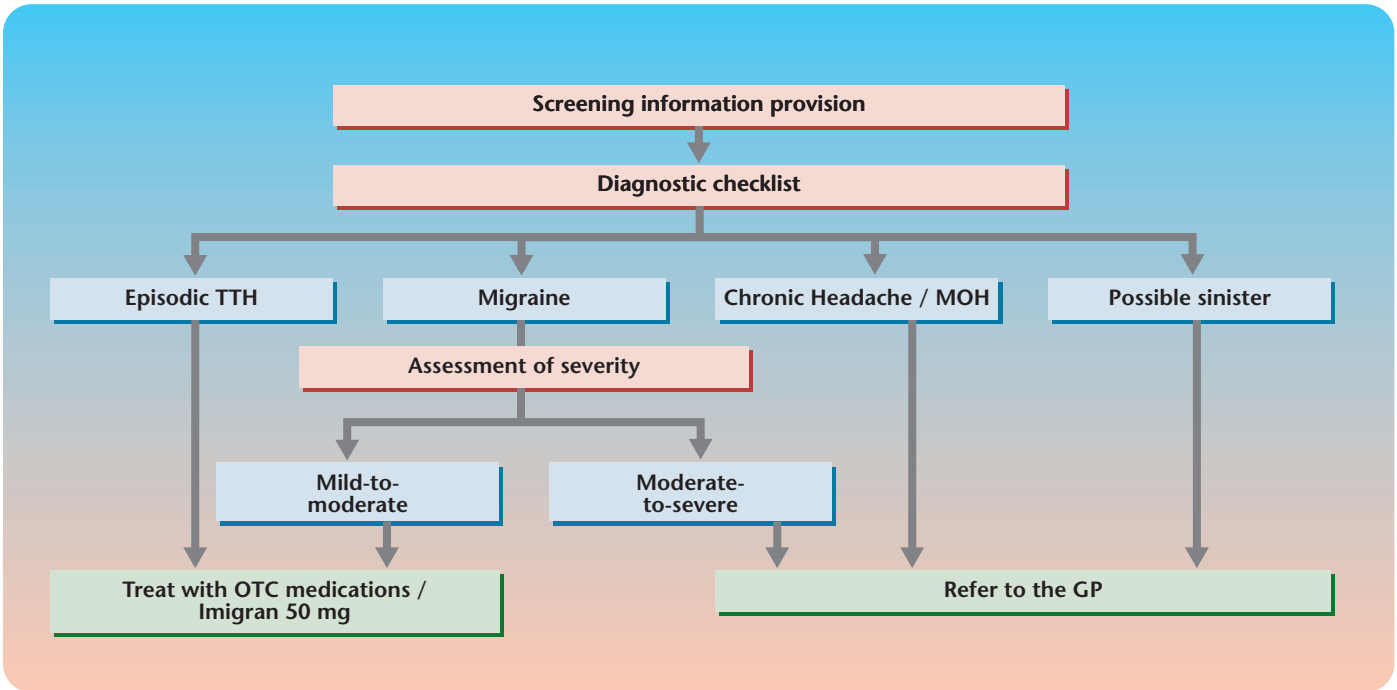

Figure 1. An algorithm for the management of headache in the pharmacy. Adapted from reference [6]

Follow up

Patients should be asked to return after 1 month for review. Patients treated effectively with acute medications should continue on this therapy, but those who have not responded need to be offered another medication, or referred to their GP if analgesics are clearly failing. Patients should also be referred if chronic headache is suspected. Lifestyle, behavioural, physical and complementary therapies are not immediately effective and the patient may require encouragement to continue with them.

The primary care headache team

MIPCA encourages a team approach to the management of headache in primary care.[4] The GP concentrates on diagnosis and prescription of appropriate treatments, while the practice nurse forms the first point of contact for the patient and conducts routine assessment procedures. Pharmacists and other healthcare professionals identify patients and direct them into the team. As described here, pharmacists manage appropriate patients and also dispense prescription medications to patients who have consulted with their GP. Dialogue and meetings between team members are encouraged for its smooth working.

Issues and challenges

1. The NHS encourages an enhanced role for pharmacists in disease management,[8] although payment for such services needs to be provided.
2. Private consultation areas are required in pharmacies, and are increasingly available.
3. Appropriate training in headache management is required for pharmacists and counter staff. New training schemes need to be developed.
4. The pharmacy algorithm (Figure 1) needs to be further developed to include information on medications, adverse events, drug interactions, and patients' concurrent medications and co-morbidities, to allow the pharmacist to make informed decisions. It would be useful to develop a computer-based program for this, for delivery via websites or mobile apps.
5. Local agreements between pharmacists and GP surgeries may be required to implement the headache team.
6. Headache services need to be monitored, probably by the use of audits.

The future

Current NHS planning envisages enhanced roles for pharmacists that will extend their range of health service provision, including that for headache:

1. Further oral triptans may be switched from POM to P status.[9]
2. Some pharmacists will become supplementary prescribers following the development of patient-specific Clinical Management Plans in conjunction with the GP and the patient.[10] Pharmacists will require comprehensive training for this.[11]

MIPCA guidelines for the management of migraine in primary care[4]

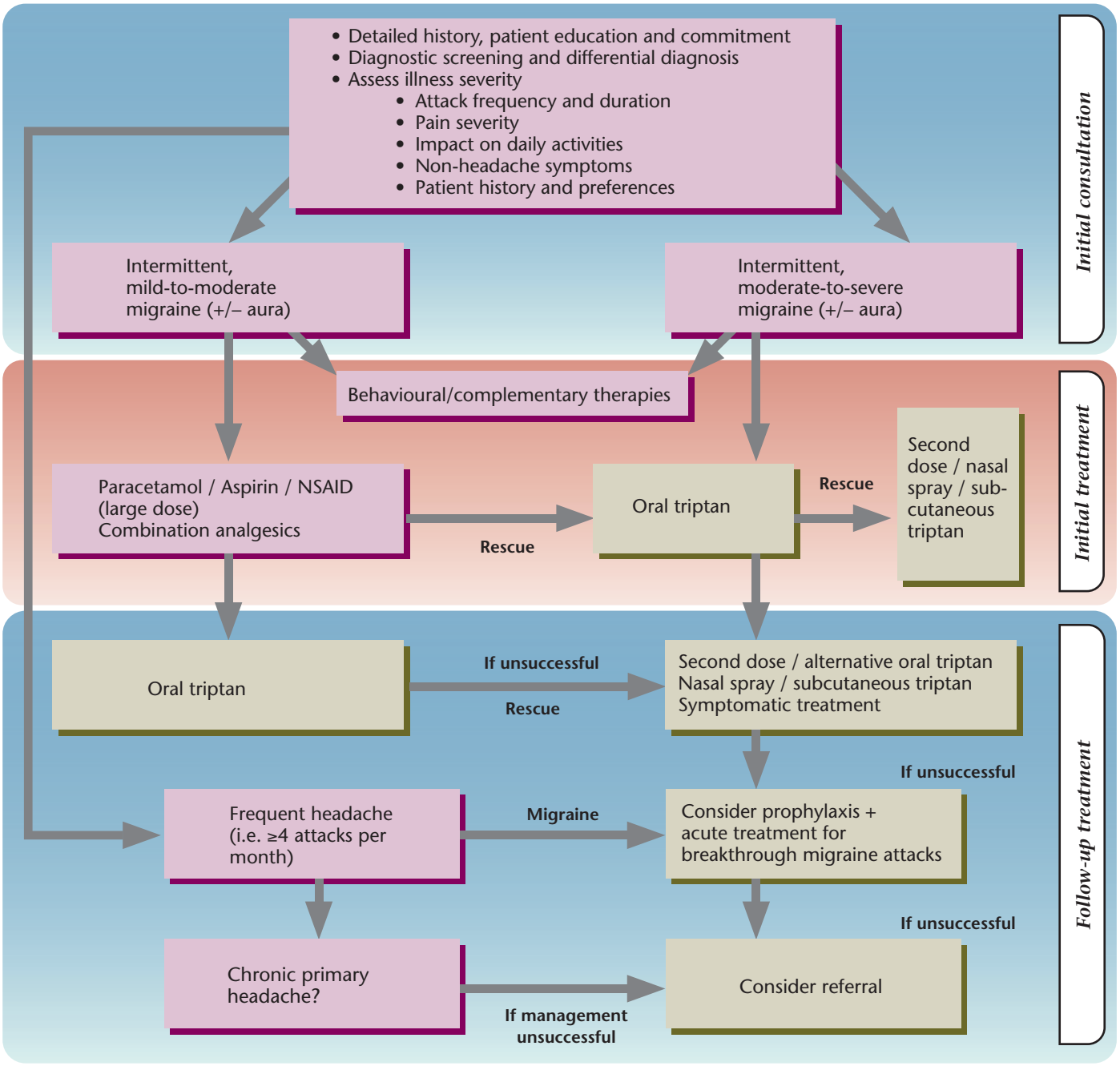

Figure 2. MIPCA algorithm for the management of migraine in primary care.[4] The boxes in red indicate actions that the pharmacist might reasonably be expected to conduct. The boxes in green indicate actions that at present are conducted by the GP.

References

1. Lipton RB, Goadsby PJ, Sawyer JPC et al. Migraine: diagnosis and assessment of disability. Rev Contemp Pharmacother 2000;11:63–73.
2. Headache Classification Committee of the International Headache Society. The international classification of headache disorders; 2nd Edition. Cephalalgia 2004;24(Suppl 1):1–160.
3. Olesen J, Bousser M-G, Diener H-C et al. New Appendix Criteria open for a broader concept of chronic migraine. Cephalalgia 2006;26:742-746.
4. Dowson AJ, Lipscombe S, Sender J et al. New guidelines for the management of migraine in primary care. Curr Med Res Opin 2002;18:414–39.
5. Dowson AJ, Bradford S, Lipscombe S et al. Managing chronic headaches in the clinic. Int J Clin Pract 2004;58:1142–51.
6. Glover C, Greensmith S, Ranftler A et al. Guidelines for community pharmacists on the management of headaches. Pharmaceutical J 2008;280:.
7. Dowson AJ, Turner A, Kilminster S et al. Development and validation of the headache Diagnostic Screening Questionnaire (DSQ): a new questionnaire for the differential diagnosis of headache for use in primary care. Headache Care 2005;2:111–18.
8. Department of Health. A vision for pharmacy in the new NHS. www.dh.gov.uk/publications, 2003.
9. Royal Pharmaceutical Society. Potential candidates for reclassification from POM to P. www.rpsgb.org.uk/pdfs/pomtopreclasslist.pdf, 2004.
10. Royal Pharmaceutical Society of Great Britain. Supplementary prescribing by pharmacists. www.rpsgb.org.uk/pdfs/supplprescphbrief.pdf, 2005.
11. Royal Pharmaceutical Society of Great Britain. Outline curriculum for training programmes to prepare pharmacist supplementary prescribers. www.rpsgb.org.uk/pdfs/supplprescphout.pdf, 2002.

MIPCA

MIGRAINE IN PRIMARY CARE ADVISORS

MIPCA is an independent charity (Registration No. 1092433) working through research and education to set standards for the care of headache sufferers. MIPCA is a group of physicians, nurses, pharmacists and other healthcare professionals dedicated to the improvement of headache management in primary care.

If you are interested in joining MIPCA, please contact:

Ms Rebecca Salt,
Merrow Park Surgery,
Kingfisher Drive,
Merrow,
Guildford
GU4 7EP

Tel 01483 450755
Fax 01483 456740

website: www.mipca.org.uk

email: info@mipca.org.uk

MIGRAINE ACTION

Migraine Action is a registered charity (Registration No. 207783), bridging the gap between the migraine sufferer and the medical world by providing information on all aspects of the condition and its management. Migraine Action aims to raise awareness of migraine, support research and offer advice to migraineurs, their families, friends and colleagues, healthcare professionals and the general public.

If you are interested in joining MA, please contact:

Migraine Action,
4th Floor,
27 East Street,
Leicester,
LE1 6NB

Tel 0116 275 8317
Fax 0116 254 2023

website: www.migraine.org.uk

e-mail: info@migraine.org.uk

Acknowledgements

This updated newsletter was sponsored in part by an unrestricted educational grant from Allergan. Dr Peter Blakeborough was the medical communications consultant. Paul Burt designed the newsletter.