Headache Care for Practising Clinicians

Headache Care for Practising Clinicians (HCPC) is an independent organisation working through research and education to improve headache management by practising clinicians worldwide. HCPC includes all healthcare professionals with an interest in headache, including physicians, nurses, pharmacists and other practitioners.

Establishing principles for migraine management in primary care

In the past few years, initiatives in the UK and the USA have resulted in rational, evidence-based guidelines for migraine designed for use in primary care.[1–3] These initiatives have set new standards for the screening, diagnosis, management, treatment and follow-up of patients. The challenge now is to produce guidelines that are applicable to migraine care in countries around the world. As a first step towards this objective, two meetings of the HCPC organisation were set up in 2002 to review existing best practice for primary care migraine management in different countries, and produce agreed principles for international management guidelines. Twelve principles of migraine management were identified, covering screening, diagnosis, management and treatments (Table 1).

Screening and diagnosis	
1.	*Almost all headaches are benign/primary and can be managed by all practising clinicians.*
2.	*Use questions / a questionnaire to assess the impact on daily living and everyday activities, for diagnostic screening and to aid management decisions.*
Management	
3.	*Share migraine management between the clinician and the patient.*
4.	*Provide individualised care for migraine and encourage patients to manage their migraine.*
5.	*Follow-up patients, preferably with migraine calendars or diaries.*
6.	*Regularly re-evaluate the success of therapy using specific outcome measures and monitor the use of acute and prophylactic medications regularly.*
7.	*Adapt migraine management to changes that occur in the illness and its presentation over the years.*
Treatments	
8.	*Provide acute medication to all migraine patients and recommend it is taken at the appropriate time during the attack.*
9.	*Provide rescue medication / symptomatic treatment for when the initial therapy fails.*
10.	*Offer to prescribe prophylactic medications, as well as lifestyle changes, to patients who have four or more migraine attacks per month or who are resistant to acute medications.*
11.	*Consider concurrent co-morbidities in the choice of appropriate prophylactic medication.*
12.	*Work with the patient to achieve comfort with the mutally agreed upon treatment and ensure that it is practical for their lifestyle and headache presentation.*

Table 1. The 12 principles of migraine management identified by HCPC

Using these principles, the practising clinician can screen and diagnose their headache patients, and manage migraine patients over the long-term. In this way, the majority of migraine patients can be well treated in primary care, providing a structured and individualised approach to care, and conserving valuable healthcare resources.

Screening and diagnosis

1. *Almost all headaches are benign/primary and can be managed by all practising clinicians*

While almost all headaches encountered in general/family practice are subtypes of migraine, tension-type headache (TTH) and chronic daily headache (CDH), the physician must screen for the possible (but very rare) occurrence of secondary (sinister or worrisome) headaches (Figure 1).

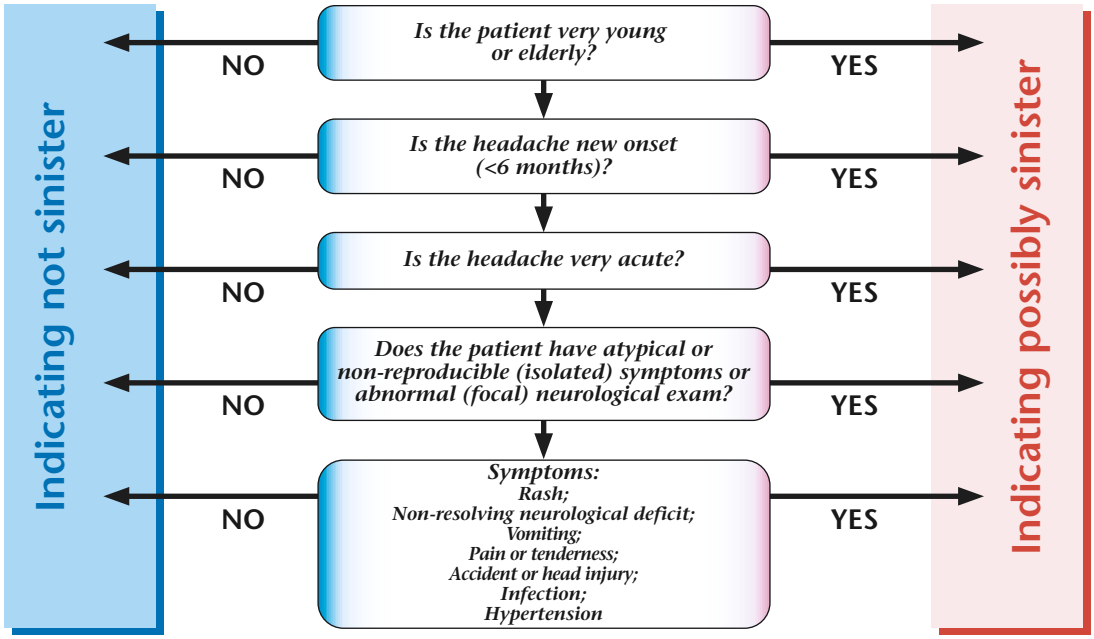

Figure 1. A new proposed algorithm for the exclusion of sinister headache in primary care.

2. *Use questions / a questionnaire to assess the impact on daily living and everyday activities, for diagnostic screening and to aid management decisions*

Evidence shows that patients presenting to their primary care physicians with episodic, high impact headaches most frequently have migraine (Figure 2). Such patients should be given a default diagnosis of migraine, with the diagnosis confirmed, if necessary, by further questioning. Additionally, migraine can sometimes present with features suggestive of TTH or migrainous headache (where all but one of the migraine criteria are present).

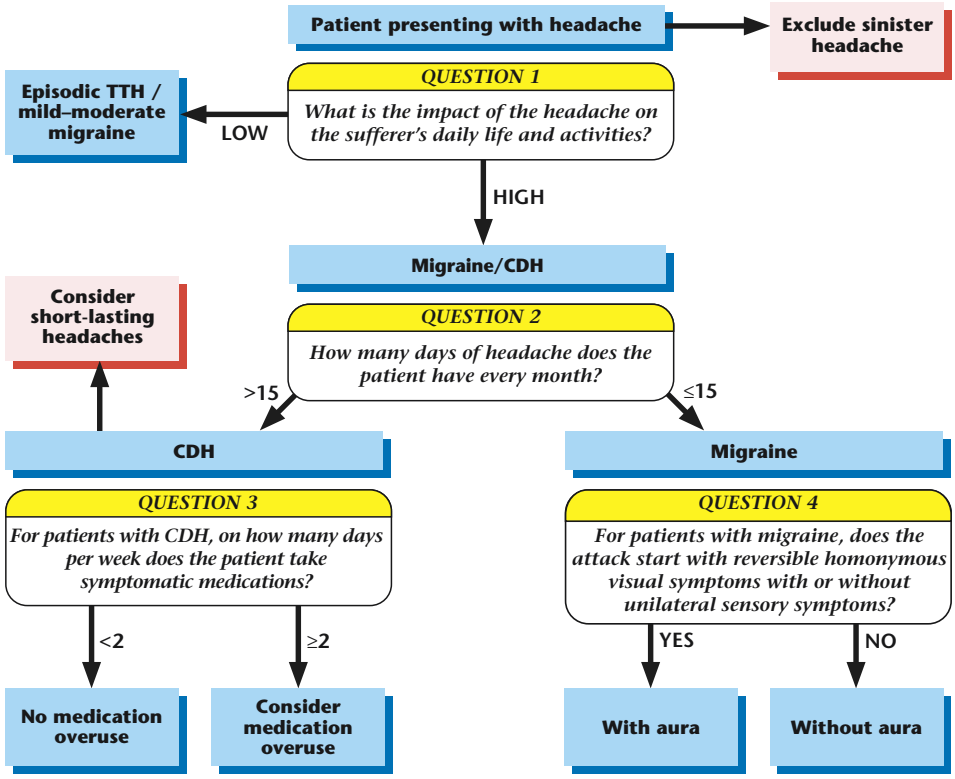

Figure 2. A new proposed questionnaire for the diagnostic screening of headache patients in primary care.[1]

Management (Figure 3)

3. Share migraine management between the clinician and the patient

The patient should be encouraged by the primary care physician to take control of their own migraine management. The physician's role is to provide education and guidance, and to encourage the patient to commit to the care management programme.

4. Provide individualised care for migraine and encourage patients to manage their migraine

Patients should be encouraged to rate the severity of each individual attack, and to treat with acute medication appropriate to the severity of the presenting attack. Patients should also have access to rescue medication for when their initial therapy fails. In practice, the patient initiates treatment for each attack with one acute treatment. If this treatment fails, they can take alternative medications as rescue therapy.

5. Follow-up patients, preferably with migraine calendars or diaries

Proactive follow-up procedures are necessary for the successful long-term management of migraine. The primary care physician should invite the patient to return for further management at regular intervals, monitor the patient's pattern of headaches, and re-evaluate the outcome of therapy carefully. Headache diaries and impact questionnaires are an invaluable aid for these assessments.

6. Regularly re-evaluate the success of therapy using specific outcome measures and monitor the use of acute and prophylactic medications regularly

The success of interventions needs to be evaluated carefully so that the physician can select the appropriate choice of treatment during the evolution of migraine management. Validated outcome measures are required, and the MIDAS and HIT-6 Questionnaires are useful.

7. Adapt migraine management to changes that occur in the illness and its presentation over the years

Migraine usually occurs over several decades of the patient's life, from childhood or adolescence into middle age, and sometimes old age. During this long time period, the pattern of headaches, e.g. their frequency, duration, symptomatology and impact, may all change, necessitating changes to management practices.

Treatments (Figure 3)

8. Provide acute medication to all migraine patients and recommend it is taken at the appropriate time during the attack

Acute medications are required for all migraine patients, as no prophylactic treatment achieves 100% efficacy and rescue medication is required for breakthrough attacks. Specific therapies should be selected based on the individual patient and their treatment goals. Aspirin, NSAIDs and analgesic-combination medications may be effective for lower impact attacks, and are best taken after the attack starts, but before the headache develops. Triptans are the most effective acute medications for migraine and should be used for higher impact attacks. Some evidence suggests that triptans may be best taken as soon as possible after the headache starts when it is mild in intensity. The use of drugs that may cause analgesic-dependent headache, e.g. regular analgesics (especially in compound form with caffeine), opioids and ergotamine should be avoided if possible. However, the intermittent and supervised use of codeine-containing preparations may be appropriate, principally for rescue therapy (although overuse and dependency should be closely monitored). On average, acute medications should be limited to use on no more than 2 days per week.

9. Provide rescue medication / symptomatic treatment for when the initial therapy fails

Patients should receive rescue medication to be used for when the initial acute therapy fails. This can be a migraine-specific medication or symptomatic therapy for severe symptoms. At follow-up, patients who have failed on previous therapies should be switched to medications that have a greater chance of success.

10. Offer to prescribe prophylactic medications, as well as lifestyle changes, to patients who have four or more migraine attacks per month or who are resistant to acute medications

Prophylactic medications should be considered on an individual basis to patients who have frequent, high-impact attacks, and/or to those who are resistant or intolerant to acute medications. First-line prophylactic medications are beta-blockers, flunarizine (in certain countries), sodium valproate and amitriptyline. Many prophylactic medications can be started at low doses, and titrated up as necessary to the maximum dose over a period of weeks or months.

11. Consider concurrent co-morbidities in the choice of appropriate prophylactic medication

Migraine patients commonly suffer from other co-morbid illnesses. The physician needs to choose the prophylactic medication carefully for these patients, as some migraine prophylactic drugs are contraindicated for certain conditions. On the other hand, some prophylactic drugs have synergistic actions on migraine and the co-morbid illness.

12. Work with the patient to achieve comfort with mutally agreed upon treatment and ensure that it is practical for their lifestyle and headache presentation

Patient preference and satisfaction are important measures of the success of migraine treatment. At follow-up, the physician should ask the patient if they are satisfied with their therapies and whether they are superior to those they have previously used. Patient dissatisfaction may be a strong driver for patient dropout from treatment. Physicians should also ask specific questions about the effects of current therapies to determine if the needs of the patient are being met.

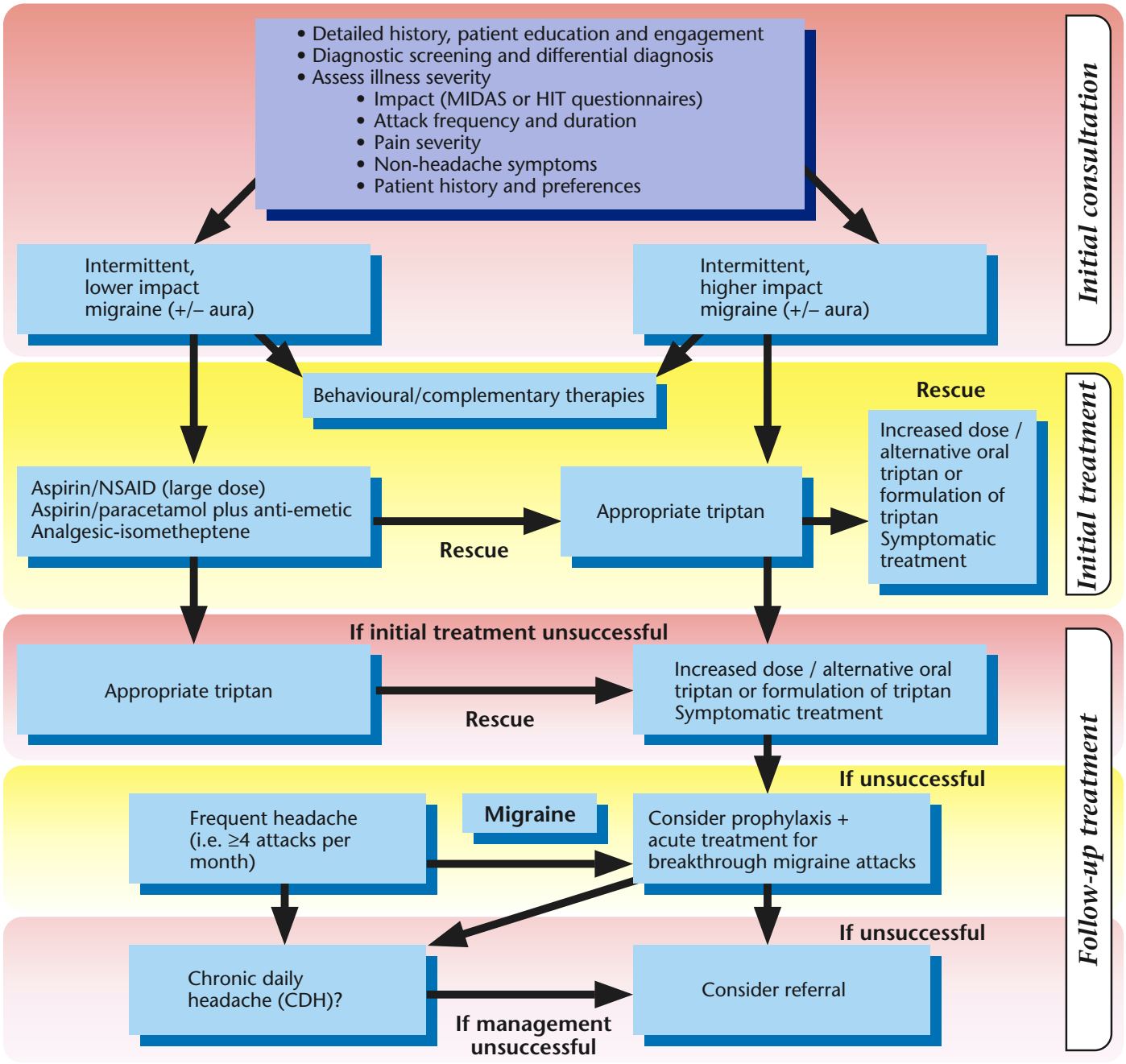

Figure 3. A proposed overall algorithm for the management of migraine in primary care.

References

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