MIPCA

MIGRAINE IN PRIMARY CARE ADVISORS

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Managing chronic headaches in the clinic

Chronic headaches constitute a range of disabling conditions that affect about 5% of the adult population, and about 2% of children. They may be viewed as difficult to treat by the GP. However, MIPCA has recently produced evidence-based guidelines for the management of these headaches,[1] which we recommend for use by the GP with an interest in headache. We provide here a brief guide as to how to recognise, diagnose and manage chronic headaches, and when referral may be necessary.

Recognising chronic headaches

Chronic headaches may be defined arbitrarily as those that occur on > 15 days per month. The International Headache Society has recently proposed criteria for the identification of these headaches:[2]

- **Chronic migraine:** the primary headache is migraine, which increases in frequency over the years. Presenting symptoms may be typical of migraine or tension-type headache (TTH).
- **Chronic TTH:** the primary headache is TTH, which increases in frequency over the years. Presenting symptoms are typical of TTH.
- **Medication overuse headache [MOH]:** either of the above headaches, but associated with overuse of all types of analgesics, ergots, triptans or combination headache medications (≥ 15 days/mo).
- **Cluster headache:** frequent (near daily to several times per day) attacks of severe, unilateral, periorbital pain lasting 15–180 minutes, with associated facial symptoms. Attacks occur in clusters, over periods of weeks or months and separated by symptom-free intervals, or chronically with few breaks.
- Several other chronic headache subtypes are recognised, but these will be seen rarely in primary care.

Diagnosis

Chronic headaches are straightforward to diagnose using the MIPCA screening algorithm (Figure 1):[3]

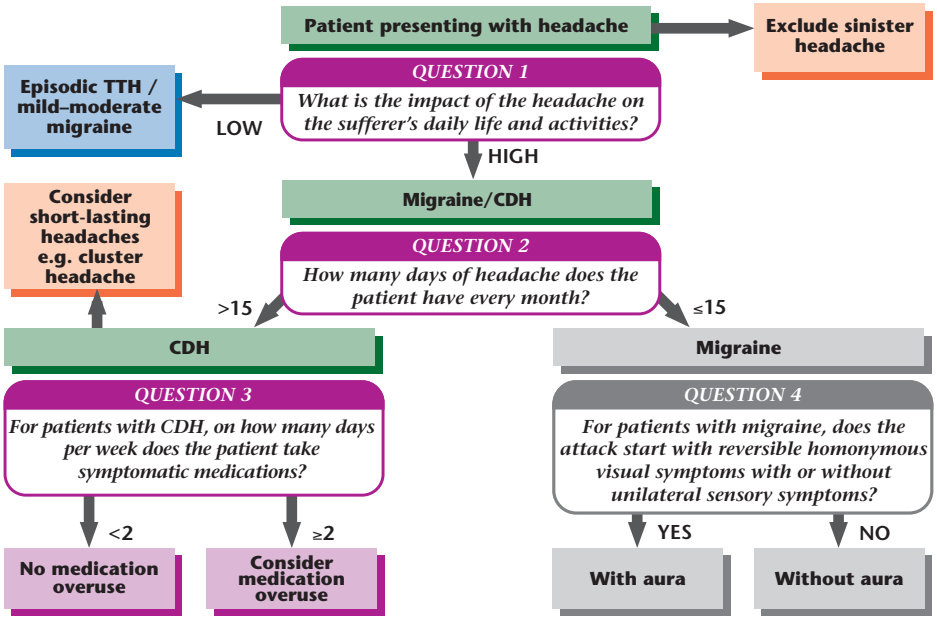

Figure 1. The MIPCA screening questionnaire for headache diagnosis (pathways leading to chronic headache are emphasised).

- Possible sinister headaches should always be excluded before asking any of the questions.
- **Question 1:** A high-impact headache indicates migraine or chronic headache.
- **Question 2:** chronic headache is indicated if the patient has headache on > 15 days every month.
  - Chronic migraine or chronic TTH are indicated if the headache last > 4 hours.
  - Cluster headache is indicated if the headache lasts 15–180 minutes, occurs near-daily to several times daily in clusters, is of excruciating intensity and accompanied by red and/or watering eyes and a blocked nose. Cluster-type headache of different durations should be investigated further and the patient referred.
- **Question 3:** MOH is indicated if the patient takes symptomatic medications (e.g. analgesics, ergots or triptans) on two or more days per week.

Principles of care

As with migraine, chronic headache management includes processes of screening, diagnosis, assessing illness severity, providing therapies appropriate to the individual patient's needs, long-term follow up, all in a team approach utilising the physician, practice nurse and other healthcare professionals.[3]

Management of chronic migraine and chronic TTH (Figure 2)

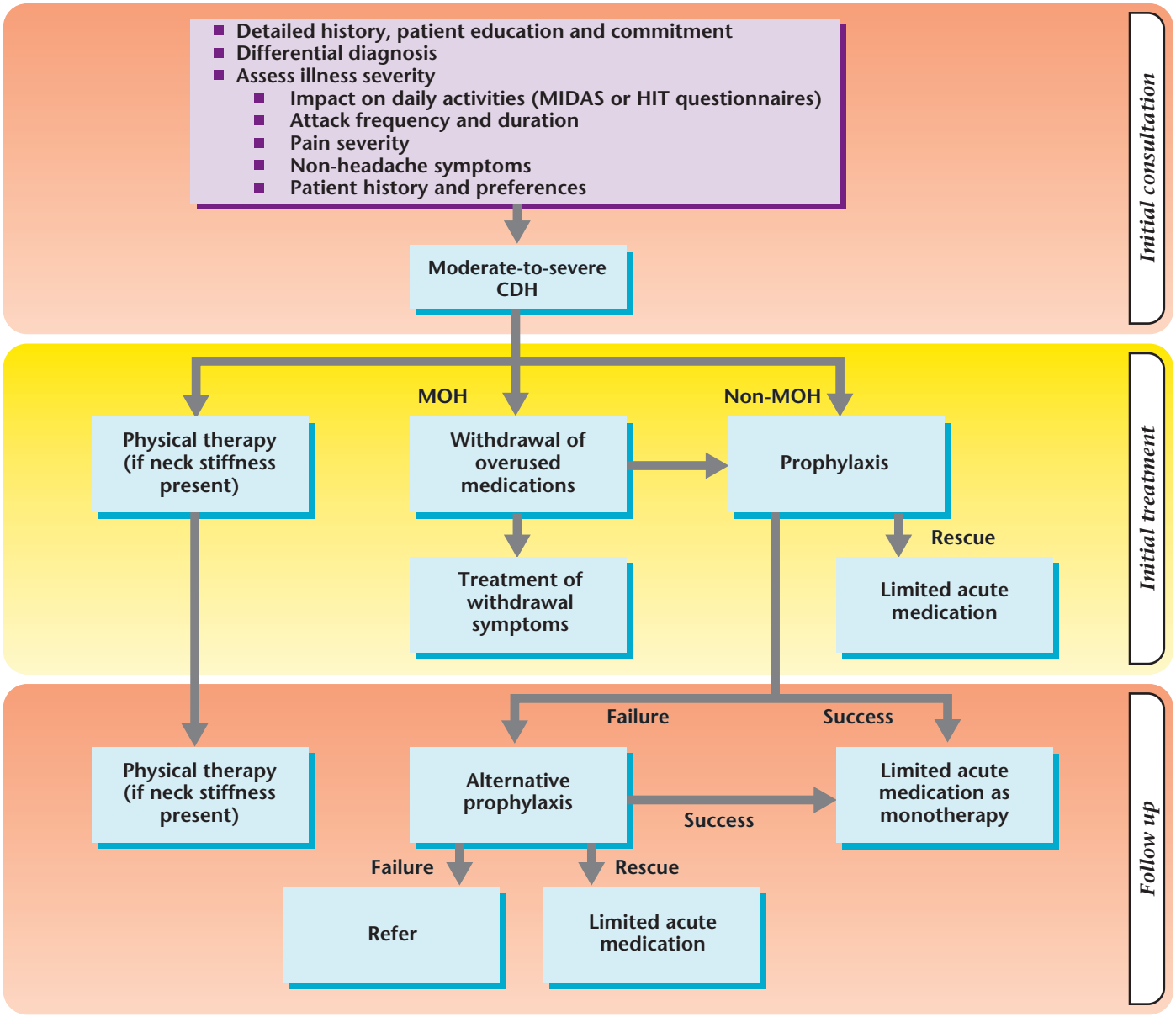

Figure 2. MIPCA management algorithm for chronic migraine and chronic TTH

- **Goals of therapy:**
  Relieve the pattern of chronic headaches and reduce the impact on the patient's activities of daily living.
- **First-line treatments:**
  - Patients with a history of head injury, and/or those with current neck stiffness or restricted neck movement usually benefit from physical therapy and exercises for the neck.
  - Patients with MOH should have the overused medications withdrawn. Withdrawal symptoms may develop, but can be managed with a 6-day course of prednisolone 20 mg.
  - Prophylaxis should be introduced to reduce the frequency of the headaches. Amitriptyline and sodium valproate have been shown to be effective as prophylaxis for chronic headaches and may be used in practice. 'Fashionable' alternatives include other serotoninergic agents (e.g. fluoxetine or paroxetine) or neuromodulator agents (e.g. topiramate, gabapentin or BOTOX).
  - Acute medications should be used to treat breakthrough headache attacks and to manage the original episodic primary headache. A triptan is the logical medication for patients with chronic migraine. Use should be strictly limited to no more than 12 doses per month.[1]
- **Follow up:**
  When a successful response is achieved, prophylactic medications can be withdrawn gradually, relying solely on acute medications for relief of the original episodic headache. However, if one prophylactic medication fails, another may be tried.

Management of cluster headache (Figure 3)

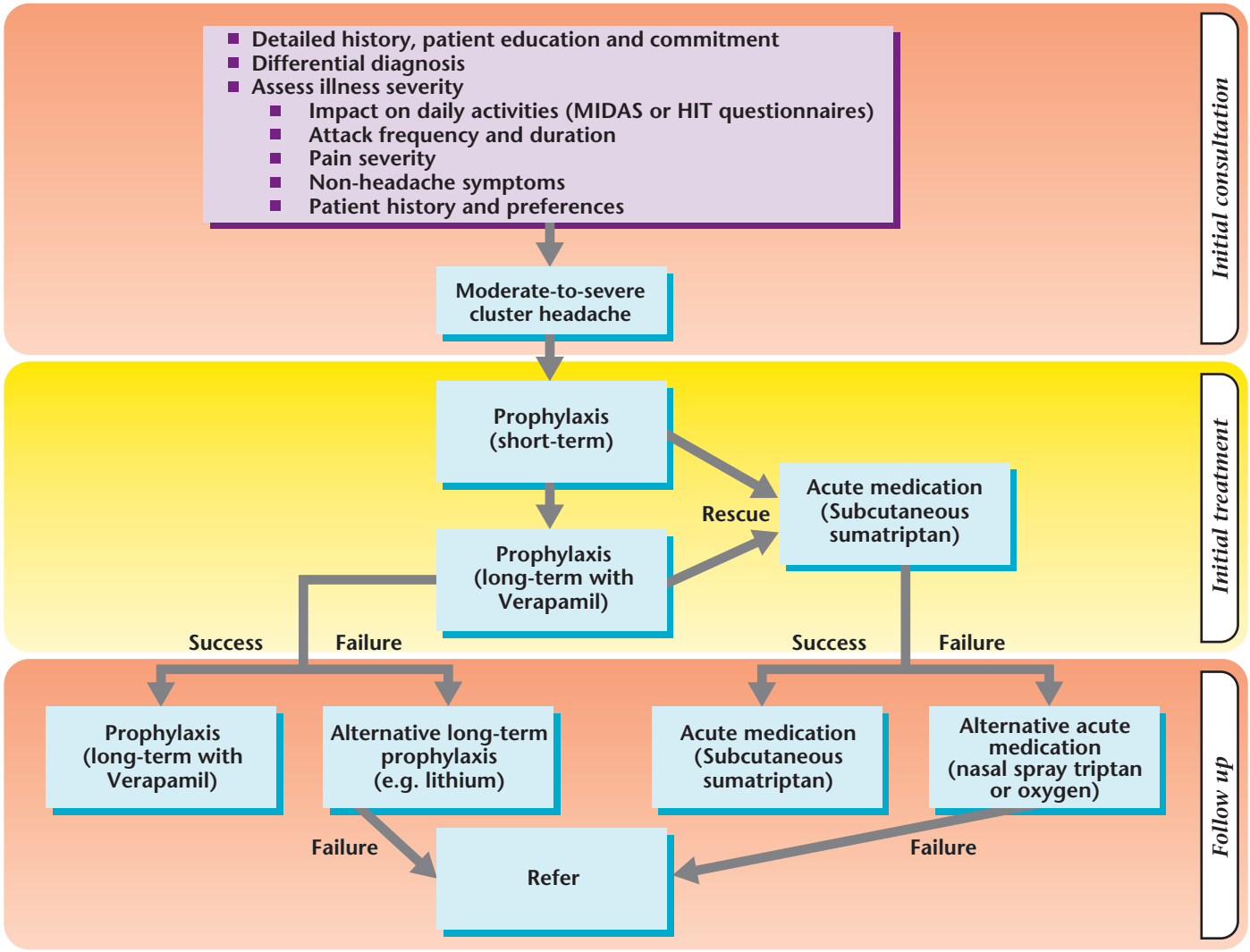

Figure 3. MIPCA management algorithm for cluster headache

- **Goals of therapy:** Prevent the occurrence of the headaches, while effectively and rapidly treating attacks that occur and reducing their impact on the patient's daily activities.
- **First-line treatments:**
  - Prophylaxis is the mainstay of cluster headache management, initiated at the beginning of a new cluster period. Corticosteroids are the preferred therapy for short-term relief, to 'buy a good week' and/or to help in the introduction of long-term prophylaxis. They are dramatically effective, but should only be used for 1 week to minimise side effects, and prednisolone 30 mg/day for 7 days is an effective first-line therapy. Methysergide and ergotamine can be used as second-line agents. Verapamil is the gold standard therapy for long-term prophylaxis.
  - Acute treatments are used as rescue medication, when breakthrough attacks occur despite the use of prophylaxis. Subcutaneous sumatriptan 6 mg is the gold standard treatment.
- **Follow up:** therapy is required for the duration of the cluster periods, as they occur. Lithium is a suitable prophylactic agent for when verapamil fails, while nasal spray triptans or inhalation of high flow-rate (10 L/min) oxygen via a mask can be used as alternative acute medications.[1] Diving masks can be obtained from specialist retailers, or on loan from the Migraine Action Association (www.migraine.org.uk) or the Organisation for the Understanding of Cluster Headache (www.ouch-uk.org).

When to refer

The GP who is experienced in headache management should be able to successfully manage most patients with chronic headaches. However, referral to specialist neurology or headache services may be necessary when:

- A sinister headache is suspected.
- The diagnosis does not clearly identify patients with chronic migraine, chronic TTH or cluster headache.
- The patient is refractory to repeated acute and/or prophylactic medications.
- The frequency of the patient's headaches increases, despite intervention.

The GP who is not so experienced in headache management may wish to refer all their patients who have chronic headaches.

Implementation of headache services in the UK

For the successful management of headaches (chronic and acute), a partnership needs to be developed between the GP and the specialist physician. A new form of intermediate specialist care is now in development in the UK, the General Practitioner with Special Interest (GPwSI) service. GPs are encouraged to develop specialist services in certain disease areas and run their own clinics. The GP with experience in headache management forms the ideal candidate to become a GPwSI in headache. A framework document for the GPwSI in headache service has been published.[4]

The lobbying group *Headache UK* has developed a framework for UK headache services (Figure 4).

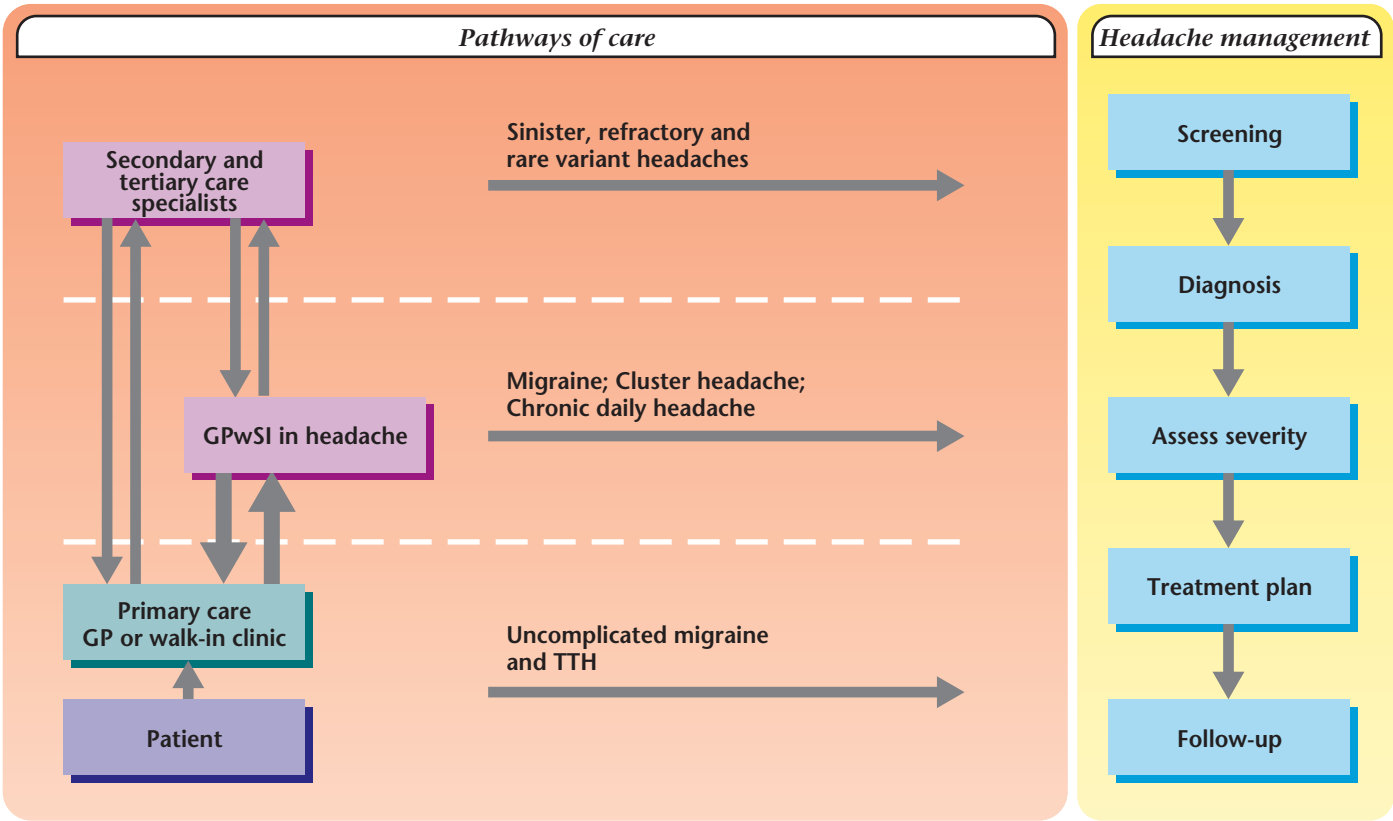

Figure 4. Pathways of care identified by Headache UK to link primary care physicians, GPwSI in headache and secondary and tertiary care physicians

- GPs and the new walk-in clinics deal with TTH and uncomplicated migraine using their own practice teams.
- Patients with chronic headaches, more complicated migraine and those with facial pain syndromes are dealt with by the GPwSI in headache, also located in primary care.
- Patients with more specialist, or more urgent medical needs may need to be referred immediately to a neurologist or headache specialist by the GP or GPwSI in headache. Such patients include those with suspected sinister headache, those refractory to repeated treatments and those with rare headache subtypes (e.g. the rare migraine and chronic headache variants). Some refractory patients benefit from referral to specialist pain management clinics, where group sessions and counselling can be made available, where necessary.

References

1 Dowson AJ, Bradford S, Lipscombe S et al. Managing chronic headaches in the clinic. Int J Clin Pract 2004; in press.

2 Headache Classification Subcommittee of the International Headache Society. The international classification of headache disorders. Cephalalgia 2004;24 (Suppl 1):1–160.

3 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.

4 Department of Health. Guidelines for the appointment of General Practitioners with special interests in the delivery of clinical services: Headache. April 2003, www.doh.gov.uk/pricare/gp-special interests/headache.pdf.

5 Sender J, Bradford S, Watson D et al. Setting up a specialist headache clinic in primary care: General Practitioners with a Special Interest (GPwSI) in headache. Headache Care 2004;1: in press.

Acknowledgements

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